Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Broken Hill Civic Centre,
31 Chloride Street, Broken Hill, NSW

Wednesday, 22 May 2024 at 9.30am

(Day 030)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**

Also present:

Mr Richard Cheney with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning, everyone. Can I begin today by acknowledging the Wilyakali people, the traditional owners of the land on which we gather today, and pay my respects to their Elders past and present and I extend that respect to any Aboriginal or Torres Strait Islander peoples here today.

Yes, Mr Muston?

MR MUSTON: Commissioner, this marks the opening of our public hearings in Broken Hill, focusing on the delivery of health services to remote communities of the Far West LHD. Over past two days we've had an opportunity to see and speak to a number of people and services that make up the patch work that come together in an attempt to meet the health needs of the sparse but important community of people that live across a very wide area within the LHD.

We visited the Royal Flying Doctor Service at Broken Hill, spoke to many of the people involved in their operations, two representatives of that organisation will be giving evidence in a moment to tell us not only about the emergency retrieval and patient transfer service for which that organisation is very well known, but also about the significant role that the organisation plays in the delivery of primary care and dental care in many rural and remote communities, and in many communities that people might not still regard as truly remote. We have heard increasingly as we have toured around the state of that shift eastward of the line where the traditionally remote forms of delivery of health care are becoming the norm.

We toured Broken Hill Hospital yesterday and were shown the operations at Menindee Health Service and Wilcannia Hospital. Each of those facilities is very different in terms of their size and scale of the services offered but they each face the same challenges that we've heard about in previous hearings, serious workforce challenges, greatly exacerbated by remoteness, increasing presentations and acuity referable to serious issues with accessibility to stable primary care, and challenges arising out of an inability, particularly in Broken Hill, to discharge older patients who are stable into residential aged care facilities, so they continue to take up acute beds, which is not good from the perspective of bed flow, if you are a hospital administrator, but far more importantly, probably the worst place for an elderly person

who is stable and not needing to be there from the perspective of their health.

Critically important in this region is the delivery of health care to its First Nations communities, and we have had the very great pleasure of visiting a number of facilities and speaking to a number of people involved with the local Aboriginal community controlled health organisation, Maari Ma. They've been very generous with their time in speaking to us, but equally in showing us their facilities here in Broken Hill and the magnificent new facility that they have in Wilcannia.

It is hoped that at some point in the future - perhaps not this week - we will be able to capture some of what they shared with us in an evidentiary form. But this week, what we have been told will certainly inform questions which we ask of other witnesses during the course of the public hearings and will guide our inquiries in that respect, as will information and experiences which were shared with us during the Inquiry's community listening sessions held on Monday and discussions we have had with other individuals during our trip around a small part of a very large LHD over the past couple of days.

Without further ado, I call Greg Sam and Associate Professor Shannon Nott.

<GREG SAM, affirmed: **[9.34am]**

<SHANNON NOTT, sworn:

<EXAMINATION BY MR MUSTON:

MR MUSTON: Mr Sam, you are the chief executive officer of the Royal Flying Doctor Service (South Eastern Section).

MR SAM: That's correct.

MR MUSTON: It's a role you have held since February 2014?

MR SAM: That's right.

MR MUSTON: And Associate Professor Nott, you are the executive general manager, health and clinical services and the chief medical officer of RFDS SE?

DR NOTT: Yes, I am.

MR MUSTON: Which is a role you have held I think since March 2024?

DR NOTT: Correct.

MR MUSTON: Prior to that, you held a role in Western NSW Local Health District?

DR NOTT: Correct.

MR MUSTON: Could you briefly explain to us or tell us what that role was?

DR NOTT: Prior to coming into this new role with the Royal Flying Doctor Service, I was the rural health director of medical services for Western NSW Local Health District. That role oversaw medical services, clinical governance, safety and quality across 35 rural and remote hospitals in the Western NSW LHD footprint.

MR MUSTON: How long did you hold that role for?

DR NOTT: Seven years.

MR MUSTON: Are there significant differences that you have observed between the delivery - or issues associated with the delivery of health care in Western New South Wales as distinct to what you are experiencing now, albeit in a different role, in the delivery of health care in Far West New South Wales?

DR NOTT: I think when you consider the roles across both health organisations, one being NSW Health and RFDS being a not-for-profit, the principles in terms of delivery and the challenges of delivery of high quality care are very much the same. If you look at disadvantage and health inequity across the Western LHD footprint, the Far West LHD footprint and the organisations that are trying to bend the curve in relation to that, we are all dealing with the same quite sinister and longstanding challenges that exist across rural and remote parts of New South Wales but more broadly Australia.

One of the continual challenges for us all is that within health care and the provision of health care, we

have significant workforce challenges and the smaller and more remote the communities are, the more sinister and challenging those problems become, and the more that we have to think about innovative ways to be able to address workforce challenges and models of care and delivering health outcomes that matter to patients particularly in remote communities.

The other thing around that, and for us, ultimately, to be able to deliver better outcomes for our communities, we must consider two things, in my opinion: one is the social determinants of health. We can address the access, we can address models of care and work with community around the health care provision at a place-based basis, but without policy, without programs that appropriately address the underlying social determinants of health care or health more broadly, so things like housing, education, what people eat, those preventative factors that we know that support wellbeing in community, we will never change outcomes for rural and remote communities. And when you consider health prevention programs and high-quality, I suppose, areas or policies to address underlying social determinants, what we need to consider is the health in all policies approach, that that is not the responsibility solely of those people that operate in the health care industry, it is a responsibility at a societal level.

The other big challenge across both roles that I have been traversing is the fact that we need to find ways to develop and run programs that are invested in terms of community need and are underpinned by holistic, longitudinal primary care. And that is one of the biggest challenges for us to be able to deliver appropriate primary care in a way that aligns with the principles of universal health care access, so looking at health care need through an equity lens that allows us to take into consideration social disadvantage, resourcing, geography, First Nations status and remoteness is incredibly important for us, and what we need to be able to do in that primary care space is look at how health partners can holistically plan around what communities need at that local level and be, I suppose, enabled to work collaboratively together to design programs that allow us to actually achieve that.

MR MUSTON: We're repeatedly told in evidence that primary health is a Commonwealth responsibility. Put to one side the technicalities around how well that might work from

a funding and legislation point of view, the reality is, is it not, that the Commonwealth doesn't actively engage in service delivery in the primary health care space?

DR NOTT: I think if we take this back to a principle level, there is irrefutable evidence that investment in primary care is the best return on investment that we can make for our health care dollar. That is irrefutable. There is copious amounts of data and evidence globally in that space. And so if our aim is to improve health outcomes, we need to find solutions that invest appropriately in that primary care space. For our communities and the work that we do across communities with Royal Flying Doctor Service, it is very clear to us also that community members do not want to be drawn into the politics, is this a state, federal or a local problem, the reality is that people want and deserve to have access to care in a way that actually meets their health care need.

If you look at a number of enablers around how do we achieve universal health care access, which is underpinned by quality primary care, the way that that should be done is around pooled resourcing, and in this country that means all levels of government being able to invest in strong primary care that meets community need, and again is applied through an equity of access lens that allows us to take into account those factors that I mentioned before - social disadvantage, health care need, burden of chronic disease.

And so for us, as an operator that works both across Commonwealth, state and alongside local councils and with community to be able to deliver health care, the matter of who is responsible or not is less of an issue; it's how do we get dollars through a pipeline to frontline services. We believe that pooled funding is a way of being able to do that, but we need to ensure that pipelines see the flow of that resourcing dollar directly to patients.

MR MUSTON: In the context of the stratified system that we work in from a funding perspective, the pooling of those resources requires in a practical sense a high level of collaboration.

DR NOTT: Yes.

MR MUSTON: Starting with your experience in Western

New South Wales, did you get the sense that that collaboration within Western New South Wales was working well in terms of pooling of resources to deliver on health outcomes in the way that you have said is so important?

DR NOTT: I think reflecting on my former roles, there is every intent to be able to work collaboratively with people, and there are great pockets of examples of that, and I think some of my colleagues in Western talked to some of those programs, so things like the Four Ts project, working with community local councils to be able to deliver care locally. But there are also examples of where that can be done better.

I think if you look more broadly at a system level around health planning, health needs assessments, the richness of data that is provided between PHNs and LHDs around health need assessment at a community level is incredibly important for us to be able to plan services.

If we take that a step further, well, what do we need to do when we recognise that there are significant gaps, significant challenges in community? How do we operationalise? How do we wrap around clinical services for those communities? There needs to be an additional step where the relevant players at a place-based and community-based level can get together and utilise that data to plan clinical services moving forward with the community at the table and applying a patient-centred approach.

This is something that we do and aspire to and aspire to continuing to do within RFDS, is working with community, understanding community, understanding the levers, the motivations, the real challenges at a local level is something that's built intrinsically as a rural and remote organisation that we do.

Being able to build that trust - and trust is incredibly important. You mentioned that the team here have been travelling throughout Far West region. You will note, just travelling and speaking with people, that trust with healthcare providers is paramount in terms of actually achieving health equity and health access.

For us, what we do as an organisation, we as the RFDS, is actually working and building that trust at a local

level and seeing our role as being able to work with community around how do we address the challenges that they see as paramount to their community, and if you look at the health planning process, that next step of yes, we've got health needs assessments done, but actually mandating a process and resourcing it appropriately that gets the right players in the room and realising that a lead player in terms of operationally running clinical services may be different in different communities because of that level of trust and that level of understanding. In some settings, that may be an organisation like ours. In other settings, it may be a state government run organisation, it may be a private organisation, it may be a GP practice that is well embedded into those communities.

So for us, I think, again going back to a principle-based approach to this, is that community trust, community understanding is an incredibly important aspect around how do we translate and action the gaps that we find through a health needs assessment into meaningful programs, and that is something that we certainly see our role as RFDS.

MR MUSTON: So in the local area, might that look something like this: to the extent that health services planning is happening, you would get your key players in a room dealing community by community with the way in which needs are identified in the health needs assessment are potentially going to be met, which locally would mean by the LHD, obviously enough, probably you and perhaps Maari Ma, and then the PHN, potentially, at least as a source of information if not potentially having some input into how primary health might be dealt with, although I gather that there is not a huge number of private primary health providers distributed throughout the more remote parts of your community, the human faces of the PHN are not really there?

DR NOTT: For us, we have traditionally operated in a space where traditional markets are not able to run. RFDS has been built from that premise of there are communities across Australia, and for us across New South Wales, that, by the way that resources are distributed in a traditional environment or an MBS-type model, there is no other providers, and for us, our point of difference is being able to operate in that way and deliver services in innovative ways to be able to actually meet that community

need, and sit down at the table, as you say, with other providers around how we can work together.

The other thing I would add to your comments is that the community absolutely need to be a key player there. There is sometimes a disconnect between what can be done and expectation, and what we need to be able to do is work around a table, around how can we deliver the best care to meet community need with the resources that we have; that also, as I mentioned before, there needs to be an understanding - and, as you have mentioned, there are different levers of funding components that each of those players can bring to a table - districts will have access to different funding programs to PHNs.

One of the challenges for an organisation like ours to be able to get those dollars coming out of the purse or purses, we have to apply in multiple different ways to try and get programs run and funded at a local level.

If you were able to have a forum that allowed us to sit at a table, plan with those key players and streamline the way in which money is filtered at a community level and also made more efficient so that the money that is delivered at a community level is streamlined and synergistic, as opposed to fragmenting and causing potential overlap - unintentionally - that would be better overall for our vulnerable communities.

MR MUSTON: Might that potentially mean where there is, say, some grant funding available as part of this roundtable discussion, yourselves, the LHD, Maari Ma, at least as the potential recipients of that funding, might sit down before anyone's started to actively compete for it and say, "There is a funding source. As a group, how could we best use that to fill part of the patchwork of services that we're delivering? This is the way we're going to do it. You apply for that grant funding for that purpose; we over here, we obviously won't do that, but we might have something else that we are doing over here that as a group we have collectively decided is the best way to utilise all of the available funding sources that are out there."

DR NOTT: Yes, and collaborating together around how that can work. Ideally, in an ideal world, we look at this longitudinally, but the challenge with grants is that they are time limited. For us to be able to recruit staff into

time limited roles, particularly in really remote and rural locations, is incredibly challenging because, just think of it for yourselves, would you apply for a role that's only got secured funding for one year, relocate your family into a remote location, for one year worth of work? Or would you do that for something that you might give you a guarantee for five or 10 years? So there needs to be a challenge around the way that we look at opportunities to fund programs that are addressing key challenges and health needs for communities as well.

MR MUSTON: Does that potentially mean starting with an identification of the programs that would make up that best fit health service within what seems to be reasonably achievable, and then finding funding sources to meet those services rather than doing it in reverse - identifying the funding source which might be tied to something and thinking: well, that would be pretty good if we could offer that, so let's, if we can get that, plonk that in there. If we can't get that, or if it disappears after a year because the funding disappears we'll stop doing that?

DR NOTT: Yes, and there are examples across many parts where services that have been doing great work, because of the funding cycles have had to cease, and the reality is that the people that are at the end of that are people who need those services the most. And for us, also, it's building into an evidence base around how are we adding to or changing, shifting the dial or improving health outcomes and working on ways that we actually, within funding cycles or programs that are run, are evaluating those and having the space for evaluation to make sure that not only the programs that are being run are meeting the need that they are designed for, but how do we also improve those moving forward?

MR MUSTON: You talked about the critical importance of community involvement, so just stepping that through as a group of potential deliverers of health services, you might sit down initially, look at the health needs assessments that you have got, workshop ways in which those needs might be met collectively by your respective organisations, and then bring the community in to talk to the community, whether it be the local council, whether it be representatives of the local First Nations community - in each little community there will be different groups

which probably are important to be part of the process - you would talk to them about the health needs assessment information that you've got and the way in which it might be met with a view to seeking their input on whether or not they are the needs and, if so, is it the right way to deal with them?

DR NOTT: Yes. So my experience in working with community and certainly something that we've found as an organisation is that data only tells part of the story, and particularly in remote communities being able - and I think for - the principle of co-design is empowering communities to be able to help be part of the solution and be empowered to be able to contribute to solutions. Part of that, as health organisations and subject matter experts in this space - health, I don't need to tell this Inquiry, is incredibly complex - for people that are on the receiving end, the complexities are not necessarily obvious.

So part of what we need to do for true co-design is, yes, present this data, sense check it around is this actually what you were seeing on the ground? Is this what matters to people? Is this what people are chatting around the cafe or the post office or whatever venue people gather around? Is this the thing that keeps people up at night?

In some circumstances, people say "Yes", in others, they will say, "Actually, you are missing out on X, Y and Z." So there needs to be a marrying up of the data versus patient community feedback and, then, also in terms of improving that health system, literacy and knowledge around how do we translate that knowledge into actionable models of care.

Now, this is something that, for us, one of the most important aspects of our organisation is the community engagement team. The community engagement team go out to community and have these conversations. They sense check what we're delivering on the ground. They also work with community around what we are offering, because you can create services, but if people don't know about them or know how to navigate them, then those services are not meeting the mark. And so, for us, everything that we do, particularly in that community primary care, dental, mental health space, is grounded by our connection with community, and that's where we see a real difference in terms of the approach that we take to some other organisations.

MR MUSTON: So you mentioned a moment ago the importance of evaluation. Does that work at two levels - evaluating it from the point of view of assessing the health outcomes longitudinally to the extent that you can, based on data, amongst other things, but also, is there an important need to continue to work collaboratively with the community that is being served by these services to make sure that the way in which they are being delivered is actually working and, if not, what is it that they can tell you about how those services need to be changed, for example, to make them more accessible or more desirable from the perspective of the end consumer?

DR NOTT: Absolutely. One of the key components that I see as incredibly important around evaluation is actually consideration of the quadruple aim, so the data in terms of patient outcomes and then I think the key component that sometimes we forget as we research or evaluate is that it's not just patient outcomes that we perceive to be important; the premise of the quadruple aim is that the patient outcomes that matter to patients matter to community. And so part of that design around how do we quantify outcomes needs to be also a co-design process around, well, what matters to you? Other aspects around patient experience. So integrating within our evaluations the experience that patients have within the system, clinician experience in terms of delivering that care, and then looking at the system-wide impacts, whether that's through an economic lens, through a community lens, through the broader social benefit that our health care programs bring.

Those four broad areas are what most, in my opinion - and certainly in the experiences that we're progressing as an organisation with RFDS - should be measured and reported on and add value in terms of the evidence base that we are providing in terms of rural and remote health care.

MR MUSTON: Measuring those things is very difficult, is it not, if you have strictly siloed modes of delivering health care - acute on the one hand, sitting in its own silo, primary care sitting in the other, and allied health potentially sitting in a third silo - working out what's important to a community member who has received health care, for example, someone who has had a knee replacement, it may be important to them that they can go and do their shopping independently, that might be the outcome that

really matters. That's not something you can really pick up if your information ends at the point at which a clinically better person is discharged from your acute facility.

DR NOTT: Correct. We need to - the reality is that humans are not a conglomeration of diseases or individual sort of systems. They are people. And for us, in terms of health care, it is understanding that patient-centred aspect of care; the community-centredness that many rural and remote people see themselves fitting within; and how do we actually make sure that we are gauging that.

There are systems around - complex systems around patient reported outcome measures, but you are right, the challenge in this space around how do we look at a sort of system-wide or a community-wide wellness or health care outcome scale is challenged because evaluations usually are refined around a service, a program that has these imagined or refined borders, but the reality is that health care or health access, health outcomes, transcend programs, or go beyond disease subsets.

MR SAM: If I may, I think what you are suggesting is what we would see as the model, that what it requires, though, is a resetting, I guess, of the priority of that approach relative to the major driver still around episodic care, of getting people into care, through care, out of care.

It speaks, as Dr Nott said, to the idea of how do individuals and communities hold a health relationship over time, and in failed and thin markets, it becomes even more important that it's as much around the strength of that relationship, exchange of information, exchange of being able to manage with finite resources, and variable access that will change over time.

In a rural context, and particularly in a remote context, one can't make an assumption that you are going to hold a treatment pathway or a care pathway consistently over time for a variety of factors, whether that is the availability of clinical resources or just trying to prioritise demand, or in fact that individuals and community needs will change quite rapidly. Holding some form of overarching relationship with the community that can help meter that change within a straight sort of service provision model is also something that's quite

lacking here.

In a metropolitan context, if you are seeing your general practice three or four or more times a year, with some continuity of a relationship about your health and wellbeing, you are engaging your dentist, your chiropractor, your mental health professional, your community health service, there is some constant reinforcing around the holistic view of what your needs are over time, and that being underpinned by commonalities around recording medical records, so that everyone who is participating in that shares in your overall provision of care is what underpins good primary care.

In a rural context, that is much more difficult, because of all those other factors that enable that at times are - and in most cases - challenged.

So I think reframing the approach to how we provide or how care is provided over time requires some commitment and continuity of it, rather than saying "We get together once a year, we get the map out, we see who is around the table then and decide how that care will be allocated and managed. We fund it and then we come back in a year and evaluate it". I think that still has a lot of limitations in terms of how iteratively the system works together, and that's probably the next major need at the moment.

MR MUSTON: So without needing to identify with real precision whether it is a fortnightly meeting or a monthly meeting, the general thrust of what you tell us is it is not just about a periodic planning process where everyone gets together with their ideas and then walks away and continues to do independently the things that they do but, rather, that planning has to happen collaboratively and then --

MR SAM: There should be a shared responsibility and accountability for monitoring that, as all services will within their own domain. But that collective view of more frequent monitoring of community-based need, without a single responsible entity, becomes difficult and often impossible.

DR NOTT: Just to add to that as well, one of the things that we need to consider is that to do what Greg has described well requires resourcing, and a lot of funding is

targeted towards the doing piece - not the planning, not the evaluating, not the consideration of are we doing what is right, are we addressing the challenges that we have identified. So there needs to be some sophistication and acknowledgment of the real challenge that to do this right, to plan our services and to operationalise them in a sophisticated way that means something to people, that has to be resourced appropriately.

MR MUSTON: I will come back to that. It's probably a useful segue, though, as we talk about bringing all the pieces together, for me to ask you, Mr Sam, probably the most appropriate person to answer this question, but Dr Nott, jump in if you want to add to it or pick it up. What are the services that the RFDS is delivering into the community of the Far West? We all have childhood memories of the television show where people who had suffered a trauma on a farm or bitten by a snake were picked up and taken by a fairly sophisticated airborne ambulance, but what is it that the RFDS actually delivers into this patchwork of services.

MR SAM: We still do that and still make television shows about it, I might add. However, I think our core role as an emergency service, the mantle of safety, is still very much at the core of our purpose and mission. That speaks to sort of locational presence and also extends to the fact that part of our role is really breaching the access divide to get people in to care and to get people - or care to people.

So we have a primary role, still, in emergency retrieval. We support the movement of patients across the health system as well. So both in terms of moving patients from the site of trauma or, indeed, the site of an emergency event, but moving patients between hospitals, particularly from sort of lower levels of hospital into a higher acuity or a more tertiary context, so we fly a lot of patients from rural areas into regional and metropolitan services and back again.

We also move patients who have less acute requirements - that is, a lower emergency level - again, moving them into care, out of care, but also providing support through that process.

However, in the last decade in particular, the

majority of our patient contacts now are in a primary care context, and that has seen us respond to both a need and a demand, particularly for general practice primary care and mental health services in rural and remote areas, dental services in particular, alcohol and other drug services and, increasingly, trying to fill some gaps in a few allied health spaces.

Perhaps the most significant driver of how our service has evolved has been the shifting pattern of availability and access to a broad range of services within community, which this Inquiry will be well versed around, particularly primary care, but also, I think, the rapid decline of what was a longstanding model into rural communities of a general practice and associated relationship with a small hospital or a hospital within proximity, where the relationship between primary care, general practice during the day, and the hospital being able to provide some form of acute care, serviced quite a need.

With, I guess, rationalisation of service and role delineation amongst health facilities now, that is quite dispersed. With the decline of general practice, again, that relationship within communities about who holds responsibility for care has declined, and we have increasingly moved more and more into more communities providing a broader range of services.

MR MUSTON: In relation to that, is the anecdotal sense that we have, or that seems to be developing, that that line beyond which primary care is traditionally met by organisations like yours is creeping eastward. As a deliverer of those services, is that something that you have practically observed in terms of the way you are delivering services?

MR SAM: Yes. So I think there is a definition issue, if I may, around the concept of primary care. Often, it is assigned to the MBS or Medicare-based system as an insurance that drives a funding source for primary care in a general practice context or a primary care setting. There is also the definition that says it is where you receive your care and from whom, and what is that care that you are receiving, across a continuum of primary prevention through to a range of subacute intervention. But as a charity, our organisation fundamentally has grown and evolved from being a failed market solution, that we were

able to invest through various funding sources into the provision of services and grow, by attracting funding, but importantly, 50 per cent of our funding comes from fundraising and donations. So our appeal to the community has broadened to say, "In supporting the RFDS, you are supporting now a broader suite of services, particularly primary care, in addition to those traditional emergency services."

The challenge we have had is that as a failed market, and increasingly now more into what I would call thin market environments, that we often sit in the cracks between the traditional funding lines for the provision of health service and, like many for-purpose, and indeed for many health organisations, now compete pretty much exclusively for all services that we provide and over time the level of investment we've had to make in our own fundraising has not kept up with the cost of being able to meet this increasing demand and the complexity of service provision, which again will have been stated many times through this hearing.

As a result of that, we've lost our capacity to see a lot of growth and development into markets that have failed, so we are responding now primarily to emergent needs, and we are more reliant upon other systems for our funding to provide care.

So our model has evolved but our ability to act and self-determine and self-direct a lot of our own resource has been diminished quite significantly over the last few years.

MR MUSTON: In terms of - I just want to explore the concept of a failed market that you have spoken of. Would it be right to assume that, historically, there was a primary care in the sense of GP based primary care or care that would traditionally be GP based or community dentist based, which was always delivered by the RFDS in areas that were so remote that there was no market, failed or otherwise, no doubt you have examples of towns over the history or your organisation where it has always delivered the dental care and GP based check-ups and primary care; would that be right?

MR SAM: That's correct. The focus had been very much on casting a relationship with remote communities,

fundamentally for providing that emergency coverage, so a 24/7 availability.

Whilst we were waiting - so the concept of if we're not retrieving you, we could utilise resources to provide some remote outreach clinics, and these were largely fly-around or drive-around clinics using the resources within the service that would have otherwise been used just exclusively for emergency care. So that was, and still remains, I guess, a core amount of our service. However --

MR MUSTON: Is that different to the failed markets that you are talking about?

MR SAM: Well, markets are failing and I think what is different is that that line, that geographic line and demographic line, is now sort of moving eastwards, and so what we're seeing now are communities that aren't classified as the most remotest, without service, and we are increasingly being sought by communities, and others, to provide services into those.

So it's an expansion, I guess, of the failed market concept, and what is now seen as a thinning market, that once one or two threads start to disappear in community, you see an inevitable decline in the availability of other services.

THE COMMISSIONER: Can I just ask a question so I understand this. We haven't mentioned this statement yet, I don't think. Is that going to go into evidence?

MR MUSTON: I think it is probably not. It's a joint outline, I think --

THE COMMISSIONER: Do you have the outline of evidence that was prepared? Can you just look at paragraph 6 for me and help me with - in paragraph 6 you talk about in the last four years alone you have provided more than 300,000 occasions of care, and in (ii) and (iii) - (ii) there is a mention of 28,700 GP medical practice consultations, and in (iii), 30,000 primary health consultations. What's the distinguishing factor between those?

DR NOTT: So the distinguishing factor between those is that we wanted to highlight the difference between, I suppose, the services that we've always provided in rural

and remote settings, so the 30,000 primary health care consultations are a mix of both nurse-led primary care clinics in incredibly remote locations and, as Greg described, the fly-in fly-out or drive-in drive-out communities that we've served for quite a long time.

The growing space is that point (ii) that you have highlighted, the 28,000-plus GP medical practice consultations, and this is to the point that is being made around an increasing draw or requirement or pull from communities for us to step into a traditionally MBS-run primary care market, and I think there may have been evidence already within this Inquiry that in our Western New South Wales PHN footprint there are predictors of the 41 towns across its remit that may be without a GP practice within - by the close of the decade.

Now, that should ring significant warning bells for everyone across that geography. A number of practices are sole GP practices. A number of them do not have succession planning or clear lines of succession planning, and the pipeline for GP workforce --

THE COMMISSIONER: There may be no-one willing to step into the practice or buy the practice.

DR NOTT: Exactly. The pipeline we know nationally, general practice - taking aside even the challenges of rural/remote - nationally, metropolitan, rural/remote, regional, there is a declining interest in medical students wanting to enter general practice. So not only are we seeing a gap, but that gap is widening. And so if you look at compound annual growth rates of medical specialties across this country, regional and rural are actually - we are bending the curve in most sub-specialty areas except for the specialty area of general practice.

So in every other area, as cohorts, medical sub-specialists are growing higher in regional areas, so we're doing something right in that space. But in terms of general practice, if you compare metropolitan compound annual growth rates of people entering general practice in this country in urban versus rural/remote, urban continues to increase at a rate higher than rural/remote. So not only do we have a gap now, the gap is widening, and if we had the sophistication to split that out between regional, rural, remote, you would probably see that the rural/remote

are declining or sort of growing at a rate that is a lot less than the combined figure.

So we do have a significant problem here, and what we need to look at is actually also workforce solutions. The pipeline needs to be fixed, and it needs to be fixed now.

The challenge with us, if we implement evidence-based programs that allow us to promote rural health and rural GP careers, we will have a gap of approximately 10 years before we can start seeing the fruits of that. So in the meantime, there needs to be considerable work done around how do we maintain, one, the workforce that we have at the moment, how do we support them; but also, how do we create models where we know - and the numbers are suggesting that we will have less people on the ground to do the work that is likely going to grow as well.

THE COMMISSIONER: Can I just also while we're on this before I go back to Mr Muston, just on this paragraph, looking at (iv) and the 14,000 mental health, alcohol and drugs consultations, is that also a growing area of services that you are providing?

DR NOTT: Yes, and a significant one in terms of the demand on our services, the extent and the programs that we are growing in partnership with the local health district but also off our own resources as well, that is a growing space.

If you look at some of our traditional mental health programs, they have been in that space of there is no other provider. But - and I just met with our mental health team yesterday - the work that they are doing is increasingly so in town that is may have had some of these services provided through other means, and also the services that we are providing in that space are increasing in the diversity of those. So through programs like We've Got Your Back, where we're training up people within community to assist in the sort of mental wellbeing of community members, programs that allow us to get nurses or mental health clinicians into communities where we can intersect with existing service providers.

If you look across the PHN footprint in this part of the world, our rates of mental health presentations are significantly higher, it's around 50 to 60 per cent higher

than the rest of the state. The challenge with that is that not only is there a mental health and wellbeing challenge there, but we know that people who have poorly managed mental health disorders or challenges are actually disproportionately affected around their physical health outcomes.

And so that flow-on effect actually creates a much - much more pressure on the system, and that again leads back to some of the conversations we've had earlier around how do we get in front of this, how do we keep people well in community, how do we resource appropriately programs that get out to community on the ground and are able to assure that people don't end up in acute care facilities.

MR MUSTON: In terms of the GP medical practice consultations that you have told us about, that distinction between the more traditional primary health consultations in remote areas and the GP medical practice consultations, are they consultations which occurred in facilities like the one that you operate now in Warren?

DR NOTT: Yes, correct.

MR MUSTON: Could I perhaps just ask you to give us a little bit of history as to how that Warren project came to be?

MR SAM: Yes. So, previously, the administration of that practice had been managed by a workforce agency in consultation with local government and the practice itself.

MR MUSTON: Just pausing there, the small town of Warren in Western New South Wales had a GP practice which provided primary care to the people of that town.

MR SAM: That's correct. It was, I guess, supported and administered as a practice - supported by a workforce agency as well. So it fundamentally operated as a small private business, but supported in terms of how it, as a quality practice, would have registrars, et cetera, pass through.

MR MUSTON: Could I, just in terms of the support, just unpack a little bit how that operated? We can imagine the small private practice in a town has one or more GPs who are the owners of that practice and deliver the medical

care whilst also dealing with the back-of-house side of running a medical practice. What was the support that was provided by the workforce agency?

MR SAM: It was largely to provide, I guess, corporate type support services, but also to help with, I guess, the management of workforce through it, so to enable continuity of care in those small towns, to enable locum relief, for example, and other types of support, with a combination of I guess the ageing GP workforce, and we know that's another major issue about general practitioners intent to want to retire, and the declining financial viability of Medicare billing, so that the economic viability of supporting those practices all started to decline around the same time, and with the withdrawal of the workforce agency support for that, which was their decision, that town, in particular local government, saw that the inevitability was that that practice would close.

MR MUSTON: Pausing there, who was funding the workforce agency to provide that support?

MR SAM: It is a combination, but largely there are both sort of Commonwealth and a range of different fee-for-service arrangements.

MR MUSTON: Sorry. I interrupted you.

MR SAM: It was the local government who first reached out to us, because we provide some primary care services in and around that district, so they were aware of our presence. We had also operated general practice services out of a clinic here in Broken Hill, which a lot of people in Western and Far Western New South Wales were aware of. So those discussions began largely with local government about (a) their need and our interest, and it evolved from there.

MR MUSTON: When you say it evolved, what was the process that led to --

MR SAM: The process was really a decision for our board to consider taking on an ownership model of that practice, and then working with the staff there to transition over to becoming employees for RFDS, and that we very heavily focused on continuity of care through that. So it was really a quick transition once we had made an assessment of (a) were we able to support it; and was it aligned,

I guess, to our own health services plan; and, indeed, you know, does it still meet our mission requirements of access to care. The board and our members were certainly of the view that it was a good thing to do, and that has happened on four occasions now. So there are similar communities that we've gone through a very similar process.

MR MUSTON: In terms of the question that you ask yourself, are we able to do this, there are at least two considerations that feed into that, I assume. The first is economically or financially, is it viable for us to do this, having regard to the MBS billing that it might generate coupled with other potential sources of income; and, secondly, workforce considerations around the ability to actually staff it. Going through them in turn, what was the thought process or what is it that makes it viable for you as an organisation to do that work?

MR SAM: The first thing is really we don't have a profit motive, so there is not a specific economic threshold that we test assessment against. It was really looked at in a broader context of what is the value of us being able to operate and not lose money as a charity. We were also seeing that there were a number of reforms proposed within the MBS system, the changes to MyMedicare, which hopefully were going to increase the potential billing. And in terms of the workforce consideration, we see a future very much around being able to look at, I guess, integrating practice based general practice - that is, fixed general practice in community - with the way that we want to evolve our primary care offering more generally, which is community based but also remote based.

So it provides us with more infrastructure within small rural communities with which, in the future, we can use to grow and enhance, I guess, our ability to reach into more remote areas.

So it fits more broadly with our aim to provide more care in more areas that are under-serviced, and it also enables us to evolve capacity and capability within the Medicare system.

DR NOTT: If I may, in addition to what Greg has mentioned, that capacity and capability piece, for us to build - and Greg mentioned about the workforce side of things - for us to be, I suppose, part of a solution, to be

able to address access to quality medical professionals and more broadly clinical staff to meet needs of community, we need to also transition into a workforce training environment and an environment that allows us to be able to provide, one, at the centre, patient-centred care, but, two, also, how do we look at succession planning, growing our own, supporting community in terms of being able to get more health professionals out there.

The space in which we've found ourselves in this, I suppose, more traditional GP practice environment allows us to also support the training system. It will allow us to be able to bring GP registrars through, so GP trainees through, give them positive experiences in rural and remote, but also working alongside the local health district, so for instance in Warren, we could use the example, but other places as well, we have arrangements in place where we can work collaboratively with the LHD to be able to utilise our workforce, as we grow it, to be able to also support the local hospital. So the Warren Hospital and Gilgandra don't necessarily have a full complement of medical staff particularly to be able to service those hospitals, but as we grow, we see our responsibility as not just a not-for-profit that's going to look after our own practice, but we've got a responsibility and an obligation to be able to support the community need.

If you take the concept of rural generalism, so The Collingrove Agreement, which essentially is that there are specialist GPs in community that have advanced skills to meet their community need and support the acute care services as well as their primary care obligations, that is a space that we, and the board, have very much an intent to be able to work within.

If you expand that beyond the medical space, about how do we have rural generalist nurses, allied health, we need to be part of that solution, and for us to be able to have the infrastructure, the spaces in terms of being able to have safe and positive training environments, we'll be able to continue to grow our workforce in partnership and collaboration with local health districts.

MR MUSTON: Are there any particular challenges in terms of the way in which those services are currently funded which stand in the way of you achieving those objectives or potentially even expanding your operations to pick up need

in other thin markets?

MR SAM: I think there are obvious challenges with the viability, I guess, of the current Medicare-based model, particularly in communities where that volume and economy of scale at times is hard to predict or, indeed, to plan and budget for. It's still very much seen as a community service.

Secondly, I think in relation to an earlier comment, the role of general practice and general practitioners and the primary care workforce that centre around a general practice in relation to the rest of the health services, as Dr Nott has said, it varies from community to community. So GPs may in fact provide services to multi-purpose centres or hospitals as part of local workforce, and so the interrelationship between that can be challenged if those other services are also changing. So the model within community can be quite dynamic.

I think the final thing to say is that the challenge is really just being able to coordinate across so many different systems from a Commonwealth and state and local perspective, and I think that speaks potentially to an opportunity for us, as a for-purpose organisation, to be able to, if resourced, take on that role of I guess representing community interest and holding that relationship with community that we spoke about earlier.

So I think overall it is very much an innovative model for us to step in to general practice in this form, but we see that it's going to have benefits, provided that we can maintain that quality and workforce component.

DR NOTT: One thing I will add in addition to that around the resourcing component is that it takes time, effort and investment to proactively and positively train a next generation of health professionals. Again, going back to some of my previous comments, we aren't always resourced to do that component. There is the doing of delivering care, which is central and incredibly important, but the planning pieces that will enable us to do that effectively, like workforce training, are a challenge.

One of the things that has potential for unintended consequence is that as state systems look at incentivising within state organisations, workforce, it will create

further, I suppose, inequity in terms of those that want to enter a primary care space. So if, for instance, there was a scholarship designed for only health staff, that puts us behind the eight ball unless that is actually going to be extended beyond, and that actually disadvantages these small rural communities, because, as Greg said, there is not the activity or space for us to sort of have this wall up between what is state acute care and what is primary.

The more rural and remote you get, those spheres essentially become one. It is the same workforce trying to achieve the same things, and so we need to look at incentives that work for the community and meet that overarching aim that we are all working toward, which is improvements in health care.

MR MUSTON: Is that really a facet of the place-based pooling of resources that you opened with?

DR NOTT: Yes.

MR MUSTON: That indication that getting together all of the resources, both financial and other resources, that are available to meet the needs of the community and working out the best way to distribute them is impacted adversely if only part of those resources, in a workforce sense, have access to certain incentives or at different levels of pay or conditions because of awards being different and the like, so all of these little issues can contribute to making it more difficult to do that single place based pooling of resources, planning of the way in which those pooled resources will be used.

DR NOTT: Absolutely agree.

MR MUSTON: You told us. I think earlier on, Greg, that something in excess of 50 per cent of your organisation's total funding is derived from bequests and donations, and I think presumably also the sale of bears and T-shirts and all those other things that organisations like yours do as part of their fundraising activities. Do we take it from that that the moneys that you are receiving for the delivery of your core business are not sufficient for that purpose? Perhaps let's break that down into a few components, and look at the primary care in Warren, for example?

MR SAM: I think, perhaps to contextualise this, our traditional services that I spoke about before, which is the retrieval into remote - what I will loosely call the failed market traditional services of RFDS - was always I think supported and enabled by both community and government on the basis that we would make a contribution. So it was very much the essence of how the RFDS operated traditionally.

What we've seen increasingly, and certainly in the last decade, major reforms to the way that funding into the for-purpose sector is provided, so a big shift away from block grant funding to, I guess, competitive based service level agreements, which has, on one hand, I think, increased the efficiency and the accountability of services. However, the downside of that shift is it's largely a model which suits high activity and high population density. So a shift to activity-based price-based services agreements has put additional pressure on the fact that per capita, it costs a lot more to provide that service in a remote context.

Secondly, our organisation and our board are quite committed to the fact that we base and centre our services in regional and rural, and hence our most populous bases from a workforce point of view in New South Wales are in Broken Hill and Dubbo, and that brings with it the set of inflationary drivers that rural has generally. And we've seen significant increases in our cost base, particularly through COVID and emerging from COVID.

The third element is we are a highly regulated entity. We operate in an aviation context, a health context, and we are a charity, and we're rural and remote. Each of those elements require us to commit more and more of our own resource to maintaining standards compliance, et cetera. That is not generally built into activity-based service provision.

So in general, what I would say is that we have transactional relationships with funders that put a lot of emphasis on quality and accountability and efficiency. However, it has come at the cost of, I guess, our core funding into supporting our fixed costs, our infrastructure costs, our compliance costs, et cetera, and as our service has grown, the workforce has grown considerably, and that has also been a major driver of cost escalation, because we

are now competing with a health system which in and of itself is suffering the effects of workforce inflation.

The power of the brand, if I can call it that, as a charity still has a high level of attraction. However, the idea that we can offer anything other than at least parity in terms of employment, employment conditions now is almost a standard. So we have to meet the same workforce, employment, salary conditions as those services that are operating around us. So that has been a major driver.

In terms of the cost for our Medicare billing GP practices, we're very cautious to make sure that we don't, I guess, diffuse our charity work into operating these practices along commercial lines and they are accountable along those commercial lines, hence my earlier comment about we assess that before we make a decision to move into that.

I think it's recognised that our cost base fundamentally has just failed to - funding has failed to keep up with that, and that's our single biggest issue, which means we are now diverting the majority of our fundraising money into sort of paying utility bills and supporting keeping the lights on at both Broken Hill and Dubbo bases, where previously we were operating surpluses built around the fact that our fundraising was where we could direct our services and determine to go into those so-called failed market communities.

THE COMMISSIONER: Your fundraising, is most of it, of the donations or bequests made to your organisation, just for general use, or do some donors say, "I'm going to give you X dollars but I want you to use it for this specific purpose"?

MR SAM: Both, and increasingly, donors want to see us providing service, not just sustaining, hence that idea that increasingly --

THE COMMISSIONER: In other words "I'm going to give you money, but I expect that it's not for the electricity bill; it's for you doing some specific health care service".

MR SAM: That's correct, and particularly given our fundraising in rural areas, it tends to reflect this issue of how the community feels priorities sit, hence a large

growth in our mental health service has been enabled by community saying "That's where we want to see our funds being redirected".

DR NOTT: I might just add with that, there is significant opportunity cost through us having to divert that funding into some of the, I suppose, keeping the lights on, as Greg has mentioned.

THE COMMISSIONER: By that, you mean you could be doing things that you are not currently doing?

DR NOTT: We could be doing things that we're not currently doing.

THE COMMISSIONER: Don't let me cut you off.

DR NOTT: Yes, absolutely. We could be doing things that we know the community want, that if we had the freedom and flexibility, as Greg mentioned before, around self-determining alongside community where those dollars go to, then we can be operating in areas that traditional funding mechanisms would not allow us to and, also, innovate in a way that perhaps some of the rigidity of traditional funding mechanisms doesn't allow us to.

THE COMMISSIONER: Can you give some examples?

DR NOTT: So, for instance, there is increasing - even to the points around the primary care space, there is increasing request, even just last night I received some messages from a doctor in a community requesting help. And so if we had more freedom around our charitable dollars, we would be able to look at where we can supplement existing health services, where we know through our connections and connection with community, we could be delivering more primary care, more mental health, we could potentially be looking at sub-specialist or specialty services that we might bring into community.

We hear consistently across the system that access to paediatric care is a real challenge. It would be great for us as an organisation to work with community around how our charitable dollars might address some of that and work, back to some of my earlier points, collaboratively with stakeholders to say "We have this ability to actually look at some of the challenges that communities have that are

based on both data and community need and feedback", but at the moment we don't have that, that's taken away from us.

MR MUSTON: Do you both have a copy of the statement or the outline that was prepared in front of you?

THE COMMISSIONER: I think given I asked a question about it, ultimately this should be tendered.

MR MUSTON: Yes, Commissioner, I am going to deal with it. It's [SCI.0009.0110.0001] at 0005. I raised this with my friend, and he is content for us to proceed on this basis. Have you both had an opportunity to read and consider that document?

DR NOTT: Yes, this document.

MR MUSTON: Are you both satisfied that it reflects or is true and correct to the best of your respective knowledge?

MR SAM: Yes.

DR NOTT: Yes.

MR MUSTON: That will in due course form part of the bulk tender. Could I ask now to go to 0005. Do you see paragraph 24 there? You have identified a range of guiding principles that warrant consideration. What you tell us in those paragraphs is relatively self-evident, but can I ask in relation to the first point there, equity, where you talk about the need to involve a range of organisations, including not-for-profits, how does one control in that context or through that exercise the risk of increased fragmentation of health care?

DR NOTT: Fragmentation is a real part of and a real challenge across the health care system. For us, I think, it goes down to some of those comments I made earlier around collaborative planning and resourcing to be able to do that. Some key enablers for us are health care is increasingly becoming digitised. Digital systems are an enabler to avoid fragmentation, but if designed inappropriately, they can actually promote fragmentation of system.

We need to find ways in which we can appropriately share patient data between organisations in a way that

ensures patient privacy and the expectations of community are met, but also promotes collaborative work together around how do different organisations work in an environment to treat the patient in the set-up.

So in health care, having knowledge is incredibly powerful. If I saw, as a doctor, a patient who has complex medical conditions, and they have seen multiple other providers, in most settings today I wouldn't necessarily have visibility, even with My Health Record, of what tests have been ordered, what plans are of different sub-specialty providers, and so on and so forth.

Digital systems will allow us to be able to close that gap, but there needs to be, again, some focus around how do we actually achieve it in an environment where the reality is that with health care, there will be private organisations, there will be not-for-profits or NGOs, there will be state health systems, and so technically joining the dots is actually quite a difficult one. But if, for instance, in our space, there is willingness to collaborate, it can be done. So I would take an example of Wilcannia.

So we operate both primary care services within Wilcannia as well as obviously our aero-medical retrieval service. Far West LHD has an MPS there and Maari Ma also support through a community-controlled health organisation.

Now, any individual in Wilcannia can traverse any one of those organisations, and if you took a traditional lens of it, we will all keep our data separate and the patient is sort of stuck in between.

We've got agreements between ourselves and Maari Ma around read-only access to each other's medical records, recognising that our clients in that community will, at times, sometimes see Royal Flying Doctor Service and sometimes see Maari Ma.

Our emergency team and our aero-medical team also provide 24/7 medical support into Wilcannia as an acute care service, and our doctors are cross-credentialled with Far West LHD, so they have every right, all the rights, I suppose, digital rights, to access of the NSW Health data, and in fact, when they provide a consult through telehealth to that facility, they document directly into

the Far West LHD system that allows nurses to have full visibility of what we are writing around management plans that improves communication. As opposed to just telling someone on the phone or on the video, "Can you do X, Y and Z", it ensures clarity of information, clarity and transparency of management plans, and promotes safety.

Our doctors also, if they are prescribing into those facilities when somebody has an acute episode, will chart medication utilising the Far West systems. They will order tests through the Far West systems. They will have access to every hospital presentation that patient may have made within the Far West network. So that transparency of data is actually incredibly powerful. It can be done, and certainly we work through workarounds as opposed to the system enabling this sometimes, but we work through workarounds because of goodwill and the reality is that out here we all need to roll our sleeves up and do our best for patients. So that digital component is one of the areas that fragmentation can be addressed.

The collaborative planning and the remit, as I mentioned before, around getting the providers in the room regularly, as Greg discussed, and having accountability of those providers to actually achieve the outcomes that we set out for is also going to avoid that fragmentation, and having that planned approach to going "Okay, organisation X, this will be your role. We'll play this role. We'll work together. We'll set up appropriate governance and systems where we work as a team across organisations to meet that community need".

MR MUSTON: We've talked about this collaborative planning and delivery as a model that we should all be striving toward. To what extent in the Far West do you feel that that is happening at the moment, recognising that your time here, Dr Nott, has not been long.

DR NOTT: So being new within a leadership role within the RFDS - and Greg might want to comment as well - I see that we do it well in pockets and, like any organisation, there is always room to improve around the way in which we interact with our partners. But, overall, the integration of RFDS within LHD systems, I have not seen that degree of collaboration in many other areas of the New South Wales health system.

So the point - I sit on and my colleagues sit on a number of different Far West committees for implementing new projects or programs, feeding into policy developments, we have regular catch-ups around shared interests and programs and projects that are co-funded or funded directly by Far West. Though, what we were talking about before, around the higher strategic view around how we plan and deliver services, that certainly can be improved.

MR MUSTON: Viewed from the perspective of a participant in that collaboration, do you have a sense that Maari Ma is currently involved as a co-collaborator to the same extent as you are?

DR NOTT: I wouldn't be able to comment due to my short time within the organisation, but I am aware that with, for instance, dental programs, where there is shared interest between the entities, that we have been getting together to plan. I'm not sure if you have got further comments there, Greg?

MR SAM: There is and has been, certainly in my time, a strong goodwill. I think the challenge is really the system that supports us all, to convert a lot of that intent to activity over time. So there will be opportunities that will come from working with the LHD or the PHN or Maari Ma or another organisation that might centre around a particular initiative, or it might centre around a particular funding opportunity, but the idea of, I guess, a regular structured supported process still has some ways to go.

MR MUSTON: When you say "supported", what is the support that you had in mind? It may be many things.

MR SAM: I think it is a level, I guess, of responsibility and accountability for that process. At the moment it does require goodwill and timing and resource, and often that is at each organisation's initiation, if you will. Certainly, I think both the LHD and PHN have taken on, in Far West, a greater role in trying to coordinate this, but that puts pressure on their own organisations to a degree. So I think we've spoken about it before, it's reframing the priority around how services are planned, monitored and delivered, and appropriately resourced.

MR MUSTON: One last question I want to ask, which is

perhaps a little bit more operational, but in our discussions with First Nations people, an issue that has been raised repeatedly is the fact that patient transport is often not a return trip and a real challenge that a lot of consumers tell us or have told us that they face is they are delivered to a location a long way away, often, from where they live and where their community support exists to receive medical care that they are in need of; they receive that care and are then discharged and have to make their own way back and that is, we are told, a real problem.

Is that something that the RFDS has any visibility of, or are you more just the air taxi that is booked by someone else to make these trips?

DR NOTT: We certainly have visibility of that, and we see it through nearly all of our health services. And it's even more pronounced in the outpatient space where people sometimes are expected to go on their own back both ways, and yes, there are IPTAAS programs and those types of things, but it is a real barrier to access.

A number of people will also forgo access to other services that they need to go elsewhere for because of that drive, because of the cost associated with travel and accommodation, and even as you rightly pointed out, in acute care environments, some people who absolutely need to move between facilities because the acuity of their condition is such that they are required to go to a higher level of care will decide to not go or decide to leave hospital. And so certainly that is an absolute barrier and challenge that our clinicians deal with on a day-to-day basis.

MR MUSTON: It is a barrier or a challenge which is presumably manifesting itself in inferior health outcomes for those people who face it.

DR NOTT: Yes. As I said, people - I personally, as a doctor who has worked across both primary care branches and retrieval branches, have numerous cases where patients - I have had to have long conversations with patients about their care, what I see through the lens of a doctor in terms of the benefits of going versus the risks of staying, and we do have to grapple with that in terms of knowing that best or better care can be provided elsewhere, but through the lens of that patient they would rather stay

in community knowing that they may deteriorate or problems escalate to a point, sometimes, that they are risking their own lives.

MR MUSTON: Are there systemic changes that you think could or should be made to try and remove or reduce some of those barriers?

DR NOTT: Yes, the simple thing would be looking at programs that allow us to ensure that those - particularly those with significant socioeconomic disadvantage - are able to access travel back home and are assisted in coordinating that, because the challenge with a lot of access schemes or programs is that often patients have to apply for those themselves and particularly in our remote areas, we need to recognise that many people do not have the levels of education that would be expected to be able to fill out or even know that these programs exist. Greg mentioned that sort of health navigator role. That type of role should transcend not just the travel issues but in terms of access, how to access programs, how to access support.

Even as a doctor that's worked within the system and worked at a system level, I find it challenging daily to know exactly what programs any individual or patient may be able to access for their particular set of challenges.

MR MUSTON: If you as a doctor working in the system with deep experience in the system find it challenging, I presume the inference is that the patient who is sitting on the other side of the desk may have absolutely no idea.

DR NOTT: Absolutely. I come from a farming family, I grew up with farmers and people who work off farms and I've always approached health care provision through the lens that if my dad wouldn't know how to access a program, a significant proportion of our community won't, and my father, to be able to know - he wouldn't know that IPTAAS programs exist, wouldn't know how to access them, and managing complex and chronic disease is even more challenging for people who don't know how to navigate the system. It's hard enough for us to navigate it when we do have that knowledge.

MR SAM: It is a problem. It is a challenge. It has, I guess, continued to evolve as differentiation of

different levels of service across the state start to, I guess, put more distance between people's residences and where they receive their care, and whilst I think technology has helped in some cases and will continue, I think, to improve, this issue of the line between at what point does it cease being a medical need and becomes more a social need I think is the challenge, which to me speaks to, again, the strength of a locally planned model that says community transport, for example, may well be resolved locally quite differently in different communities, based on referral patterns and access patterns, whereas a lot of the schemes at the moment generally are universal and are sort of application derived.

So I think we are very much aware of transportation as a major restriction on access. Even getting in to a GP practice from out of town can be a challenge for some people.

MR MUSTON: Ultimately, it is right, isn't it, that if there is a barrier that prevents access to that service, it might be the best service in the world, but for that particular consumer, it just doesn't exist.

(The witnesses nodded)

MR MUSTON: I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: No, thank you.

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

DR NOTT: Thank you.

MR SAM: Thank you.

THE COMMISSIONER: You are excused.

<THE WITNESSES WITHDREW

THE COMMISSIONER: Is that a convenient time to take an adjournment now? We'll adjourn until 11.30 then.

SHORT ADJOURNMENT

THE COMMISSIONER: Are you ready, Mr Fraser?

MR FRASER: Yes, Commissioner. I call Jenna Bottrell, who is in the witness box.

<JENNA MAREE BOTTRELL, affirmed: [11.32am]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Could you give your full name, please?
A. Jenna Maree Bottrell.

Q. Is it correct that you are the area manager for the Western and Far West New South Wales region for Mission Australia; is that right?
A. Yes, that's correct, looking after the mental health, AOD and suicide prevention portfolio.

Q. Just by way of introduction, can you give a brief overview of outline of Mission Australia?
A. Yes. Definitely. So I've worked for Mission Australia for 13 years locally. The Broken Hill branch of Mission Australia offers 17 different programs and services and there is a large non-government organisation in the region. Locally in the Far West we employ about 35 staff across our programs and support domains.

Q. In terms of Mission Australia as a national organisation, it is a Christian NGO; is that right?
A. We are a Christian NGO and we have nationwide services, with our strategy being to help end homelessness in Australia, partnering to strengthen communities, supporting people in need to thrive and driving excellence within those services and communities.

Q. I should have said, there is an outline of your evidence that has been prepared, it is [SCI.0009.0107.0001], and have you read through that before giving evidence today?
A. Yes.

Q. And is it, as far as you are concerned, true and correct?
A. Yes.

Q. There is nothing you want to change?
A. No, I don't believe any of it is incorrect.

Q. We will be adding to it as we go, thank you very much.
A. Yes.

Q. Thank you, Ms Bottrell. In terms of your responsibilities here, or what is within your portfolio, I understand there is a number of discrete services?
A. Yes, definitely.

Q. All funded, or many of them funded from different sources?
A. Yes. Certainly. So a range of mental health, AOD and support services, some of those being funded by the Ministry of Health, some of these being funded by Commonwealth, Western New South Wales PHN providing that funding or contracting that funding to Mission Australia. So the Enhanced Adult Community Living Support program -- do you want me to go through those programs?

Q. I will ask you about them briefly one by one. So the Enhanced Adult Community Living Support program, that's based in three locations; is that right?
A. Currently we're funded to provide that Dareton, Far West New South Wales, Dubbo and Orange, Western New South Wales. That program assists individuals with severe mental health issues and highly complex needs in the community. We receive clinical support to that program from the Western NSW Local Health District and also Far West Local Health District.

Q. When you say "clinical support", what do you mean by that?
A. So the program is designed, Mission Australia is contracted to provide the psychosocial support component of the program. I would say one of the biggest - one of the biggest things we support people in that program with is connecting them to appropriate clinical supports within the health system or whether that be with their GP or with other local clinical support services such as, you know, mental health support, psychiatry, psychologists, ongoing care in that way.

In Dareton, specifically, we are only funded for 0.5 FTE. In Dubbo and Orange we are funded for a larger amount, I think we're funded for 35 hours of support

delivery a day for that service.

Q. Just in terms of what you are providing, your workers --
A. Yes.

Q. -- what discipline are the workers?
A. So those workers are caseworkers. They need to have a minimum of a Cert IV in mental health to be eligible for the role. Out here in these areas we often support people to access that training and qualification due to lack of education opportunities at times or lack of workforce, and it does make it hard for recruitment and retention. So they must be a Cert IV or above in mental health, and as I said, their role is around psychosocial support needs and case work, so those person-centred care plans around, you know, supporting people to access clinical supports but, as we know, things like housing, homelessness, education, employment, family conflict, domestic and family violence play into people's health and wellbeing. So that's our role, is to help people address and connect with services that can also support with that whilst also connecting with clinical health service to address their mental health concerns.

Q. And in terms of just how your workers provide that service, so Dubbo and Orange I think you said that's 35 hours per week?
A. A day.

Q. Thank you. You have a number of workers providing that?
A. We have a number of workers providing that. However, I wouldn't say we have enough workers to provide that. So when you think of a day, a staff member works eight hours in a day, so we must record every minute that that staff member does during that day, so every meeting, every email, every break now - you also think they have annual leave, they have sick leave, unexpected leave, we're humans. We have to record that as well. So at times it might not really reflect the work that is being done in the community and it may translate as face-to-face hours for each person but it isn't often that and I think hours based support programs are something that we need to be mindful of, how we read that in terms of the support hours delivered in the community. When we're only funded 35 hours a day, yes, but we're funded the exact amount of workers for that.

Q. And just to be clear, the 35 hours a day, is that face-to-face time with clients or is that for all work relating to providing the service?
A. All work required that may be provided. If it takes two hours to travel to a client's residence, if it takes four hours for a staff member to complete a training session, it could - it also certainly does, they certainly do spend a high amount of hours face-to-face with consumers. However, it doesn't accurately represent the time spent with consumers and the time spent either travelling or training or - yes, education, other internal, you know, meetings, et cetera, that must take place with our staff.

Q. In terms of services, are they generally provided face-to-face at premises, either yours or a community location, or is it provided in the home, or is it a mix?
A. It is a mix. So we like to look at the way we provide services being what's best for that consumer. So we do have office spaces available in various communities where we can meet with people. However, we will also provide home visits or, you know, meetings in the community where they may feel safe, et cetera. We also provide transport to and from appointments or to or fro locations to make it easier for people to access the service.

Q. Just sticking with Dubbo and Orange, is that operated as a single service over the two locations, or are they separate services?
A. So the - it is one service in two locations. We have an office in Dubbo and Orange, so the management structure remains the same but caseworkers are based in both location.

Q. How many caseworkers does it take to cover 35 hours per day?
A. So 35 divided by eight. So 4.4 we usually go by, but it's certainly not enough when you look at - when you look at what that includes, it's not enough to be able to provide the support needed to these consumers in the community.

Q. And in terms of demand for the service, are you able to see all the clients that need to be - that require that service or are seeking that service?
A. In Dubbo and Orange specifically, we're contracted to

provide the Enhanced Adult Community Living Support program, CLS, and another organisation is contracted to provide the Housing Accommodation Support Initiative. So together, we are able to, I guess, effectively try and manage waitlisting. CLS and HASI are very similar programs and over the next two years they are actually being consulted on. That process has started through the Ministry of Health, to be able to look at what that looks like moving forward. So we are able to work with the other NGO and LHD to be able to manage some of that capacity. However, I would say at times there are times that we cannot meet the demand, yes.

THE COMMISSIONER: Q. Can I just stop you there, so that I understand some of this evidence. You said that - when you said that you were providing 35 hours a day, support delivery for the service that you are talking about --
A. Yes.

Q. And you have to record every minute that that staff member does during the day, every meeting, every email, every break. What does that mean?
A. So basically our staffing model is based off what we've been funded to provide hourly a day. So our support hours that we must report on back to the ministry, so, for example, for CLS in the western region, it's 35 hours a day. So for us to report back on that, the only way you could ever possibly meet that maximum target of the KPI is to report every possible minute of a staff member's day.

Q. What does that actually - at a practical level, what does that involve?
A. A lot of admin work. It involves staff being very accountable for every action. You know, we're recording all of our emails, phone calls. We have a cloud-based case management system that that gets entered into, and we actually have a data team that then has to go through that data, pull out the data, record it back into the Ministry of Health system. A lot of work goes into that, and when you look at the time that takes away from support, face-to-face support hours and hours that we're able to spend within the community, it's quite significant.

Q. But this is a requirement from the ministry, is it?
A. Yes.

Q. As to what they need to see to justify --

A. Yes, it is a KPI. They have been - and if I may, I will say they have been quite understanding when we've been explaining this to them and have been quite open to feedback and the Ministry of Health is currently consulting the HASI and CLS program, and I believe that will be one of the - it would be my belief that that will be one of the biggest points raised in terms of an hours based KPI.

Q. Mr Fraser asked you how many caseworkers does it take to cover 35 hours a day, and you said divided by 8, so it's 4.4, but your answer was, "It's certainly not enough when you look at it. When you look at what that includes, it's not enough to be able to provide the support needed to these consumers in the community." Can you explain to me why it's not enough?
A. To me, I believe when you look at what the service description is, so we're working with people with severe mental health needs, with intensive - they have got highly complex needs within the community, so we're not talking about we're just going out doing a brief visit. Sometimes these consumers require and deserve comprehensive case plans and intensive support, and that may mean five hours of support a day, it may - today, it might mean six hours of support tomorrow, it might mean one hour of support the next day, because mental health is not linear and it needs to be flexible and innovative like that, and if we're pushing staff into an hours based service model on something that's so stringent like that, I believe that we require more staff so we can say flexible, innovative and responsive in nature to people's actual needs and remain being a person-centred program.

MR FRASER: Q. Can I just ask you this, Ms Bottrell. You are providing that service in the Western NSW Local Health District out of those two locations, Dubbo and Orange. Is that service provided in other locations within that district by other NGOs?
A. The CLS service.

Q. The CLS service, to your knowledge?
A. Not within West and the Far West, no.

Q. So that service is effectively - that is the entirety of the service for the entire district.
A. Western region.

Q. The western districts?

A. Yes.

Q. So for those based - those clients based --
A. Based out further.

Q. -- out further, say in Bourke, Brewarrina, long distances from both Dubbo and Orange --
A. They would not be able to access the service that they deserve.

Q. So no-one is providing that service, to your knowledge?
A. Not CLS, to my knowledge. However, I do believe the Housing Accommodation Support Initiative, currently contracted to another NGO, does outreach to some of those areas, but as said, it's - a lot of that is outreach meaning travel there, they are not based there, which that service model would look very different to what someone would receive in a more metro or built-up community.

Q. And if I can just ask how those services came to be - I think you have said that it's through the Ministry of Health; is that right?
A. CLS is through --

Q. That particular service?
A. CLS is through the Ministry of Health, the mental health branch, yes.

Q. Funded and contracted by them?
A. Yes.

Q. How is it that that service came to be delivered by yourselves? Was there a tender process, or were you part of some planning for that service to be established?
A. For CLS originally, we tendered for that program. There has been consultations since most of those have been initiated now.

Q. I just wish to ask you now about the Far West Local Health District. You provide a service, you said, out of Dareton?
A. Yes.

Q. In the southern --
A. The CLS.

Q. -- part of this local health district. That is, you have said, an equivalent 0.5 FTE, or half time for one person?
A. Yes.

Q. Is it still, though, contracted on an hours-based model?
A. Yes, it is.

Q. Again, is that service provided elsewhere within the district by anybody else?
A. Not to my understanding, not the CLS program, no.

Q. I will come to what you term the HASI service in a moment, because it seems to have some at least overlap in clientele.
A. Definitely.

Q. But again, if you are elsewhere within the district, you are only able to access that through Dareton?
A. Yes, that's correct. Dareton's funded for 15 hours of support a week, so three hours a day.

Q. So for those places located close to Dareton, it may be accessible?
A. Certainly not those ones far away, it wouldn't be logistically possible, or be able to be safely delivered.

Q. Just to take that example, again, I presume tendered for by yourselves?
A. Yes.

Q. When you tendered for it, were you tendering for a service that had been already identified to be provided out of Dareton, or were you tendering for a service for the district --
A. To be provided within the Far West.

Q. How was it identified that the service would be provided out of Dareton as opposed to, say, Broken Hill?
A. So it was actually part of a conversation with the Far West Local Health District about a service gap which had been identified. So we are also actually funded in Far West to provide the HASI service and, as I've mentioned, they are similar services, HASI and CLS. So we're funded in Far West to deliver HASI. When we were successful receiving the CLS tender, we felt that it was best placed

in Dareton because we were unable to service that area with what we were currently funded for HASI in Far West. So that was our way of trying to - which was quite effective, yeah? We were trying to be flexible and innovative of nature, because otherwise, if we were to place that service wholly and solely in Broken Hill, it would then become impossible for people in Dareton to access.

Q. So that decision is - you provide the HASI service in Broken Hill and were already doing so --
A. Yes.

Q. -- as a product of Mission Australia giving thought to how, between the two services that you then had been contracted for, you could provide greatest coverage for the district --
A. If we were to place that in Dareton, yes.

Q. I might come to the HASI service. Just remind us what HASI stands for?
A. The Housing Accommodation Support Initiative.

Q. And is that being funded by the ministry?
A. Yes, the mental health branch.

Q. I think what you referred to in the outline is a service that offers flexible support to people over 16 years, with a severe and persistent mental illness through psychosocial recovery support within the community?
A. Yes, that's correct.

Q. Your workers, who are providing that service, do they have similar qualifications as the other service?
A. Similar, yes, similar qualifications. Must have a Cert IV in mental health or similar, and preferably previous work experience in the area.

Q. How much - your funding for that service, how is that? Are you funded for an hours per week model or a per day --
A. Hours a day. So HASI in the Far West is funded for 28 hours a day, so that's our maximum amount of support hours. So we've actually placed, because - if I may, the CLS program, as I mentioned, was 0.5 FTE, very hard and almost impossible to recruit a part-time worker in the Dareton area, so we also deliver partial HASI down there as well, so then we're able to then call that a full-time role. That also was being discussed with the Far West

Local Health District, and the Ministry of Health, in our regular governance meetings.

Q. So you have a worker in Dareton who's effectively providing four hours of the HASI service a day and four hours of the CLS service per day. I presume it's not necessarily specifically demarcated --
A. Certainly not as specifically as that, but it means that community is able to access that service in a much more, I guess, person-centred and accessible way.

Q. And the remainder of your 28 hours a day, so 24 hours a day is effectively being delivered here in Broken Hill?
A. Yes.

Q. By three and a half workers, if we do the divide by 8 process?
A. Yes, 3.5, yes.

Q. Just in terms of that, how do you factor in people who have leave - and you mentioned that already.
A. Certainly difficult. People deserve to have leave. We have to, I guess, do what we can with those positions and, during periods of leave, back-fill those roles. I guess we're in a position where we're a large organisation, so we're able to support that somewhat, but it's certainly not feasible ongoing.

Q. Does the funding cover leave provision, or --
A. No, it doesn't take into consideration when staff take leave.

THE COMMISSIONER: Q. Can I just ask you, you've got your statement, the outline in front of you?
A. Yes.

Q. And paragraph 4 where some of these services are outlined, (a), the housing accommodation support initiative, what actually is it?
A. What actually is the HASI program?

Q. Yes.
A. Yes. So, basically, HASI supports individuals with severe mental health issues and complex needs within the community, particularly in terms of accessing housing and accommodation or maintaining their housing and accommodation within the community.

Q. So in practical terms, what does that involve? What's the support given to the individuals? It is to find housing, is it?
A. Somewhat. Sometimes it's to maintain that housing and build their own independence within our community and to be able to maintain that long term without service involvement, and certainly remaining engaged with their clinical support, psychiatry, psychologists and maintaining their wellbeing within our community.

The program certainly again, as I mentioned, is being consulted over the coming two years. Particularly a lot of that consultation will be around the introduction of the NDIS and now where HASI fits in that as well.

Q. And how long - you mentioned you are funded 28 hours per day for that program?
A. Mmm-hmm.

Q. How long does that funding agreement last?
A. How long do we currently have the funding agreement to?

Q. Yes.
A. We've recently been given an extension until June 2026.

Q. How was the 28 hours per day arrived at? Was that the result of a tender? What was it based on?
A. I'm assuming it would have been based on data within the health system. We've had ongoing discussions with the Ministry of Health where they, I believe, are aware that the hours aren't truly reflective of, one, community need; and --

Q. Stopping there, "community" being the Far Western NSW LHD; is that what we're talking about?
A. Yes. But all LHDs, Far West LHD, Western LHD, the hours based component and the hours KPI is not flexible and too structured for a service of this nature.

Q. Sorry, I'm not following now, but all LHDs. When you say "all", is it 28 hours per day for every LHD in the state?
A. Oh, sorry, so it's 28 hours per day for the Far West, yes.

Q. The Enhanced Adult Community Living Support program that you've given some evidence about, CLS, which is the program that you are funded for 35 hours per day; correct?
A. That's in Western NSW LHD.

Q. In Western NSW LHD, but not Far West?
A. No, for Far West LHD, the CLS program is funded for three hours a day, so 15 hours a week.

Q. Three hours of the 35, or three hours additional to?
A. Three hours additional.

Q. And that program is funded through the Ministry of Health?
A. Yes.

Q. And you said it was a tender?
A. Yes.

Q. The 35 hours and the three hours, what was that - how was that arrived at, do you know?
A. I believe that those figures were created off data through the Ministry of Health and the mental health branch. They came to that conclusion.

Q. Was that then - was the tender, was it to provide 35 hours and three hours, or was it that you tendered and said "We can provide this service in 35 hours or three hours"?
A. No, that was their expectation, I understand.

Q. And precisely what is the Enhanced Adult Community Living Support program, CLS? What do you do with that, what is it exactly?
A. So it also assists people with severe mental health issues providing individual support within each local community, whether that be Dareton or Dubbo.

Q. Through the caseworkers you mentioned?
A. Through the caseworkers.

Q. The youth residential rehabilitation services in Dubbo provided with the Department of Communities and Justice. I assume that means it's funded through DCJ not Health?
A. Yes.

Q. Safe Haven provided in partnership with Far West LHD. One, what is Safe Haven and what do you mean by "partnership" with Far West LHD?
A. Sure. So the Safe Haven is part of the Towards Zero Suicides initiative through NSW Health. The Far West Local Health District have - we were successful in a grant to deliver the Safe Haven service within Far West, and when I say Far West, just to be clear, I'm speaking the service is available in Broken Hill. So the Safe Haven provides an alternative to the emergency department, particularly when people are in suicidal crisis. When I say --

Q. Sorry, tell me how it works?
A. When I say "partnership", Mission Australia is funded to provide the peer work component of the service and operational component of the service. The Far West Local Health District provide the clinical support of the service and clinical oversight. So we are collocated in the Safe Haven building. They provide also a suicide prevention outreach team out of the same building. So we've been doing that for three years now. The service was - so when we were successful in that tender process, a part of that tender process was that we would be involved in the consultation and co-design of that service, which we were, and to me, Safe Haven is a good example of how health services work well when there is proper consultation and co-design with community and stakeholders, and services are designed to suit - to address a community need, to fit for purpose for our community, but then also then evaluated once they are in, once they are implemented within a community, and Safe Haven has had that as well, and we were closely aligned with what we originally said we would do from the outcome of consultation and co-design.

Q. Is your organisation's involvement in Safe Haven funded by the Far West LHD?
A. Yes.

Q. The AOD, alcohol and other drugs coordinated care programs?
A. Yes.

Q. What are they?
A. So that is funded by the Ministry of Health, the Centre for Alcohol and Other Drugs. The AOD CCC service, if it is okay, I will call it the CCC service, assists adults with substance use disorders and complex needs in

the community who have been referred or would like to access an AOD clinician within our community - when I say "community", the service is called "AOD CCC", for example, in Far West, "Far West". However, we are only funded for one staff member, one caseworker, that is, to service the Far West. So we only service Broken Hill, because logistically, we cannot service the entire Far West with one staff member.

MR FRASER: Q. Is that a product of what you tendered for?
A. Yes, so --

Q. In terms of the service that you tendered - was it a tender process for that service as well?
A. Yes. Yes, it was a tender process.

Q. And when you tendered for it, the funding was of a set amount?
A. Yes, a set amount.

Q. Is that service in Dubbo and Orange that you have described there in Western, in a similar --

(Audio interference)

THE COMMISSIONER: Keep going.

MR FRASER: Q. In terms of each of - it's very distracting - those services, again, the same in Dubbo and Orange, you are just funded effectively --
A. Yes, so the AOD CCC contract is one contract for Mission Australia for Far West and Western New South Wales, and we're funded for 1 FTE in Far West, Broken Hill; 1 FTE in Dubbo and 0.8 FTE in Orange.

Q. The only other one that I hadn't covered is The Way Back service. That's provided here in Broken Hill; is that right?
A. The Way Back service is funded by the PHN, the Western New South Wales PHN and yes, we are funded to provide the service here in Broken Hill. However, last year in March, the service was decommissioned and we were then recommissioned several weeks later. Half of that funding was then placed into Orange, New South Wales, so now we deliver The Way Back in Broken Hill and in Orange, New South Wales.

Q. Is anyone else providing it in other locations in either district?
A. Not that I'm aware of, no. The Way Back service is part of universal aftercare funding, and universal aftercare is also being consulted on over the next 12 month.

Q. By the PHN or by whom?
A. By NSW Health.

Q. So although it is a service commissioned by the PHN, the Ministry of Health is conducting a review?
A. Yes, is in - yes, involved in that process.

THE COMMISSIONER: Q. What precisely is The Way Back Support Service?
A. The Way Back provides intensive support for people for 12 weeks following a suicide attempt or suicidal crisis within the community.

MR FRASER: Q. There is one other program that you have listed and that's the Connections Program?
A. Yes.

Q. That's provided - you have described it as a partnership, an innovative partnership between Mission Australia and the Far West Local Health District, mental health and drug and alcohol service?
A. Yes. So Connections is currently a Mission Australia funded initiative. It's funded by designated donations. Originally, the program started out in 2017 from a conversation with the Far West Local Health District about social isolation and loneliness and the impact that was having on our community, and then the impact that that was then having on the health service, in particular, ED.

Q. What does it actually do, or how does it work?
A. So Connections is an after-hours program that's peer led providing social activities and connections to the community. Basically it reduces barriers to people being able to access our local community, by that I mean Broken Hill, and loneliness, the effects and the symptoms of loneliness and the effects that that has on our wellbeing does have an impact on the health system, so that program provides free social activities locally so they may go to many events in town and life skills programs, pictures, out

for dinner - all of those sorts of things, which is supported by people who have lived experience of loneliness and mental health distress.

Q. This is probably a little simplistic, but you are providing a number of services which cover those with mental health issues, suicidality?
A. Mmm-hmm.

Q. And alcohol and other drug problems?
A. Yes.

Q. Would you agree there is a significant degree of overlap of the clientele of those different services at different times?
A. Yes, I would agree.

Q. Or at least some?
A. I would agree that there is some overlap. However, I also believe that, when working closely, if the collaboration and the governance is there for those services, you are able to - we've been able to provide quite an effective continuum of care for people locally.

Q. In the places where you are able to provide the service or services?
A. Definitely.

Q. And in terms of how those services have come to be, I think from your evidence, other than the Connections Program, they are a product of different tenders, albeit the Safe Haven program was part of a process of setting up a new service?
A. Yes.

Q. But there seems to be, in effect, something of a patchwork of services in different locations as a result of the limited funding in different locations at different times; is that fair?
A. Yes, I think that would be fair to say. I think that there is a lot of overlap from those services, but without some of them it would create significant service gaps.

Q. In terms of trying to maximise coverage, for instance, we've already traversed it, you as an organisation, Mission Australia, have made some attempt to maximise the coverage through coordinating the different services, such as the

HASI and the CLS programs?
A. Yes.

Q. Are you involved in - is your organisation involved in regional assessments of service needs?
A. Yes, so we are invited to be involved in several consultation processes.

Q. Could you describe those? Who invites you to these processes?
A. Often they are conducted by third parties that may be contracted by health services or different tender - prior to different tender processes at times. For myself, I think, we are also invited for our health funded programs, so, for example, the programs I've mentioned that are funded by the Ministry of Health, Centre for Alcohol and Other Drugs or the mental health branch, they have a strong component of clinical governance within them where we - where it's actually a program requirement to have that strong link to your local local health district. So we have quarterly governance meetings and, you know, the service is delivered collaboratively in nature and we're able to help each other in terms of resourcing, where possible.

Q. Are you involved in, say, any planning for or invited to play a part in planning for, say, alcohol and other drug service delivery throughout the district? Does the local health district sit down with you and maybe other NGOs and say "What services are you able to provide? Do you see the services you currently provide as meeting the needs of the client base"?
A. I wouldn't say that's done as often on a local level, I would say that's more done on a state level from a New South Wales-wide level.

Q. By the ministry?
A. Yes.

Q. Is that a regular process, annual?
A. I think it is quite regular. I think - when you look at not just health care, services like Broken Hill in particular and more rural communities such as Wilcannia, Menindee and Dareton, I think we run the risk of being a bit fatigued by consultant processes, and I think when we talk about consultation and co-design, we need to look at whether we're doing that to be genuine in nature and what

we are actually going to do with that information, or are we just seeking it so we can say that we have it. If we're not going to implement actual change with that information, we need to be careful how many times we ask and who we're sending to ask. I think it's important who asks those questions.

Q. In terms of the coverage of your services, however, they are limited in their nature by virtue of the funding that is available --
A. Most certainly.

Q. -- to you under the tenders that you have been awarded?
A. Yes, it is limited and quite often services may be called a Far West service, and I think we need to be careful in how we describe that and that services need to be funded to - for the full cost of service delivery. If a service is a Far West service, it needs to be funded to appropriately service communities such as Wilcannia, Menindee, Dareton and more broadly than that, because otherwise it's not a Far West service, it's accessible to Broken Hill. And when we're talking about services that are providing, as you would have noticed in the majority of descriptions, it provides intensive support for people with complex needs, sending a staff member to a community that is two hours away, ie Wilcannia, one day a week, that's not a level of service that they deserve. They deserve a higher level of service than that and they should not have less than because they live in Wilcannia. We should be funded to provide effective service in those communities as well.

Q. In terms of planning for that service or identification of that service gap, presumably, in your meetings with those funding it, you indicate that you are not able to provide the service outside of Broken Hill, for instance?
A. Yes.

Q. If that's where you are able to provide it?
A. Certainly we do voice that, and that has been taken on board. However, when you look at state-based funded - if they're a state-based funded services, the time it takes to implement these changes and then, you know, like I mentioned, we've been extended for HASI and CLS for another two years while there is a consultation process,

two years is a long time to still be running a service that may already not be exactly what this community needs. So I think not only do we need to look at if we are having consultations, what we're doing with that information and that we're being genuine in nature in how we implement those suggestions, but how responsive we are, I think we need to get quicker at the process, because sometimes by the time we've found the solution, the situation has completely changed.

Q. In terms of what you have said about funding the full cost of service delivery --
A. Yes.

Q. -- you've set out some of those at paragraph 13(a) of your outline. Generally, when you have tendered - and I think you answered a question to this effect from the Commissioner - the level of the service has been determined prior to your involvement in many of these cases - I'm not saying every, but in many of them?
A. Yes, in many of the cases.

Q. So the tender is for 35 hours a week?
A. Yes.

Q. Or 35 hours a day, for instance, in one case?
A. Yes, there will be set metrics or KPIs that you must deliver within that service, yes.

Q. Indeed. And do you have the opportunity, for instance, in your ongoing communication during the process - during the course of those tenders, to feed back that that does not reflect the full cost?
A. During the course of the tender process?

Q. Yes.
A. Yes, we do.

Q. Or at any time?
A. There is opportunity to obviously submit your inquiries or questions during that process. But I think, too, we need to look at the way we - when we talk on tendering processes, how we do that. I think we need to look at putting the voice and the power back in our community's hands rather than a competitive tender process. I think competitive tendering processes can make it hard in smaller communities to, I guess, ensure that services are

really fit for purpose here. You get a lot of - as you can imagine, there is a lot of NGOs competing for those tenders in these communities and to me it should be about what's best for the community and what's best for the people living in these communities, not about a competitive process all the time.

Q. And how might that be achieved to get the voice back to the community?
A. It is a good question, isn't it. I think for - to reduce the impact of competitive tendering processes, we really need to look at what we're asking people to deliver and really setting out what a service must have to be able to deliver that service. I think it's about accountability, ensuring there is accountability but ensuring that a service best placed to deliver that service in the community - that they are the ones that are supported to apply for that. So if that is an Aboriginal community controlled health organisation, then it should be them supported to apply for that tender. If that is an NGO that is based in Broken Hill or Dareton or Wilcannia, Menindee, they should be supported in that process to tender. I think there is a better way that we could do it because there are people that are better placed to deliver some services in rural communities.

Q. Presumably, that involves an understanding of what the community wants?
A. Definitely, I think, and as I said, when I say "consultation and co-design", I mean doing that genuinely and effectively. I think sometimes, like I said, we promote "We need to do a consultation and we need to co-design and we need to ask the community" - if we're going ask them, we need to make sure that we're going to do something with that information and be responsive and do it in a timely manner, because sometimes we spend so much time asking and so much time, you know, promising change, and communities don't see that and that can be really disheartening and it can be really hard to inspire hope in communities when they may feel let down at times.

Q. The other matter in terms of improving service provision that you raised is funding cycles.
A. Yes.

Q. Some of your services, they may be on a one- or two-year funding cycle; is that right?

A. Yes, some of them are. So some of them may start out as a three-year contract and then we'll often get 12 month extensions whilst there is a consultation process happening or whilst the tender process is being organised. That's very difficult for a number of reasons - staff retention, traction in the community, ensuring that we're able to meet community need.

Quite often we might not find out if that program is going to continue to be funded until quite late in the financial year. So we may find out in the end of March whether a service will continue past June, and by then we may have already lost our workforce within that service.

Recruitment is already a challenge in these areas. That then just adds another level of complexity and another complication in recruitment and retention of staff. To me, if services are appropriately implemented, we should be looking at longer-term contracts for seven years at least, possibly longer in communities that have long-term disadvantage or in particular Aboriginal and Torres Strait Islander communities. I believe that they should have longer -term funded programs to ensure they are able to be designed and implemented in communities effectively.

Q. Just lastly, like most organisations providing services in rural and regional Australia, you identify staff recruitment and retention --
A. Yes.

Q. -- and training, professional development, as a particular challenge?
A. Yes.

Q. You raised that just a moment ago in the context of your funding cycles. But in terms of the broader supply of workforce for your services --
A. Yes.

Q. -- can you outline the challenge and how you overcome it, to the extent you are able to?
A. So there is a lot of challenges with workforce recruitment and retention, some of that being the ability - well, be able to recruit to the roles with particular qualifications. So at times we, I think, Mission Australia does well to invest time and finances into training and recruiting staff to be able to deliver the services that we

are funded to deliver. However, that then becomes complicated when we're losing staff for short-term contracts or we're losing staff to other services, such as - you know, it can become quite competitive for staffing in communities like Broken Hill. If we aren't able to pay the same rate as what maybe a government organisation is paying because we have set funded amounts, not all of our contracts and funding includes CPI and indexation, so it's hard to deliver some of these services and maintain the staffing level that we require due to that.

Also, with training opportunities, whilst online training has certain - is certainly available to us, I don't feel that people should have less of - have a disadvantage to accessing education and training because of where we live. They should be able to, you know, access face-to-face training and learning opportunities and development opportunities in Sydney, where they may be held and, for that, we would need to be funded for staff to be able to access that.

Q. So in terms of the training aspect, that presumably feeds into that funding aspect that you referred to earlier of being funded for the full cost of providing the service, so recognising the cost of training and developing your staff as part of that cost?
A. Yes.

Q. Is that right?
A. Definitely feeds into funding for the full cost of service delivery - training, staffing, infrastructure. The cost of being able to access, you know, parts of our organisation such as, you know, we need to operate at a certain standard as well. We need to be accredited. We need to have clinical care and governance frame works, child and youth safe policies and procedures. Our services also need to be funded to be able to access those resources within our organisation and for our organisation to ensure that all of our services are working in line with those. So we need to genuinely look at what it costs for service delivery and fund that.

Q. And in terms of supply of sufficiently qualified staff, are you involved in any partnerships with any training organisations to train staff in your relevant disciplines?
A. Yes, we are partnered with a number. So we often,

with the Mental Health Coordinating Council, are accessing training through them. However, we also have been able, within the Far West Local Health District and the Western New South Wales Local Health District, they've opened up training opportunities for us where able, for our staff to be able to access to help upskill them. I will say, too, just earlier on the services that work closely in partnership such as Safe Haven, when services like - when organisations like Mission Australia partner so closely with an LHD like that, there is also an advantage of the skills that staff learn from working closely with different organisations. So, for example, clinical staff working with lived expertise practitioners and vice versa, it's increased our ability and understanding of the clinical health setting and it's increased their understanding of how that looks in a more broader community context. So working closely together like that has many benefits for the community, but also many benefits for both of our organisations.

MR FRASER: Commissioner, those are the questions that I have for this witness.

THE COMMISSIONER: Q. Can I just ask, in paragraph 10 where you're talking about having annual funding agreements, does that apply to all of the services you provide that you have outlined in paragraph 8? Is that all of them?
A. Yes. So then - they are annual funding agreements or they are - the majority of the time they are only extended for 12 months to two years at this stage.

THE COMMISSIONER: Thank you. Do you have any questions, Mr Cheney?

MR CHENEY: No, thank you, Commissioner.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. Professor Jones?

MR MUSTON: We might be able to finish this witness before

lunch.

<DEBRA MAREE JONES, affirmed: [12.27pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. I'm Professor Debra Maree Jones.

Q. And you are the head of rural clinical school, Broken Hill University, Department of Rural Health?
A. I am.

Q. That's a mouthful.
A. Very much.

Q. Which we understand sits within the University of Sydney Nursing School and Faculty of Medicine and Health?
A. Yes, it does.

Q. You have prepared an outline of the evidence that you are willing to provide to assist the Inquiry?
A. Yes.

Q. Have you had an opportunity to read that before today?
A. Yes, I have. Like a good academic, I edited.

Q. I take it from that answer that you are satisfied that the content of that outline is true and correct to the best of your knowledge?
A. Yes, it is.

MR MUSTON: In due course, Commissioner, that will be tendered.

THE COMMISSIONER: Sure.

MR MUSTON: Q. Whilst you tell us in that document that the rural clinical school sits within the University of Sydney's Nursing School and Faculty of Medicine and Health, could you actually just give us a slightly broader picture of what the rural clinical school at Broken Hill is?
A. Yes, I can. We're one of about 19 university partners for rural health, even though we are termed a rural clinical school. That's an organisational structure term that makes sense of the other Commonwealth funded programs.

So we're one of 19 nationally located. Most - well, all UDRHs are allocated to universities because we're academic departments. So the University of Sydney itself has three rural clinical schools. We have a sister facility in Lismore. We have the Dubbo and Orange rural clinical school and the Broken Hill University Department of Rural Health. So all of these entities are independently funded through the Commonwealth through agreements with the host universities in which we are embedded.

So in the recent restructure that was done through the University of Sydney, the three rural clinical schools previously sat in the School of Medicine at Sydney University, but have now been distributed to ensure that the large schools all have carriage and have an embedded rural academic department in them. So we now sit with Sydney Nursing School, Lismore sits in the School of Health Sciences and our Dubbo and Orange colleagues sit with Sydney Medical School. Collectively we form the rural precinct.

Q. While you have got that formal connection with the University of Sydney, do you regard yourself as an outpost of the University of Sydney, or are you a separate entity?
A. No, we are part of the University of Sydney and extremely proud of that alignment. In saying that, as part of the University Department of Rural Health Commonwealth program parameters, we do engage with over 25 Australian universities in the placement of students from across multiple disciplines.

Q. Is that something that you do in Far West LHD?
A. We - I - our campus, our school, has three campuses, so we have a campus at Broken Hill, which is the main campus. We then have a campus in Bourke and a campus which - new offices hopefully, will be developed in Wentworth in the South West footprint. So we cover two LHDs, Western New South Wales and Far West LHD.

Q. You have told us about the collaboration that you have with a wide range of different universities. How does that actually work in terms of what you do in an organisation?
A. They are two approaches when we engage with additional universities. One is that through the ClinConnect system, which is a New South Wales health system around student placement allocations, universities can come in and allocate students to placement availability, so that's one

stream of activity. Through our partnership with Far West Local Health District, we actually coordinate the ClinConnect system on their behalf so we become the one-stop shop for student activity, accommodation, pastoral support, education programs.

The other approach we take is actually working collaboratively with like minded universities across different disciplines to design programs of relevance for student activity. An example would be we have a tripartisan university relationship around extended duration medical student placements, which brings University of Adelaide, Wollongong University and Sydney Medical School, and that has actually been designed to be fit for context in place through those levels of collaboration.

We also have similar collaborative approaches to these models for nursing and now a growing one around allied health extended duration placements.

Q. So you referred to your organisation as the one-stop shop for student placements in Far West LHD. Do we gather from that that instead of all of the universities that might have students to offer who need placements, contacting the LHD and trying to compete with one another for a spot somewhere, you, as an organisation, get all of the universities' students together and identify the best way to make sure that placements can be offered to as many of them as is practical?

A. And that's done in collaboration with our host sites because we not only place students in our LHD facilities but we also place them in our social care services, our schools, Aboriginal community controlled health organisations, NDIS and the RFDS are some examples of where we place them. But this enables the repository to come in for student applications for placements where universities will say, "We would like to send X number of students from this discipline to placements in semester 1 or semester 2 of student program."

We will collaborate with our host sites about placement capacity so we're not overburdening with student numbers. We also try to ensure a level of flexibility because we know work forces can change very rapidly, so where commitments may have previously been made, if you lose a number of your workforce, it's very difficult then

to provide the supervision for students. So we have to be quite nimble footed in ensuring that we're not oversaturated in services. So yes, we help promote, hopefully, a consistency.

We also have student accommodation. So that enables us, then, when students are accepted to undertake their placements, to allocate those students directly into student accommodation as well.

Q. That student accommodation presumably is not only available to Sydney University students --
A. No.

Q. -- but also Monash, Wollongong?
A. A host of universities.

Q. Anyone who wants to come?
A. Yes.

Q. You mentioned a moment ago that placements went beyond the LHD facilities. Does that suggest that your one-stop shop arrangement is not only with the LHD but, also, say with organisations like Maari Ma and various other providers of health care throughout the Far West; is that right?
A. Yes. Yes, that's correct. We don't impose that on key stakeholders and partners, but if that is their preference, that is what we would do. So we then also work on student compliance, so ensuring students have the right immunisation, the right clearance checks, so will we cover off all of those I suppose operational components of student placements which releases the burden on those host sites.

We then provide an overarching level of pastoral care and supervision for students whilst they're also on site and engage closely with those sites just to make sure, and it's always better for us to identify issues earlier through that close engagement than finding out later that something may have gone wrong and we haven't had a chance to respond.

Q. You say you don't force a participation in that program on organisations providing health care in the Far West but is it the sense you have that almost all of them actually --

A. They will direct universities to us to act on their behalf to help coordinate those placements and we will engage heavily with them, similar to the LHDs around placement capacity in students. When we talk about developing student placement programs, which is separate to the more random ClinConnect where universities will come and say "We want to allocate these students to placements", when we actually develop programmatic approaches, they are basically informed by community identified need or aspiration for student activity in the footprint.

So we will work very closely not only with our partner universities but with our host sites in designing up those placements so they make sense in context.

Q. You have told us about the student accommodation, which is reasonably self-explanatory. But the pastoral care services that you provide to students who are out here on placement, what does that look like in a practical sense?

A. That's very much because we know students are people and that they will bring with them challenges, that things can occur whilst they are on placement, such as illness in families, deaths in families, break-up of relationships - a number of things can still unfold while students are undertaking their placement. So our academic and our professional staff work very closely on social debriefs, more clinical reflection sessions, just to try to make sure that if any issues do arise, we're providing support in the right way. That support could be giving a client an empathetic ear for students to talk to if they work through some challenges, to the point where, if it is significant, discussing with that student their home university, the need for that student to return home.

Q. What do you see as the importance and value of clinical placements for university students in areas like the Far West?

A. Well, the evidence will tell us that if you don't experience it, how do you know that it could be a career option for you? This comes down to the two streams of workforce engagement, which is rural exposure via our larger regional and metropolitan students, so that is very much around bringing students out, providing them with a quality and valuable not only learning experience but social and community embedded experience.

Q. How do you deal with that second aspect?
A. The community embeddedness? We do a lot of work promoting student engagement in social events, footy clubs, soccer clubs, netball clubs, hiking clubs, so the students are given a whole array. Most of the students, I will speak Broken Hill, for example, are encouraged to participate in the Broken Hill festival, they all go to the races.

Our students are placed - it is a multidisciplinary student cohort, so we build up the social learning network of students and it is collegiate support and I can remember having conversations with some community members where a lot of rural community will see an attrition of this age grout out of community's defined work. What our programs seem to do is bring that age group back into communities where they may be experiencing that attrition. So, you know, our 22-year-olds plus in age coming back into - coming into our communities to undertake a placement.

We also know that a sense of social accountability and connectedness is critical. But that takes time to establish. So I think we spoke about, you know, the implications of shorter-rapid duration placements which lack that ability to really embed our students into our communities so they actually feel like they belong, and what we notice is the longer students stay, the change in language, from they are going home when they return, to coming home to us if they go away and come back during their placement. So that change of language around their sense of where they belong and who they are connected to.

Q. I might have interrupted you earlier, you were talking about two different cohorts or streams, the metro based student who comes and has a rural experience embedded in a way that hopefully makes it a meaningful experience for them. The second stream is what?
A. Rural origin. So the two streams that the evidence tells us that are critically important are the metropolitan or larger regional exposure to rural and remote practice, plus then also embedding activities around rural origin peoples. The evidence tells us that rural origin people are more likely to return to their community or like communities to practise once they are registered. So it is about providing both pathways of engagement so we're trying to get the best we can out of both streams. So we invest in health career academies in our secondary schools from

years 7 to 12, with a strong focus on First Nations engagement in those career pathway programs, and that's across medicine, nursing, and our allied health discipline exposures. We then seek to engage students whether they want to choose a TAFE pathway or go through to university pathways and then prioritise our locals coming back for placement, as a priority for placement access. So we keep them connected to region.

Q. In terms of the first stream, the metro based students who are coming out to have that rural experience, in the time that you have been involved in this program, have you seen it pay dividends in terms of metro students who --
A. Uptake of practice --

Q. -- having had one of those experiences come back?
A. -- in rural remote? I think most universities will tell you tracking students outcomes can be extremely difficult in where students work. We have a significant success rate with social work students returning. We have some social work students who complete their placement, don't need to go back to university and will commence work. I think that's because there is a sense of greater flexibility in where social work students can be placed and the roles they can undertake. It can be challenging, when you are working in this space, where there may not be jobs for these students to take up, because we - you know, health services and other key agencies only have a certain amount of funding to employ.

So if they don't have the positions vacant, then it is very difficult to attract students back into those areas of employment. We see a good uptake of our nursing students entering into new graduate years when they come out on placement. There is a longer draw time for medical students because they then have to go through junior doctor internship and, then, if they go down a rural generalist or a GP pathway, it can take a bit longer to bring those medical students back.

Some research has been done by our Dubbo Orange rural clinical school college. They say that there can be a 14- to 15-year time lag between student exposure to seeing students return as practising medical staff.

Q. In terms of the rural origin students, is it a different experience there that you have had in terms of

the extent to which those who come through those programs have been observed to stay?
A. It can be age related. We can find that our younger rural origins may want to go off and have grand adventures, like any other young person may once they actually have a qualification and profession they can use. I think for our more mature aged, those who are making that sea change in their careers later in life, if they are embedded, if their family are here, if they own the house, it makes sense working here.

Q. For those who are off on adventures, have you been in the system long enough to see them come back at a slightly later stage in their lives?
A. Yes, and I was one of those as well. I went off and had eight to 10 years of adventuring in rural remote locations in Australia and then returned home.

Q. There is no shortage of adventures in Broken Hill --
A. No.

Q. -- we've discovered over the last two days.
A. Yeah.

Q. In terms of the school, the way in which you work with local schools, you told us a little bit about the efforts that you are making to attract school-aged students into medicine. Could you just talk through that a little bit in more detail?
A. It is across the health disciplines. So we established health career academies back in about 2008/2009 as a pathway. That was based on we were working on another initiative with our high schools, and we were actually approached by our primary schools saying "Where is the career pathway for our kids?" So the health career academy program was established.

It was specifically to focus in on, in the first instance, nursing given that nurses are the biggest workforce in our rural/remote communities. Feedback from those initial pilots was really positive and it also spoke to a desire for exposure to other disciplines, which then led to us responding to that, bringing in the medicine academy, mental health academies, allied health academies, to try and give students, I suppose, a taster across multiple disciplines so they could get a sense of whether one actually resonated more with them or another.

So we are seeing some uptake from those programs, but another component of those programs is also around elevating health knowledge and understanding for our kids. It's not only about saying "Here is a pathway"; it is about saying "What information and knowledge can we share which may help you make healthy decisions in your own life as you move forward into adulthood?"

Q. If you don't know the exact number, ballpark would be fine. How many high schools are there in the Far West LHD?
A. Well, we engage with two in Broken Hill, so that's Willyama and Broken Hill High School. We also engage with Coomealla High around health career academies in that south-west footprint, so that's the Dareton-Wentworth communities, and we also have levels of engagement in our Bourke community as well.

So annually we would probably see more students transitioning into the TAFE-based pathways to some degree, which is their assistant in nursing, assistant in allied health. That's potentially linked to the school-based apprenticeship and traineeship programs that the Far West Local Health District run as well. So students can see a direct in-community pathway to that. So the LHD offer about 14 to 18 of those school-based traineeship pathways annually for locals.

Q. Do you know where geographically those pathways are offered?
A. The SBA/Ts? Yeah, basically in Broken Hill but they can also be offered in Menindee or Wilcannia. The LHD put a significant amount of effort in trying to make sure where they have students who are expressing that transition into those SBA/T programs that they can be delivered in site. I know that in Balranald, they can also be offered in Balranald. So I think there is a sense to try to distribute them so there is not just a focus on Broken Hill as the primary site.

Q. The academy programs that you run, do they give you an insight into the importance of actively engaging with schools and students in terms of the extent to which training opportunities like that are taken up?
A. I think that's critically important. Once again, being an academic, the evidence will tell us and theory tells us that our little people can start making career

decisions as young as four and five, so those decisions can actually be influenced by family context, cultural context, what I'm exposed to and what I'm told I can achieve. So part of what we're trying to do is a complex interplay of initiatives. We work very closely with the LHD to deliver health services directly on school campuses, so that's part of role modelling to our little people, that you can actually be one of these health professionals and if you can see them and you understand what they do, you can create then a career aspiration to be that and, then, like I said, we invest heavily on the years 7 to 12 pathway then for the more mature students.

Q. Do you think, recognising that there is resourcing issues that would be associated with it, there would be benefit in having that slightly more intensive engagement with careers teachers and students in high schools in particular across the LHD?
A. Yes. We recently published a paper - health career academies in some way shape or form delivered across the three rural clinical schools, that the University of Sydney has carriage of, and it was about lessons learned from trying to implement grow your own sorts of initiatives. I think some of the critical component of having that funded specifically is how do you contextualise that and how do you sustain that.

And it was interesting listening to the prior speaker talking about sustainability of initiatives. So whilst I think there is a great capacity for us to think in a much more clever way around career pathway at a very early age, there is how do you do that in context, how do you ensure that you have First Nations visibility and leadership in those programs? Our health career academies are inclusive but are led by First Nations academic staff to ensure that our First Nations kids and our First Nations communities can see that that investment is there and those career pathways are available. So it's that authenticity of, you know, you can't be what you can't see.

Q. Did the studies that you have done arising out of this give you any indication as to the extent to which a program delivered in that way increases the uptake in training places and ultimately workforce positions by First Nations community members?
A. This becomes very difficult as well, trying to track where your past participants go, especially if they leave

your community. Most of the time you try and work out by word of mouth, so mums, dads, families, will say "So-and-so is now off, they're doing nursing". So it can be very hard to get a determination beyond I think the SBA/Ts. The SBA/Ts give us a very clear indicator of who in our past healthcare academy programs have transitioned then into that workforce. Once they go to university, it can be very hard then to track where these students are going and what disciplines they are entering into, unless they are seeking to come back on placement.

Q. So these - just so we understand it, those programs there are the programs in which a school student might be finishing year 11 and 12 as part of a mix of subjects they are doing, it will include some vocational training and some placement within hospital settings or non-hospital settings operated by the LHD?
A. And I think the critical thing, too, is that it's not only about the training pathways, it's about the employment that comes with it. So I know that Brad and colleagues working at the LHD are investing heavily in trying to ensure that every young person that engages in a school-based traineeship pathway has an employment outcome.

Q. Is there scope to extend that, perhaps facilitated by the LHD, into non-LHD providers of health care within region, for example, and ACCHOs?
A. Look, I think there is great capacity. In most of our communities our ACCHOs are partners in delivering this program, so that may mean that they open the doors so that we can take these students directly into their health services and they can engage. When we run our First Nations specific academies, we will take them to Coomealla Health Aboriginal Corporation, we will engage with Maari Ma to see if we can get them there. We will also try and take them, as they mature, out to the RFDS and other places. So they can understand that there is a scope of employment opportunity if this is a pathway that they choose, that it is not only working in an LHD or a hospital facility, that there is a broad career opportunity available.

Q. You tell us in paragraph 10 of your outline that your organisation seeks to collaborate rather than compete with other universities to provide clinical placements, access funding for student placements such as scholarships and student accommodation and research in rural, regional and remote communities. Part of that, I assume, is the

one-stop shop arrangement that you operate. Are there other aspects of that collaboration?
A. Look, there are significant aspects to this collaboration. So we work collaboratively with the Far West Local Health District, for example, on designing up fit for purpose health career pathway frameworks, so actually looking at using theory and evidence to inform the career pathways that we establish in this space. We've looked very closely at research and how we are undertaking our research and what are the drivers for that research. So part of our mandate under our parameters that we're funded is to undertake research of relevance to our context and regions which is critically important.

We also know that if we're not working collaboratively in this space to understand what's happening with our workforce investments and the impacts and outcomes we're having, we can actually be fragmenting individuals' career pathways. We can be, you know, duplicating and resource wasting.

So part of working collaboratively is us being clever with the resources we do have, because none of us have endless buckets of funds. So it's very much can we co-fund positions, can we co-fund programs, can we co-fund projects to be able to give us I think the greatest efficiency and effectiveness that we can within the resources we have.

Q. You mentioned the slightly longer clinical placements.
A. Extended durations, yes.

Q. Could you tell us a little bit about them and what the benefits that you see they carry?
A. All right. So extended duration placements are very much embedded in medical workforce education. So six to 12 months to two-year placements as part of your degree in medicine is quite normal. For nursing, it's really atypical to have an extended duration placement. Most of our nursing placements are somewhere between two to six weeks. You might get eight to 10 at a push. The evidence tells us that it's about 18 weeks if you want to see an uptake of rural practice as part of a placement.

So we've been working collaboratively with a number of key regional stakeholders and universities in designing extended duration nursing placements, so we're now in I think about our fourth semester of a 20-week duration

nursing placement. We've just started to draft up the publications around the evidence. So the evidence coming out of that, there is a significant sense of work readiness by these participants, a significant sense of belonging in context, a much deeper and more complex understanding of what rural remote health care entails, a deeper understanding of personal resilience and fragility in these spaces and how you need to look after yourself, and with the nursing program we're now seeing a significant uptake from that program into new graduate year in region.

So we've used the evidence both from medicine and what is now emerging from nursing in our footprint, and I would highlight that we're probably the only footprint nationally who are pushing the boundaries on nursing duration of placements, but we're now engaged with a number of other universities who are interested in understanding how you co-design those models and make them work in your remote context. And we've just come out of a co-design workshop in April with three universities and a number of regional stakeholders around extended duration allied health placements based on that same theoretical proposition that the longer we can keep students in situ learning, the more embeddedness we bring, the more sense of accountability, and the more sense of knowing they can thrive and survive in rural remote contexts we're seeing.

Q. So these are programs where university students who are studying nursing or allied health will be brought out and they will do a placement for 20 to 24 weeks instead of the more conventional shorter placement. Does that mean that part of their non-practical education is needing to be delivered to them while they are out doing the placement, or is the placement being seen as --
A. A clinical placement in isolation to their theoretical learning?

Q. Yes.
A. No, these are blended models. The nursing program is a blended model, so what we do with the students during their semester timeframe of their placement. They will have three days in practice and then they will have two days released to engage with their curriculum. The other thing we acknowledge is that it is not only their core curriculum that's of critical importance to their placement experience and their capacity to progress in their profession, it is also about how we contribute especially

in that pre-placement process in the orientation period to providing those students with curriculum of relevance to rural and remote communities and populations.

So for our nursing students in the program, they do five days intensive orientation and education with us on site, so that will include, you know, an understanding of primary health care, what does a rural nurse look like, where can we work, what do we do; an understanding of cultural safety and competence in the way that we do our work; health care complexity and what does it mean when you're actually - because rural and remote health care is complex, but I think we fail to teach any health students about the realities of what complexity is, what it looks like and then how do you navigate through it.

We also spend significant investments in community engagement. So how do you engage authentically and respectfully with communities in deciding what health care needs are and how services should be delivered, and we also present sessions around what we term to be community literate health care and what does that mean for health professionals who are engaging in rural remote contexts.

So that is our platform to springboard them, hopefully, and prepare them for success in working through the complexities they may confront as they grow into the placement and then we build in critical reflection sessions which enable the students to talk to their experiences and reflect on some of the why do we think that's happening. What is our role as health professionals in addressing those concerns that you are seeing. But we are also highly sensitive that the more sense of belonging these students have, the more sense of feeling valued by their host sites and communities, the more sense of responsibility they can carry for the inequity and disadvantage that they see in real life.

It's different to learning about inequity and disadvantage from journal articles and in a university setting versus actually coming out and seeing the authenticity of disadvantage and inequity as it is experienced in the real world of rural remote and First Nations health.

Q. So that theoretical aspect of their studies which is continuing throughout the program, is that being delivered

by you or by whichever university they happen to have come from?
A. No, our university partners actually have to make a significant contribution to making these innovative and new models work. So the universities - because we have three currently involved and two other universities in negotiation around the nursing program, so the universities have to ensure that the curriculum their students need to engage in is scheduled on the Thursday and Friday of release, so they will make sure that all workshops, all tutorials, all lectures are accessible, whether they are in real-time or whether they are pre-recorded and the students can then come in and access that.

So the universities have to do a significant amount of curriculum juggling at this stage, and I will acknowledge, for a small number of students, because these are pilot models and we are trying to prove efficacy, that these models work for students, and not only for students, for our host sites. That was one of the big catalysts as to why we're very much on this pathway to extended duration.

Our host sites, who are informing us, they were tired and fatigued. They were tired and fatigued pre-COVID. COVID just amplified that tiredness and that fatigue and, then, to have multiple students churning through these systems for placements of short duration, you have to question where the value is, not only for students but for our host sites who are meant to supervise, engage, socialise and support students on that learning journey.

So that was one of the big catalysts. Our host sites said to us "We want this to stop. We need the students here for longer if we're going to feel like the contribution we're making is equally as valued as the students coming out to us feel".

Q. In terms of that theoretical learning, when you get to your Thursday or Friday, assuming the juggle has happened at the other end, one young man on placement might log on and do his university tutorials in Adelaide --
A. Yes:

Q. -- at the university down there, whereas another young woman might be logging on --
A. To Western Sydney, to University of Sydney --

Q. -- to Wollongong --
A. -- University of Notre Dame. It's same with the extended medical placement program, their students will log into both shared tutorial sessions and then their own curriculum requirements. I think COVID, if anything, did us one favour, which was to show that remote learning can work.

Q. Acknowledging what seem to be the great benefits of the extended placements, how do they sit in a landscape where we are repeatedly told placement poverty is a real challenge that a lot of students face?
A. I think that is probably one of the biggest deterrents for students being able to participate in these extended placements, it was with interest that the Commonwealth Government has now made a commitment to cost of living support for specifically nursing and social work students I think commencing in June/July 2025, which will give students access to I think about $320 a week for the placements they undertake.

So for us I suppose the interesting thing is that placement poverty doesn't discriminate against - by the discipline you are enrolled in or you're training in, so I think we can make assumptions and say medical students might be better socioeconomically, but I think that's a false assumption. So it will be interesting to see what happens now for our medical and our allied health students who aren't given access to this first wave, unless there is changed by the Commonwealth about which students will be included.

So I think that will relieve some of the placement burden that we have. I think the tension there also sits with this concept of students employees and workers, or are they actually students who are learning in context, and whether students should be employed as part of their placement experience. To me, that creates some concerns, that students need to be afforded the opportunity to learn and to practise in a safe way, to learn their craft and their skill in a safe way.

The concern is that if you push them into becoming employees before they have that capacity to actually work at that level of independence and autonomy, that we're likely to cause potentially more harm, unintended harm, for students in that space. So for us, there is always - you

know, it is really very live for me at the moment. I have a university partner who is committed to 20-week placements for speech pathology, occupational therapy and physiotherapy students, commencing in semester 2 next year. The issue is how do we ensure that those students don't confront placement poverty and where can we access scholarships and bursaries that are commensurate to placement duration commitment. That is the other challenge, that we can have state and Commonwealth scholarships and bursaries for students to undertake rural/remote placements, but they may be at the same price - the same cost of that, so it might be a $1,500 scholarship whether you are doing a 2- to 4-week placement or a 20-week placement and that is not commensurate to the commitment being made by these students coming out on these extended placement programs.

Q. In relation to that scholarship, do you also operate as a one-stop shop for students in terms of informing them of and helping them to navigate their way through scholarships and bursaries?
A. Yes, we try to link students to scholarships routinely. The other challenge can be that students can apply for a scholarship, be successful, but not receive that scholarship until they have completed their placement. So they have to still carry a financial burden, or their families carry that financial burden of supporting that student until that scholarship is actually released. So timing of release can be a challenge.

Q. One last question. In paragraph 21 of your outline you tell us that you regard our rural/remote and First Nations communities as the local scholars who hold the deep understanding of the needs of their communities and can contribute to the solutions required to meet the challenges confronted. In practice, how do you, as an organisation, really seek to harness that well of knowledge that lies with those or within those local scholars?
A. Can I say, this isn't easy. I think people talk about community engagement and they think it is something we all do routinely. It is extremely complex. It requires a really deep level of authentic and sincere caring for your communities and a sense of who are we accountable to. The one thing we say as a department, yes, we're accountable to our university, we are accountable to our Commonwealth funders, but primarily we're accountable to our communities.

We cannot progress any of the work that we do without communities engaging with us and knowing that we will respect them in that level of engagement.

So the language we use is - and because most of my - well, all of my team live in our regions, whether they are in Bourke, whether they are down south or whether they are in Broken Hill, so not only are we employees, we are community members, you know, we are mums, we are daughters, we are son, wives, family members. So I'm very privileged in the fact that a lot of my staff have deep connections across communities and across a number of different agencies. So we're very receptive to sitting and talking and listening.

I think one of the things that the local people we employ are great at is in being able to interpret what they are hearing, because we know we have to try and take the language of community and translate that into a way that our universities understand the message we're trying to give, or policymakers or health providers, because the way we need to message needs to resonate not only with our communities but with those we're trying to influence and impact and leverage into. So I think being able to interpret that and ensure that we're interpreting that correctly is a critical component.

I think the language we use to define our communities can actually act to undermine that. You know, they can be our patients, they can be our consumers - they are actually the owners of our healthcare systems and we need to use that language if we're to show a deep respect.

We need to also understand and acknowledge knowledge sovereignty and leadership of that knowledge sovereignty. The language of decolonising our perspectives on what is good health care and what is not and from whose perspective I think we need to deeply reflect on, and I would say that the privilege we have is that we sit in that unique position where we can draw on that capacity, because we're not driven by the same KPIs as an LHD or an ACCHO, so we have greater flexibility and expectation that we will engage in ways that are respectful and meaningful to get the outcomes we need.

An example of how this plays out in the authentic

world is, through that deep engagement with a number of our key stakeholders and communities we've been working for 12 months to establish what we're calling our Cross-Sector First Nations Research Collaboration where through a partnership between ourselves and four key agencies, we're launching the First Nations Research Network tomorrow. That is very much around decolonising traditional Westernised, you know, paradigms of who controls research, can do research on who. This is about giving knowledge sovereignty, knowledge production and knowledge leadership back to our First Nations peoples.

So to me, you know, something that's been 12 months in negotiation and discussion and getting clarity comes to fruition tomorrow. So these are the things that we can do. But I think the other thing, you know, is that deep connection to our communities, you know? This is my home. I've watched for a number of decades, you know, past harms being perpetrated by individuals or agencies against each other, you know, untruths being told. So you don't want to find yourself in that position. Your creditability is shot. People's trust in you is shot if you don't engage in those ways and we can't be effective if we don't engage in those ways, as we say, community literate behaviours - have a deep understanding, have a deep level of respect and engagement. Commit to what you are going to do and then deliver on it and do it in a way that engages your community partners in not only designing what we want to do, implementing what we do, but evaluating the impacts of what we do.

Q. By evaluating you mean constantly checking in with the community to make sure that it's actually doing what everyone hopes it would do and, if not, why no?
A. Yes, and that can be a formal evaluation where we will have robust research frameworks wrapped around these initiatives to understand impact and outcomes, or it can be as much as sitting down and saying, "Now, how did that work for you", and if it didn't work well, and, see, that's those multiple feedback loops, that different perspectives inform how you polish - you know, you can start with a lump of coal and hopefully, over time, you can polish it up to a diamond.

MR MUSTON: Commissioner, I have no further questions.

THE COMMISSIONER: Q. The First Nations Research Network

that you are launching you said was a partnership between yourselves and four key agencies. Who are the other agencies?
A. The Far West Local Health District is one of those key agencies, the Royal Flying Doctor Service is another key agency, Coomealla Health Aboriginal Corporation, and we have a cross-border partnership with Monash Rural Health in Mildura, so they will be coming to the table as well. So their First Nations representatives will be leading that network and they will be supported by the University of Sydney's Poche Centre for Indigenous Health Research.

Q. What does it involve and what do you hope to achieve through it?
A. I haven't determined that, because I'm not a First Nations woman. So part of the intent is that group will come together and they will talk about what initially will be a 12-month pathway and journey of learning, hopefully, very much research methodologies that are embedded in First Nations ways of knowing, being and doing. They will also be determining as a group their governance structure and the terms of reference to which they will work and my role is to help facilitate that and to keep that space safe for those First Nations representatives.

Q. So despite it being launched, it is fairly embryonic?
A. It is very embryonic and it is not prescriptive. That would be totally inappropriate and go against the whole sense of Firsts Nation sovereignty and leadership.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much, Professor, for your time. We're very grateful. You are excused and we will adjourn until 10 past 2, I think.

<THE WITNESS WITHDREW

LUNCHEON ADJOURNMENT

MR FRASER: Commissioner, we have in the witness box David Green. I call Mr Green.

<DAVID GRAHAM GREEN, sworn: [2.10pm]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Mr Green, would you give your full name, please?
A. David Graham Green.

Q. Mr Green, you are currently the director of people and culture at the Far West Local Health District; is that right?
A. That's correct.

Q. And we understand that you have held that position since April of 2022; is that correct?
A. That's correct.

Q. And in terms of your experience, you have worked in a number of health related industries; is that right?
A. Correct.

Q. I think from looking at your CV, this position is your first position working for the strictly public health system --
A. That's correct.

Q. -- in terms of governance; is that right?
A. Yes.

Q. You prepared an outline of evidence; is that right?
A. That's correct.

Q. That's [MOH.9999.1263.0001]. Mr Green, you have read through that prior to giving evidence today; is that right?
A. I have.

Q. Are you content that it is accurate and correct, as far as you can tell?
A. As far as I can tell, yes.

MR FRASER: Thank you. That will form part of the bulk tender along with Mr Green's CV in due course.

Q. Mr Green, I would like to just tease out a few things from your statement. Overall, you have said in paragraph 4 of your outline that you are responsible for all people and culture programs in the district, and then you've gone on

to list a number of specific programs; is that right?
A. That's correct.

Q. Can I just ask you about some of those. Attraction and retention, is that of staff generally to the district?
A. Generally, but more specifically because I'm not directly responsible for nursing graduates and medical services, we tend to focus on the roles outside those areas. However, we do provide support in the administration of the systems that allow the applications to apply, the processing of the application, the interviewing process and also the letters of offer and so forth generally.

Q. I will ask you then, you have said you are not responsible for nursing graduates --
A. Mmm-hmm.

Q. -- directly. Who is?
A. The recruitment of nursing graduates falls under the directorate of nursing and midwifery and clinical governance. They liaise with the Ministry of Health department, which is I think called NAMO, or there is a centralised recruitment program. We provide, for want of a better expression, back-end support in terms of letters of offer and so forth, but we're not directly responsible for the graduate program.

Q. Can I just ask you, that directorate, the nursing, midwifery and clinical governance directorate; is that right?
A. Correct.

Q. That's part of the local health district?
A. Yes.

Q. And that's in terms of graduate nurses. What about experienced nurses? Does that fall within your --
A. We support the recruitment of non-graduate nurses. We are responsible for fulfilling the recruitment requisitions that are triggered by the nurse manager and their relevant directors.

Q. And in terms of medical staff, is it a similar situation - you provide the back-end support?
A. At a much lower level. It tends to be centralised within the medical services directorate purely because of

the nature of the medical services, the locums, the RMOs and the consultant physicians that come in. There is a specialisation that staff within the medical services directorate have that my directorate doesn't have.

Q. I will come back to some of those matters as we progress in terms of some of the particular areas that you touch upon. You have also referred in paragraph 4 to being responsible for learning and development. Again, is that across staff and the district?
A. It is across the district, but it varies in terms of your definition of "learning and development". There is professional development, and if I could use, for example, nursing, the clinical development, you have clinical nurse educators, you have a team of CNEs that operate under the director of nursing midwifery and clinical governance who provide specific professional training. We're not involved in that. We provide, again, back-end support in some of the systems that are used, My Health Learning, for example, which is the learning database which sits across all roles in the district, and most of NSW Health. We do the onboarding, we do the mandatory training, the compliance training, but again, we administer it, we don't necessarily develop the training. Much of it is driven from selected modules and driven out of the Ministry of Health.

Q. Largely coordinated through HETI?
A. Yes.

Q. You also said you are responsible for organisational development. Can you explain what that means?
A. It's a fairly broad topic area. Where we are focusing is fairly embryonic. We're focusing more on employee engagement. Our major focus is - and I refer to it in my statement - people matters engagement score and then the action plan that drops out of that which is designed to improve the working environment for people and provide an opportunity for staff to meet with their managers and work out how to work, to bring the best out of them and what changes can be made at the local level, ie in the work unit, at the service level and potentially across the directorate or the district.

Q. Can you give an example of that in action, so as to say?
A. I refer to the example in my statement of evidence where I talk about the decision that was made to

incorporate as a standing agenda item in all team meetings our core values. That came out of a discussion at a workforce exec committee, which is just a committee that describes a number of workforce activities, in how we provide an avenue or a forum for staff to talk about our core values, what it means to them, where they may have identified people behaving in a way that aligned with the core values and also, conversely, where that may not be strictly in alignment, or how we can develop better ways of working together as team members that are aligned to our core values.

Q. From what you just said, another program that may be somewhat related that you are responsible for is workplace health?
A. To a degree, yes.

Q. Can you explain what workplace health means?
A. Mmm. Workplace health and safety and wellness, staff wellness, is a set of or an overarching phrase that's used to look at what used to be called occupational safety or occupational health and safety. We call it workplace health and safety, so it is fairly compliance driven at this point in time. It looks at identifying hazards and risks, we do risk audits, we have safety action plans, we have a compliance program where we have to do three-yearly audits. Much of that is driven - in effect, we outsource that service to Western NSW LHD and we provide - they provide us with the support, the risk management, the governance over that and then we enact it as best we can. We enact it during the process.

Q. I think it's safe to say, then, some of the other parameters you are responsible for fall under the umbrella of traditional what might be termed HR functions, employee relations, business partnering, payroll, those kind of functions?
A. They are what are considered the traditional HR functions. Payroll is outsourced to HealthShare. Rostering is outsourced to HealthShare and the two go hand and hand in the health environment generally. But in terms of the general - what's generally considered to be HR, yes, you are correct.

Q. I think what you have said in your statement is you had five staff members when you commenced?
A. Mmm-hmm.

Q. You now have 11; is that right?
A. Yes.

Q. Is it 11 FTE?
A. Yes.

Q. And you are currently seeking to recruit to another position that is vacant; is that right?
A. That is correct.

Q. Which is the manager of Aboriginal workforce development?
A. Correct.

Q. Is that a new position?
A. It is a newly created position, yes.

Q. That's a newly created position. We might return to that in a moment. Just in terms of the general growth in the team, is that growth from five to 11 the result of newly created - generally the product of newly created positions, or is it the product of filling previously vacant positions?
A. No, it is the creation of - it is newly created positions. To give you context, part of the remit that I was recruited for was to assess the people and culture needs, so broader than just HR, the needs of the LHD, and then make a recommendation to the chief executive about the resources that were required by the LHD to provide a modern, up-to-date, or as up-to-date as we can get, HR people and culture function. Those roles, the newly created roles, or the ones created in the last two years, reflect that.

Q. Presumably your advice to the chief executive was that there were insufficient staff to provide such a modern up-to-date service?
A. Yes.

Q. Can I ask you, I'd like to focus now - and I should have touched on it, I don't mean to overlook it - I think the welcoming service, which is provided by the Department of Regional New South Wales, or funded by, is coordinated via your directorate; is that right?
A. Correct.

Q. And a statement has been put into evidence from the individual who provides that service. But that generally aims to assist new staff members coming to the area with their integration into the community generally; is that right?
A. It's designed to make them feel as welcome as possible in the community and as welcome as possible in the organisation, with the intention that the sooner they feel welcome and settled, the more effective they will be in the workplace and, over time, potentially less likely to wish to move to another service or out of the district.

Q. That brings me to the topic I wanted to come to, which was recruitment and retention of workforce.
A. Mmm-hmm.

Q. And you have said at paragraph 11 that currently, or at least - sorry, in March of 2024, the budgeted workforce across the district was 876 full-time equivalents, FTE?
A. Yes.

Q. But that during that month, effectively, there were 788 FTE being utilised and a staffing deficit of 88, doing the maths.
A. Mmm.

Q. Can I just ask you about those figures. That 88 staffing FTE deficit, is that firstly distributed across the district, or is it particularly acute in certain parts of the district?
A. As a general observation, and not having the data in front of me, because the vast proportion of the FTE in the district resides in Broken Hill and in the hospital, it is generally within Broken Hill. The next area would be what we call the Lower Western Sector which is Baronga, Wentworth, Balranald, Dareton, and then you have the remote services Tibooburra, Wilcannia, Menindee and so forth, where the vacancy rate is probably less, but a single vacant position in those smaller services is far more impactful than in a larger service.

Q. Yes, some of those services run on only maybe two or three staff members on duty at a time?
A. Correct, yes.

Q. And just in terms of disciplines that are covered by that 88 FTE staff deficit, is it predominantly in clinical,

or is it also significantly in non-clinical positions?
A. The bulk of our FTE sits within the clinical specialisations, so by extension, you would suggest that the bulk of the vacancies sit within the clinical specialisations, but it can vary depending upon the time of year, staff moving in, where you are up to with your recruitment and so forth. So I would agree as a general comment, but wouldn't agree as a statement of fact on a recurrent basis.

Q. Just taking now as a snapshot in time, and I'm not asking you to have the up-to-date figures at your fingertips, but are there any particular disciplines that are posing a challenge as of now?
A. It depends how you define "challenge".

Q. Are there any particular disciplines where there is a particular difficulty in obtaining sufficient staff?
A. The - I will answer that question conversely, if I may. The roles that we do not have difficulty in recruiting tend to be your low to semiskilled roles that we can draw immediately from the local labour market, okay? Therefore, any other role that we can't draw from our local labour market, which is upper semiskilled to highly skilled, we tend to have to recruit externally, and they are more problematic.

Q. So ongoing difficulty with sufficient nurses; is that right?
A. Well, there has been an ongoing difficulty with sufficient nurses globally for 20 years.

Q. Just to ask you in relation to your - you have also provided some figures in relation to what you have termed your processing of recruitment requisitions.
A. Mmm, yes.

Q. This is an observation, of those 402 over the current - well, over the first three-quarters of this financial year, that's what the figures are for --
A. Effectively.

Q. -- effectively, 402 requisitions, recruitment requisitions, with outcomes of 157 FTEs permanent and 175 as agency staff, and then some smaller numbers in part-time, et cetera. Can I just ask you, in terms of those recruitment outcomes, do those reflect the outcomes

that were initially sought, generally? In other words, are there a significant number of cases where the employment outcome that was sought by the requisition has been a permanent staff member, but due to being unable to obtain a permanent staff member, the result has been an agency staff member?
A. It can be, but to make a general statement in relation to those - I would be loath to make a general statement in relation to those figures because it would require a case-by-case analysis of each of those. You will find that managers - because the hiring manager is the manager that triggers the recruitment decision. My directorate doesn't oversee that. It's up to the hiring manager. So the hiring manager can make a decision as to whether they wish to replace the role, whether there is sufficient activity, so sufficient demand, whether they have someone coming through the ranks or someone coming back from leave that they are aware of who would be suitable, and they can then choose to use another alternative, secondment, internal secondment, or secondment from another LHD or agency. So it's almost specific context to the roles.

Q. Do you have a sense of how successful people are being at filling permanent roles and having to resort to agency roles, without going into numbers?
A. My general comment will be that we tend to be relatively successful in attracting permanent roles when we set our mind to it. Now, what I mean by setting our mind to it is actually applying effective recruitment practices. That, for example, can include advertising out of district, advertising interstate, effectively managing the applicant pool, moving people through the recruitment process and the system effectively, efficiently and in a timely manner. That can make it very impactful. And then you made earlier a reference to the welcome experience, and then landing them properly, embedding them into the organisation and the community effectively. That's effective recruitment.

Q. Can I ask you what you mean, just looking at those things that you have said - what you mean by effectively managing the applicant pool?
A. Mmm. The recruitment system that all LHDs are required to use, and they call it - it is ROB, recruitment onboarding, it is an applicant tracking system. It is designed for much larger organisations and it tends to be sequential and cumbersome. The way it is currently configured is that it is almost totally up to the hiring

manager to move applicants through the process. If the hiring manager chooses not to for a whole host of reasons, some of which are incredibly valid - they may be on the floor all the time, they may not be comfortable with the system, they may not have used the system for six months, therefore you have a question of how do I use the system, that's not effectively handling the applicant pool. If you have the resources to actually apply skilled capable people to manage applicants, you can move them through the process relatively quickly.

The other side of the process is that applicants generally, particularly in nursing, just using the nursing cohort as an example, tend to apply for multiple positions at the same time. They will then take the best offer that they get. So we will find instances where they keep us on the hook, "Yes I'm interested, yes I'm interested", only to find weeks later that they've gone somewhere else, and that was their intention all along. So it depends on whether the candidate wants to come to us, and that's where early intervention, early handling, for want of a better phrase, massaging communication contact with a candidate, actually brings them on the journey to land here and become a valid employee or a valuable employee of the local health district.

Q. That what you have termed as "skilled capable people to manage applicants", is that something that your directorate is becoming involved in?
A. We are responsible for it. The issue that we have as a directorate within a small LHD is that the beast that is ROB - and that's the internal jargon - is very labour intensive and requires a large recruitment team to move people through the system quickly - through the applicant pool quickly. We don't have the resources for that and ROB has been designed for much larger organisations. It's effective in larger organisations. It becomes burdensome for smaller organisations and smaller services.

Q. What is it about ROB that requires such a large team, as you say?
A. It's the configuration. I'm not an expert in ROB or applicant tracking systems, but it's the configuration, the fact that it is sequential, you cannot move outside the system, we have checks and balances that are required by relevant pieces of legislation, we have checks and balances built into the system that come out of ministry, so

vaccination guidelines, Working With Children Checks, police checks, reference checks, all those have to be stepped through sequentially and in hopefully a timely manner, but they are all dependent upon human intervention into the step.

Q. From your understanding and observation of that, is there some scope for some streamlining of that process that may reduce that, by - let's just, for example, and it's something you identify in your statement, you have said in paragraph 28 that in relation to vaccination requirements and mandatory checks, which I presume you are referring to things such as police check, Working With Children Check -, they are not held centrally, and they have to be done each time - again, for each position applied for in a different LHD; is that right?
A. Technically, they can be, yes.

Q. Technically they can be?
A. You have to reapply and run them through the system every time. Each LHD is a separate employing entity. Even though we're effectively a wholly owned subsidiary of NSW Health, because we're an separate employing entity, we have to run through the same probity checks, which is what we're talking about, each time they apply across LHDs. So the short answer to your question is yes.

Q. Yes, about the centralised - by HealthShare or whoever it might be - do you think that could streamline the process?
A. If you take the notion that we're all employed ultimately by NSW Health, then a single database that captured the common detail that is required across NSW Health would make it much easier for not only the Far West Local Health District but all local health districts to move people through the systems.

Q. Quicker?
A. Quicker.

Q. And more efficiently?
A. Yes.

Q. And whilst those things affect every LHD, is what the bottom line of what you are saying that in a smaller district such as this, where the HR team is - I will use the generic term, if you will excuse me - of a limited

size, then those individual steps that need to be repeated each time are particularly emphasised in your ability to move people through the system?
A. There are clear diseconomies of scale for smaller services and smaller LHDs, yes.

THE COMMISSIONER: Q. Whatever ROB is, you can't - if someone's applied for a job at Sydney LHD and done all these police checks, et cetera, you can't - if they apply for a job with you, you can't just log into the system and say they've got all the checks done?
A. No, and we also have to issue them with a new letter of offer. So even on a secondment basis, and we currently have staff seconded out of Sydney LHD, we have to raise a requisition, then raise a letter - have their requisition approved, then raise a letter of offer, get that accepted by the employee, so we can actually put them into the rostering system so we can pay them.

MR FRASER: Q. I just want to ask you about a different aspect of recruitment and retention of workforce. Firstly, you have said that recently there was the appointment of a talent acquisition lead and a learning and development lead --
A. Yes.

Q. -- and that's within your directorate, is it?
A. Correct.

Q. And, presumably, they were two of the newly created positions that you effectively recommended?
A. Yes. Yes.

Q. And can you just explain how - as you have said in the outline, the intent was to improve the capability building of existing staff and to improve the capability of recruitment of staff to the district. How is it that those roles achieve that, just explain.
A. Sure. The intent behind those roles, given that they have only been in place for 18 months or so, so it's still early days, the talent acquisition lead, by way of title, it was a change from a recruitment manager, so it reflects modern day practice and acceptance that applicants are not just people - people filling a role, they are actually talent and you want to be very specific about the sort of person - talent - that you want to acquire. That then leads into things like your employee value proposition, how

you advertise, how you mark it, the channels that you use to recruit people, we're talking social media, we're talking LinkedIn, we're talking the use of SEEK in more innovative ways. We're talking about how we reword our ads so that they are attractive. That's where the talent acquisition lead comes in and those were the skills that I looked for in the successful applicant. The simple fact of the matter is that whilst I would love to employ locally as much as possible, that skill set is not readily available in Broken Hill, hence the desire or the need to look further afield and, in reality, to metro areas to find the right person to drive that process.

Q. Is there any other advantage about them being located in Sydney? Are they able to engage with professional bodies or other agencies in a way by being based in Sydney?
A. If you find, and we did, a career talent acquisition person, they are already plugged into a network of talent acquisition people which is superior in breadth and depth by virtue of scale in your metro areas in comparison to your rural locations.

Q. We'll come to techniques in a moment, and similarly your learning and development lead, presumably responsible for learning and development - does that include strategies for the retention of staff?
A. Not specifically at this stage. That is the intent. The focus of the learning and development lead is more on aligning our training, identifying what are foundational levels of training for employees and, in particular, our team leaders and lower managers, so people management skills is a clear area of focus; developing and coaching those staff and the team leaders so we can bring people through. It is all well and good to bring in calibre candidates, but you need to give them a pathway and a reason to stay. Money is not the be all and end all for most people.

If you look at any sort of engagement data and you look at the top 10 drivers of why people come to work, remuneration is normally around 7, it is about self-actualisation, career development pathways, culture, working environment. Those are the things that the learning and development lead will focus on once we move past what are the more foundational elements, and by "foundational" I mean how to have a performance management conversation with a team member; how to call out behaviour;

how to create clear expectations for your teams.

Q. So skills building in those --
A. Frontline skills, yes.

Q. Just going back to those factors that you were referring to in relation to attracting people to stay, when you say "culture" - you said "culture and working environment". What do you mean by those two?
A. Well, culture is, for me, for want of a better phrase, the vibe of where you work, I mean your values, your team ethos, your unwritten ground rules, how you interact as team members and your capacity to work effectively as a team. Your working environment encompasses that, but it also goes beyond that to include communication from senior management, communication from service managers, how the individual directorates integrate, so, for example, how your maintenance team work with your nursing staff to make sure that the equipment is working, that the configuration, the lighting is up to speed, that problems are fixed quickly. That's part of your working environment.

Q. They go hand in hand, presumably?
A. Yes, pretty much.

Q. Two aspects of similar things for an employee.
A. Almost two sides of the same coin.

Q. Can I just ask you about some of your strategies available for recruiting and retaining staff. Not one initiated by the local health district but one that you refer to in your outline is the Rural Health Worker Incentive Scheme --
A. Mmm-hmm.

Q. -- paragraph 15 onwards, introduced at a similar time to you taking up your post, it would seem?
A. Mmm.

Q. And just to confirm, whose scheme is that? Is that a ministry scheme?
A. It was developed by ministry, yes, and handed out to the rural LHDs.

Q. And as you have set out there, it offers a maximum of $20,000 per FTE that can be used in a variety of ways?
A. Mmm-hmm.

Q. Is that per annum?
A. Yes, the 20,000 is the new amount. Initially, when it was released in July 2022, it was $10,000 per annum for a full-time equivalent. It's pro rataed if you are 0.5. It was then - in my statement - it was then increased to $20,000 for the first year only.

Q. In terms of this LHD, is that something that's applied generally to all positions, or is there a decision made about supply and demand or whether that's required and whether it needs to be the maximum of 20,000 or - can you talk us through the process?
A. Sure. I don't believe you can use the word "generally" in terms of how it is applied. If you read through the policy, it's quite clear on how you select roles, the entry criteria into the scheme for existing positions. The role has to be advertised twice unsuccessfully in a six-month period before it is eligible. Eligibility does not mean you automatically get it. There is then a paperwork process that needs to be applied. That's captured and recorded.

Once the position is identified and approved as being eligible, we then use the incentive. That can apply to any position within the LHD. Now, where I backed away from the word "generally" is that, by definition, not all positions need to be advertised twice unsuccessfully. I earlier made a comment about local roles that we can fill very, very easily in Broken Hill. I give you, by way of an example, semiskilled, ward clerks, clerical assistants, cleaners, hospital assistants, if we put an ad out, we get 60 applications. Those roles, regrettably, don't meet the criteria, okay. The more specialised roles, nursing by and large, get them. The policy allows for a mapping process, so that if you have a nurse position or - and the policy is position based, not individual based; it's not employee based.

If you identify a position and it is deemed eligible and approved as eligible, it may have 10 FTE attached to that one position number. It's not a one-for-one relationship. That then means that if you apply the incentive to one person, one out of the 10 FTE against that position number, the other nine can be mapped as eligible on a retention basis.

Q. On the basis that if they left, you'd have to --
A. Advertise twice unsuccessfully, yes.

Q. I understand that. You have set out the current distribution in a table.
A. Mmm.

Q. Just to take - presumably, you have said, for instance, semiskilled here in Broken Hill, generally - and I appreciate you qualified that, but generally not a problem?
A. Mmm-hmm.

Q. Not eligible for the scheme. There are some semiskilled positions here. Extrapolating from your statement earlier, presumably those positions are generally ones located outside of Broken Hill, for instance, administration or hospital property and maintenance?
A. Mmm, they are not necessarily located outside of Broken Hill, those roles. They are on the upper level of semiskilled or trades. By way of example, your trades roles tend to be hard to recruit to just by virtue of the nature of the labour market in Broken Hill. So they can become eligible for the incentive.

Q. But just moving back to what you said about semiskilled roles in Broken Hill, what about semiskilled roles outside of Broken Hill?
A. In the smaller services, the labour market is much smaller, therefore, it is more likely that you will advertise twice unsuccessfully, which makes them eligible. You then - and you then also have to the ability to map those positions in the local - similar positions in the smaller services, by virtue of the extrapolation you just articulated where you go, "If I lose a clerk" - I've got two clerks, say, in Wilcannia, just by example, "if I lose one, I'm recruiting for one, I might as well give it to the other, because if they resign, I'm in the same position". So it's the same extrapolation.

Q. You have said in paragraph 16 that to date the scheme has not had a material impact. Is that in part due to it being relatively recent, or is that due to your assessment of it not really bridging the gap?
A. It's both.

Q. I think what you have said is - or what you have said

in your outline is that the number of retention initiatives were predominantly issued to staff already employed in the district prior to the commencement of the scheme. 297 were on a retention basis and 148 were on a recruitment basis; is that right?
A. At the time that we extracted the data for the statement. It is a moving feast.

Q. Of course. Those figures will have moved since then?
A. Yes.

Q. This is relatively recently though, certainly in the last three or four weeks, I would have thought. But in terms of the 148 recruitment positions, do you have a sense that you would have been able to fill those positions without the scheme, or --
A. The Rural Health Workforce Incentive Scheme replaced an earlier scheme where we did have capacity to assist people to relocate without a wage incentive, so it was a one-off payment. So that was already in existence.

Without the application of the Rural Health Workforce Incentive Scheme at all in New South Wales, we would have been competing on a level playing field, as level as it gets, okay, with all the disadvantages as a remote location we have. We had to step into the rural health workforce incentive scheme, because if we didn't, we would have been left even further behind. So it is a bit hard to say whether this may - whether the 148 that we have here, whether they would have come. I take the view that most of the 148 would have come here anyway, because that's the intention. The incentive just assisted their relocation or made it a little bit more attractive.

Q. So is the point that you were seeking to make by saying that it hasn't had a material impact to date is that it hasn't really improved things from the previous iteration as opposed to the alternative of having no - nothing to incentivise staff?
A. The Rural Health Workforce Incentive Scheme in comparison to the previous scheme is much more sophisticated, there are larger amounts of money attached to it. But it's had no measurable impact on our capacity - we haven't gone from five applicants to 50 applicants, as simple anecdotal evidence. I would suggest, and in talking to people and in talking to the recruitment team, the applicants who receive the money - and we apply the

incentive correctly - were probably going to come here anyway; we just sweetened the pot a little bit.

Q. Do you know if the scheme has been formally evaluated across the state?
A. Not to my knowledge.

Q. I appreciate you don't administer it.
A. No, no, nor more specifically to the LHD, I've not been approached by ministry to provide that sort of feedback.

Q. And have you provided any feedback on the scheme to the ministry?
A. Not formally, no. There's been informal conversations with those who are overseeing the program, but not in terms of "What do you think, how could we improve it", not along those lines.

Q. Can I ask you: how could you improve it, or how could it be improved, I should say?
A. That's almost a question of how long is a piece of string. The incentive is a good idea at intervening in the labour market to improve the ability of rural and remote health services to attract calibre staff. Where it struggles is a whole host of reasons. We operate in a tightly controlled environment, both jurisdictionally and industrial relations. We were effectively trying to go outside the award-making scheme. We are competing against other jurisdictions who offer far more money. We are in a wages war and I would suggest, without knowing officially, that the increase from $10,000 to $20,000 was in relation to the fact that other players just upped the money as well.

THE COMMISSIONER: Q. By "other jurisdictions", you are talking about other states --
A. Queensland, Victoria, and WA to an extent as well.

The money is effectively insufficient. $10,000 or even $20,000, if you put it on the table in front of someone, it is a big sum of money. But then you take at least a third out in tax, you then ask them to pay for their relocation expenses. You then look at how much they can earn on an annualised basis by the time - if they are a nurse or a doctor, all the other allowances that get tacked in, you go "It's actually not that much money".

I don't think the amount of money is sufficient, but I'm also not sure that you want to increase it too greatly, because you then escalate and ramp up the wages expectations of those professions across Australia in an environment that is already struggling to fill roles and find people.

MR FRASER: Q. In terms of strategies if not monetary incentives, are there other strategies that you think may assist the challenges at least for areas such as the Far West Local Health District?
A. I think we need to be more innovative and more lateral thinking in our approach. I reflect on the experiences I've had in other states and in other organisations of where we've looked at some of the structures. By way of example, when I was in Queensland as the director of HR for PresCare and I was negotiating the enterprise agreement, we were speaking to the Queensland nurses union and we couldn't afford to give them the pay increase that they wanted. It is a not-for-profit organisation. So they came back to us and said, "Well, for our nurses" - they had an increment based on hours of service, or every annual they go up an increment. They went from 1 to 8. They said, "Why can't you shorten the number of hours to make the grade". There is logic sitting in behind that, because if you look at a registered nurse level 1, increment 5 or 6, the logic behind it is that you pick up experience by on-the-job experience, so you become more valuable as a nurse or a clinician. But by the time you get to 5, 6, 7 or 8, the question of the return on that - what skills you pick up, there is a question of: well, are we just making them wait 12 months?

So we agreed to shorten the number of hours. It also then ratcheted into the fact that you have part-time employees working 50 per cent of the ordinary hours who have to wait two years for an increment increase as opposed to 12 months, and there is an equity issue. So that's one example.

I would look at - I think we are too tightly controlled, and this is just an opinion, I'm not a clinical professional, so I will caveat what I'm about to say. I think we're too tightly controlled by professional associations who, respectfully, it is in their best interest to restrict supply. A labour movement runs on controlling labour. If you restrict supply, you then have

a chance of pushing up wages. We can be more innovative. We can step outside clinical practice. We have examples in Queensland where in aged care, again, there was a huge push to - and the federal government funded the medication endorsement for endorsed nurses, to remove the need to have RNs handing out the pills. That's a very flippant comment and it would need to be sense checked against actually what it was.

But there was a massive push to do it. It was very effective for aged care. We didn't need to hire registered nurses in the numbers that we needed, because we knew the endorsed nurses with the medication endorsement could do it. They are just examples of things we should be looking at particularly in the rural/remotes. I'm not saying we have to do it in the metros and, in fact, I wouldn't encourage to do it in the metros because we need to have a competitive advantage, and if we can say to our staff "You can get accelerated professional development because we do things a little bit differently out here, but still safely", that's attractive to them.

Q. Something else you have raised in your outline that may be related to that is flexibility in conditions of employment that you can offer. I think, if we go to paragraph 24, the fact that awards and conditions are determined at the state level?
A. Mmm.

Q. With very few conditions discrete to remote services?
A. Correct.

Q. Are there any conditions discrete to remote services?
A. In the nursing award, we have an additional week of leave, if I recall totally correctly, for Ivanhoe and Tibooburra because of their remote location and also, as I understand it, because of their size, their staff are effectively on call 24/7 and their reward or the recompense for that is an additional week's leave.

Q. That's really the limit of it, is it, off the top of your hear?
A. Staff who are based in Broken Hill, for Far West, and I think it's for all of Broken Hill but I will reference the local health district - we all get an additional week's leave. So we get five weeks of leave. There is also for some staff an allowance under the Broken Hill Health

Employees (State) Award, which is called the Broken Hill town and versatility allowance, which, if I recall its premise of many years ago, it was the capacity to move people across roles or flex their roles so that it allowed - for a payment, of course. So it gave you labour flexibility. They are somewhat dated. That allowance is somewhat dated in its approach, but there are ways and options and opportunities that we could apply remotely if we were allowed some degree of flexibility outside of the existing state awards.

Q. Is there the flexibility to offer bespoke incentives to staff?
A. Not currently, but I'd love it if there was.

Q. So, for instance, staff relocating from - junior staff whose family may be on the eastern seaboard, to take an example, are you able to offer assistance with travel home --
A. Under the rural health workers incentive scheme we can, it is bespoke, but the problem with it is it is capped at $10,000 and trips home from here, family, to the eastern seaboard, on the two carriers that operate out of the Broken Hill airport, are expensive.

Q. Indeed. And also require other criteria to that scheme being met?
A. Correct.

Q. You are not able to offer that as a matter of course when advertising a position?
A. No, we need to meet the criteria of the incentive. So if the criteria were broadened or we were provided with another set of criteria that we could apply on a - in a bespoke manner, that would give us greater flexibility.

MR FRASER: Those are the questions that I have for Mr Green.

THE COMMISSIONER: Thank you.

Q. Can I just ask one further thing just so I understand what you are telling us. It is partly in your statement and partly in the evidence you gave today. If you look at 27 and 28 of your outline, I understand what you are telling me in 28 about the lack of a single database. But in 27, how should I understand where you say - when you are

talking about ROB, in the second-last sentence:

In addition, the mandated steps in the system are strictly sequential --

I understand that --

and cannot be bypassed.

I get that the system doesn't allow you to bypass a step. But why would it be useful for you to bypass a step in terms of agility of recruitment? It would have to be a step that's not absolutely crucial, I imagine. You tell me what you mean by that anyway?
A. It is the sequential nature of the steps. The way the system has been configured, they've just said "This is the way it is", and probably for very good reason. But you can look at the steps and say "Well, we could probably do two at the same time", or, "Can we take --

Q. Or out of order?
A. Out of order, change the order or, alternatively, can we take it out of the system and do it potentially manually. Even if we do that, we then have to go back into the system and put it into the system.

Q. So it's not that you want to miss steps; you just want to do it in a way that best suits the recruitment process?
A. Correct.

THE COMMISSIONER: Got it, thank you.

Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR FRASER: Mr Glover will take the next witnesses.

THE COMMISSIONER: You mentioned something about I've got to break at some stage. Is that after these witnesses?

MR GLOVER: Yes, if convenient.

THE COMMISSIONER: Whatever you tell me, thank you.

MR GLOVER: The next witnesses are Mr Nankivell and Councillor Kennedy. They will be giving evidence together.

<THOMAS KENNEDY, sworn: [3.04pm]

<JAY NANKIVELL, sworn:

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Mr Nankivell, could I start with you. Could you state your full name, please?

MR NANKIVELL: Jay Nankivell.

MR GLOVER: You are the general manager of Broken Hill City Council; correct?

MR NANKIVELL: Correct.

MR GLOVER: You have held that role since March 2021?

MR NANKIVELL: Yes.

MR GLOVER: Prior to that, you held a series of other roles with the council, including chief financial officer and manager of finance; is that right?

MR NANKIVELL: That's correct.

MR GLOVER: You first were employed at the council in about June 2016; correct?

MR NANKIVELL: Yes, that's right.

MR GLOVER: For the purposes of giving your evidence today, you prepared what's described as an outline of anticipated evidence, although I think you've signed it, it's on the screen there. Do you have a copy of it with you as well?

MS NANKIVELL: Yes, I have a copy.

MR GLOVER: I take it, prior to signing it, you read it?

MR NANKIVELL: Yes.

MR GLOVER: You are satisfied that its contents are true and correct?

MR NANKIVELL: Yes.

MR GLOVER: Councillor Kennedy, if I can come to you, can you state your full name, please?

MR KENNEDY: Thomas Kennedy.

MR GLOVER: You are the Mayor of Broken Hill City Council; correct?

MR KENNEDY: I am.

MR GLOVER: When were you first elected mayor?

MR KENNEDY: Elected mayor in 2021, December.

MR GLOVER: How long have you been on the council?

MR KENNEDY: Since first elected in 1999.

MR GLOVER: And you have been on the council continuously since 1999?

MR KENNEDY: Except for a four-year period and a two-year period.

MR GLOVER: Mr Nankivell, if we start with you, in paragraph 3 of what I will call the statement, you refer to a number of challenges facing the delivery of health care in Broken Hill. Before we go to those, can I ask you to tell us a little bit about the local government area, its size and population?

MR NANKIVELL: Yes. So the local government for Broken Hill City Council is just Broken Hill itself. We don't go out into the unincorporated area, so around 30 square kilometres. The population currently is 18,000 people, with an expected growth over the coming years. Contrary to the Department of Planning's estimations around population decline, it will be actually a gradual increase over the next five years due to a number of mining and renewable

projects that are coming online.

MR GLOVER: In terms of growth, just in ballpark figures, what's the projected numbers?

MR NANKIVELL: We're expecting an increase in the residential workforce of between 1,500 to 2,000 workers and estimating that to be around a 3,500 to 5,000 increase in population.

MR GLOVER: Can you tell us a little about the demographics of the population? Is it an ageing population, for example?

MR NANKIVELL: It is an ageing population, with a high percentage of our population over 65, a lot of the younger generation will leave at the end of high school for further education, we have a bit of a spike in those 30s, in that 30 age bracket, this is a good place to raise a family, but then we see that transition again, of that age group leaving, and then retirees being our largest proportion.

MR GLOVER: What about members of First Nations communities? Are they a significant portion of the population within Broken Hill?

MR NANKIVELL: Yes, we have about 10 per cent - from the recent ABS data, around 10 per cent of our population is Indigenous and that is continuing to grow relative to our population.

MR GLOVER: Councillor Kennedy, is there anything you would wish to add to Mr Nankivell's description of the local government's area and its demographics?

MR KENNEDY: No, though we do have a considerable amount of people that do fly into the city, most of them are residential-based workforce for mines, but we still do have some fly-in fly-out people.

MR GLOVER: Is mining the main industry within Broken Hill?

MR KENNEDY: Mining would be the biggest earner, followed by tourism.

MR GLOVER: Mr Nankivell, if we go back to paragraphs 3

and 4 of what I will describe as the statement, there you tell us that the council has become aware of concerns within the community in relation to the availability and accessibility of health care; do you see that?

MR NANKIVELL: Yes.

MR GLOVER: How does the council engage with its community about those matters?

MR NANKIVELL: So we do a four-year community strategic plan where we go out and engage with the entire community around what the residents would like to see in 20 years' time for that area, for our city, it includes aged care, it includes the health care sector, and there is a number of priorities within those community strategic plans we're working towards.

The concerns that have been highlighted around that is that continual ageing population of Broken Hill with a reduction in our current aged care beds and the strain that is putting on the general health care sector. Sorry, I'm probably answering more than I need to there. That's how we engage. We do community consultation every 12 months and every four years for the future 20 years.

MR GLOVER: Thank you. We will break up some of the things you mentioned in that answer. So, firstly, we'll come to aged care in a moment, but other than concerns about the availability and accessibility of aged care, what other concerns are you aware of within the community in relation to the availability and accessibility of healthcare services within your local government area?

MR NANKIVELL: Yes, it is probably exactly that. It is the accessibility of those healthcare services. There is a strain on our current public health system for access to those services, some people can be waiting up to 365 days for elective surgery. And then going outside of Broken Hill for those services due to our remoteness and the costs of travel, it just becomes not possible for many people in regards to the time it takes to travel outside of Broken Hill. Adelaide is our closest capital city and that's where most of our health services would come from, and the number of specialties that come to the city as well is obviously starting - I believe is starting to reduce access is still there via alternate means into the cities but we

don't actually have the same number of specialties coming to the city.

Q. What you are describing here are concerns that the community have expressed to the council through its community consultation feedback processes; correct?

MR NANKIVELL: That's correct.

MR GLOVER: You have mentioned aged care, you have mentioned what I will describe as in-hospital care. What about access to general practice and other health services within the community?

MR NANKIVELL: Yes, that's continuously raised as well. The number of GPs within the city is declining and the waiting list to see a general practitioner can be upwards of two weeks at times, which, from that consultation feedback that council gets, obviously then puts a further strain on the emergency system as well.

MR GLOVER: Are you aware of whether any general practices that are operating within Broken Hill have closed their books to new patients?

MR NANKIVELL: Yes. I think other than the super clinic, all the GPs have closed their books.

MR GLOVER: Councillor Kennedy, do you wish to add anything to those answers given by Mr Nankivell?

MR KENNEDY: Yes, for sure. For me, I am probably approached most days by different people, so my consultation also goes well outside the consultation that council does in-house. So people come to me with a range of issues. A lot of those issues, particularly some of the specialist operations that are available at the hospital, oncology particularly, a lot of people in Broken Hill, sometimes it's way too hard to travel to Adelaide or Mildura, or wherever else they may need to get those oncology specialist services, so some people don't get them, so we end up with a situation where people die in Broken Hill well before they should be dying. A lot of the time if you have to go to Adelaide, I know there are a couple of people that I'm speaking to who are going to Adelaide in the next week or two to get radiotherapy. That's a six- to eight-week stay in Adelaide, very

difficult for them to take their family down there, so you have the situation where you've got to get down there. If you are still of working age and you are not working during that period, your family, if they are of working age, can't go down there and be with you, so you lose that support. There is a good service there, Greenhill Lodge, which allows people to stay there with other people from Broken Hill that do get oncology services, but it definitely affects the survival outcomes for people in Broken Hill.

MR GLOVER: Mr Nankivell, if you can turn to paragraph 8, please there you tell us that the council is aware of a concern within the community that members of the board of the Far West Local Health District are not well known or visible. Can you just describe to us first how you have become aware of that concern?

MR NANKIVELL: That is just from general feedback. When we are discussing the general health care sector for Broken Hill, sometimes people are unaware that there is actually a local board that sits above the Far West Local Health District. They expect that it just reports straight to Sydney without any local involvement, which obviously is a concern there, and then just with the local representation, they are unaware that there is actual local representatives for Broken Hill on that board as well.

MR GLOVER: When you say there is a bit of a concern as to the lack of awareness of the existence of the board, what's the particular concern that you were referring to?

MR NANKIVELL: The local input, ensuring that there is that listening voice of what the Broken Hill residents, and I guess the broader Far West Local Health District, to make sure that the concerns of the people living in this area are actually taken on board in regards to the development of their services and the continuity of services for the city.

MR GLOVER: Tell me if I have understood you correctly. The concern is that if people don't know the board exists, they may not be aware of potential mechanisms for them to provide input and feedback into the work of that board. Is that what you are referring to?

MR NANKIVELL: Yes, that's correct.

MR GLOVER: Councillor Kennedy, do you wish to add to that?

MR KENNEDY: Yes, just on from what the general manager said, so the reason we know this is because people come to us asking about health situations when their first port of call should be to a board. They have no idea who that board is.

For us, we have a very good relationship with the Far West Local Health District. We meet relatively regularly with the CEO. We have not met with the board at all. I would be - maybe know two or three just from passing thoughts, but I wouldn't really have any idea of what their role is, what they do, how they meet with people, et cetera.

THE COMMISSIONER: In your regular meetings with the - is it the chief executive you meet with?

MR KENNEDY: Yes, it is.

THE COMMISSIONER: Have you raised this with him, that you would like to have some meetings with the board?

MR KENNEDY: We get most of the information that we require from the chief executive officer, so for me I don't need it, but the community, on the other hand, don't have direct access to the CEO of the hospital.

THE COMMISSIONER: Perhaps - maybe I didn't make my question clear enough. Have you raised with Mr Astill or anyone else in management of the LHD here that the community's got a concern they don't know the board very well and could we set up a mechanism so that there is more visibility, perhaps a community committee that involves a board member, that sort of thing?

MR KENNEDY: No, we haven't. We do have Mr Astill on our aged persons rest centre committee, which is a 355 committee. So he goes there and gives us an outline of what's happening in the hospital, but we haven't actually addressed it with him about the board and the lack of ability for the public to have access to that board.

MR GLOVER: Although it is not a matter that you have raised with Mr Astill directly, Councillor Kennedy, is

there something that you consider could be done differently to improve the engagement between the LHD board and the community within the area?

MR KENNEDY: Yes, I think if it was known just who the board were and a mechanism for people to have direct input with that board, I think it would improve outcomes in the hospital significantly. As a council, if it was based on similar to what the council has with our council meetings, for example, people know where to go if they do have a complaint or, in addition to a complaint, even to say how well things are going. So you don't always want to hear complaints, you also want to get positive feedback. So I think there is a real opportunity there to have a similar set-up to what the council has in allowing people to have that direct input to the board itself.

THE COMMISSIONER: I don't know how important these things are, perhaps very important, but in terms - there is a website, obviously, that has the board members on it, but it has photos, it doesn't seem to have a bio to describe who they are. That might be useful. It's got the board minutes, but I can't imagine many members of the community accessing them.

MR GLOVER: Perhaps I might explore that with Councillor Kennedy. So do I take it that - tell me if I have misunderstood you in any way, but the concern is to the extent that there might be processes for community to engage with members of the board, to your observation, they are not well known within the community; is that right?

MR KENNEDY: Yes, not well known at all. A lot - if you've got people that have concerns about health coming to the mayor as opposed to the board in the first instances, or the hospital themselves, there is definitely a breakdown in communication or a way for those people to communicate directly. People would feel a lot more confidence if they could go and speak directly or put their concerns directly to people. That's not happening. So what generally happens in a community of our size, the rumour mill spreads pretty quickly if something goes wrong. There is no real way to address that for people immediately, or they don't think there is a real way to address it. Perception is more important than reality when it comes to that ability to have a direct access there.

THE COMMISSIONER: Can I just ask you this, you are the elected representatives - or you are, Mr Mayor - of the local community. Have you, or to your knowledge, any of your fellow councillors ever been asked for input as to who might be a good candidate to be on the board?

MR KENNEDY: No. So a lot of the people that are on the board are people that we do know, people that I do know or people that I have had dealings with. Good people. But no, no official input into those people. I'm not sure how much input the general public has into any of those appointees to the committee anyway.

THE COMMISSIONER: I should just point out in the question I just asked, it shouldn't be taken as any indication that the board members aren't very diligent and appropriate members. It's just I wanted to know whether the council's been asked.

MR GLOVER: Councillor Kennedy, in an earlier answer you told the Commissioner that you meet fairly regularly with Mr Astill; correct?

MR KENNEDY: Yes.

MR GLOVER: How frequently do you have those meetings?

MR KENNEDY: On an official basis, probably quarterly, but social functions probably monthly. They are usually some sort of council function that he often will attend as - in a social setting but still be available to talk about any concerns that the council may have in regards to health, or any concerns they may have or help that the council can give him in those regards.

MR GLOVER: I take it from that answer and the answer you gave earlier that, at least from your perspective, you feel you have access as you need it to Mr Astill?

MR KENNEDY: Yes.

MR GLOVER: What are the sort of matters you discuss in those meetings?

MR KENNEDY: The big matters for us and probably the matters that will come out regularly in this Inquiry is the lack of child care support in Broken Hill, particularly

that early child care, birth to two years old, long day care. Mr Astill made it clear that there's probably 40 to 70 spots that could be filled at the hospital if there was - or increase in hours if there was an increase in child care services in the city.

MR GLOVER: Just pausing there, 40 to 70 staffing positions?

MR KENNEDY: Yes, yes. A lot of those are nurses. So those nurses would be able to return sooner or increase hours. Council has established that there is only one spot for every seven children that are required at that age group. The other thing that has been made really clear is the opportunity for nurses, for example, to be able to go home for a weekend. Flight prices are extremely expensive, up to $900 one way. Nurses themselves, as well as Mr Astill, have told me that a lot of them will get homesick and leave before they should.

The opportunity, if they could go home on weekends, would make a significant increase in the ability to attract them, firstly, but also retain them. One thing that these young people do is if they have a good experience, they will go back to where they come from and say how good it is. One of the things that they do like in Broken Hill is the access to sports. So sport, they get involved really early with all forms of sport, which makes it a lot easier, because they then have that social network which gives them some form of company, but they still often will miss their family and friends from away and, if that could be addressed, that would definitely improve the retention rate at the hospital.

MR GLOVER: There is probably not much that the council can do about the prices set by the airlines, but is there some work being done within the council in relation to the child care issue?

MR KENNEDY: Yes, both really strong. So one thing that council is working on is trying to get an upgrade to the runway, that's about $15 million to reinforce the runway, which would allow 737 jets to land. That would bring down the price of air fares. The other thing that we are pushing is - and have met with a number of politicians - is to implement a scheme that's similar to what is in Western Australia, where it is subsidised flights for locals,

return flights that are capped. They are similar to the flights that the airlines now provide, which are community flights, but they are often only provided a day or two out from the flight itself. In Western Australia, they offer that regardless of booking time. So we're pushing that as much as we can.

With child care, we're trying to free up land through Crown lands to existing child care facilities that would increase their numbers by up to 80 to 100 additional spots, which would then, without a doubt, have significant impacts on returning of medical staff back to the hospital.

MR GLOVER: Mr Nankivell, did you wish to add anything to the councillor's response to that series of questions?

MR NANKIVELL: I think that's covered it off.

MR GLOVER: Mr Nankivell, if you just go to paragraph 9 of your statement, there you tell us that there has been less consultation with the council than there may have previously been. Can you just - you give one particular example there, but can you just describe in general terms the concern that you are highlighting in that paragraph?

MR NANKIVELL: Yes. So the concern there is the consultation, and I'm going off on the basis of what happened prior to myself taking on the role as general manager and prior to Mr Astill. If there was any consultation around their service delivery and subsequent issues that they are experiencing at that point in time, we aren't consulted on a regular basis around the issues that they are potentially facing, whether that be bed blocks or reduction in specialty services or new programs they are bringing in. We do have very good consultation around obviously their infrastructure projects and how they are looking to expand the capacity there through those areas there with their recent grant funding and those broader issues how we can have a collaborative approach around transport in and out of the city to attract essential workers, the child care issues and, then, in general, how you can actually attract people into work into Broken Hill.

So those broader concepts we have good consultation and collaboration with, but on the basis of knowing that there is going to be an upcoming issue potentially due to aged care beds, for example, stopping elective surgery, or

residents being stuck in Adelaide and not able to return home, we generally hear that after it's become an issue as opposed to it being an upcoming issue that's going to happen over the next 24 to 48 hours.

MR GLOVER: So what would you like to see done differently in relation to those issues?

MR NANKIVELL: It's probably just in general just the heads-up that this is an issue so that we can provide that support before it becomes an issue, as opposed to the mayor regularly hearing it from concerned residents, which obviously then passes across to the operational side of council.

MR GLOVER: So when you use "consultation" in that context, it's a flow of information that you are looking to improve; is that right?

MR NANKIVELL: Yes, and not - and not so much in the formal meetings, this is probably having that more regular contact, that if there is a foreseen issue that's happening at that point in time or in that - you know, coming up on that afternoon that there are going to be issues for the residents of the city, that we know about it.

MR GLOVER: Mr Nankivell, you heard Councillor Kennedy describe some of the initiatives that are being pursued by the council to alleviate some of the stress in relation to transport and child care. Are there any other initiatives being undertaken by the council to support the delivery of health care within the region?

MR NANKIVELL: Probably just to add further to Mayor Kennedy's comments about the airport, in addition to the upgrade that's required for the funding, $15 million funding for the upgrade to the runway, we are in the process of actually reconstructing our apron and taxiways which will allow for an increased capacity in the number of aircraft that currently can land in the city, so that includes the Qantas services and REX services. At the moment, we are locked into two aircraft bays at one point, at any given point in time, to actually expand that to allow greater capacity to come into the city, which would hopefully, at a point in time, reduce the costs in the market.

Not going into anything further on the child care, but we are working collaboratively with the state government across their properties New South Wales and health as well around building a multi-storey apartment specifically for essential workers within the city, given the housing constraints are another concern for the city, as it is in every other city in New South Wales at the moment, but looking at an innovative approach where we can have essential workers into a multi-storey apartment and primarily just for those essential workers, to attract them into good living standards.

MR GLOVER: That's the project, for want of a better term, you describe in paragraph 20 of your statement; is that right?

MR NANKIVELL: Yes, paragraph 20.

MR GLOVER: If that project continues, what is it - what will be the council's role in planning and delivering that project?

MR NANKIVELL: Council's role will be the planning and the delivery of that project, to take on that role in partnership, and then what that end model looks like in regards to ownership and who has access to it is yet to be determined, but from council's housing audit that it completed in 2022, along with our strategic housing review, it was nominated within that, that the majority of essential workers, being health care workers, are looking for those easy maintenance, one- to two-bedroom apartments close to the CBD for that social life as well. So trying to increase that liveability factor to attract people from metropolitan Sydney out into Broken Hill.

MR GLOVER: Is there, to your knowledge currently, a shortage of housing available within the local government area?

MR NANKIVELL: Yes, there is currently a shortage. With our expected increases, as mentioned earlier, with the mining operations, renewable operations, we are estimated to be around 700 houses - 700 quality houses short by 2025. So that's - and the majority of that will obviously be taken up by essential workers that will need to come to the city, so we have got a housing shortage and a housing crisis.

MR GLOVER: Is the lack of available housing something that has been discussed with Mr Astill or representatives from the LHD in your regular meetings with them?

MR NANKIVELL: Yes, certainly, and Mr Astill is very supportive of the approach that we're taking with the multi-storey apartment, they've provided their support along with that. Obviously as they're pushed up the chain, we are aware that they've got funding for their additional units that they are building behind the hospital at the moment as well.

MR GLOVER: To the extent that the project is developed to this extent, how many apartments are proposed as part of this development?

MR NANKIVELL: At this stage, we'd be looking to at least 40 units, but that would be determined upon the number of - the availability of funding as well. With Broken Hill's planning controls, we're not actually capped to a certain level or size, so depending on the availability of funding, we could make that further.

MR GLOVER: Councillor Kennedy, is there anything you wish to add to those answers?

MR KENNEDY: Yes, just further to the airport, the airport's very crucial to not just that access to the city by nurses, et cetera, a lot of specialists fly in at the airport. The airport runway is coming to the end of its useful life and there will be a required reseal. If council is unable to get the funding for that, that's likely not to happen and our airport will get to the - in a condition that is not really - it won't be able to land the planes we're currently landing, which will have significant impacts on health services in Broken Hill.

MR GLOVER: Who is council engaging with about securing funding for that project?

MR KENNEDY: So we are - both state and federal. So both state and federal governments are well aware of the importance of it. The reseal is about $8 million, but only gives about 8 to 10 years' additional life. An overlay of new surface will give up to 30 years' life but also increase the capacity of the airport to land larger planes.

So both federal and state governments are well aware of it. It will also impact the Royal Flying Doctor services, which will also greatly impact some of the remote areas around here if they can no longer land their planes here.

MR GLOVER: Mr Nankivell, in paragraphs 11 to 17 you describe some of the challenges in aged care within the region. Do you see that?

MR NANKIVELL: Yes.

MR GLOVER: Firstly, in general terms, how are you aware of the matters set out in those paragraphs?

MR NANKIVELL: That is through consultation with both Southern Cross Care, the only aged care - residential aged care provider in the city, as well as the Far West Local Health District, around their constraints and concerns and then, beyond that, it is the continuous number of phone calls for help that council - the mayor in particular - receives around finding an aged care place for their elderly parents or either their husband or wife as well, with the issue that they potentially will be transferred out of Broken Hill to an alternate facility if a place can't be found locally.

MR GLOVER: Is there any work being undertaken by the council to support the delivery of aged care services within the local government area?

MR NANKIVELL: Yes, not in regards to actually delivering those aged care services, but certainly continuous advocating with the state and federal government, primarily the federal government, around assistance for Broken Hill to have its Modified Monash Model reclassified to allow for some further funding for Southern Cross Care to be able to obtain the nurses, registered nurses that are required, into the city, but furthermore, some of the stringent requirements that were introduced as a part of that review in 2023 would potentially be relaxed as well around the registered nursing hours required per resident.

MR GLOVER: Just dealing with the Modified Monash Model for a moment, is that an issue that you also discussed with Mr Astill?

MR NANKIVELL: Yes, it is.

MR GLOVER: Just describe to the Commissioner what the reclassification proposal is?

MR GLOVER: So the reclassification proposal is from our MM3, which we are currently, to MM6, and that would obviously allow us to be considered as a remote area, such as Alice Springs is currently considered, or Broome. At the moment, our MM3 classification puts us in the same category as Bathurst or Lithgow - very easy access to Sydney, whereas we're still 1100 kilometres away from Sydney and would be considered as remote as some of those other areas. It provides further funding per resident as well, which allow for further financial sustainability to aged care providers in these areas.

MR GLOVER: Councillor Kennedy?

MR KENNEDY: Yes, just with the remoteness, the reason it's really important, it was explained to council that approximately 500,000 was spent on travel and accommodation for agency nurses just this year so far, so you can see the remoteness of Broken Hill, and if we did get that classification of the 6, there would be additional funding that would alleviate some of the pressures on the aged care facility.

MR GLOVER: The 500,000 spent, was that by Southern Cross?

MR KENNEDY: That was spent by Southern Cross. Southern Cross has three aged care facilities in the city that have 218 beds between them. A stand-alone, Aruma Lodge, which has 58. The other two are part of a combined area separated, so they have to have additional staff for both with the new requirements, registered nurses. They have 218 beds total, but they only are at the amount able to fill about 180-odd, so they're not able to use all their beds because of some of the rules around nursing, et cetera.

That change in classification would alleviate that to some degree. There is currently 25 people that are waiting for an aged care spot at the local hospital. They are in emergency beds. There is only 40 emergency beds at the hospital, and 25 of them are taken up by aged care.

MR GLOVER: Which government agency is the council

engaging with to attempt to secure that reclassification?

MR KENNEDY: So the health ministers, both state and federal. We write off to the premiers, the Prime Minister, anyone that will take that on. They do acknowledge that it probably at some stage will change, but there is a set amount of time, and it's up for review in about two years' time.

MR GLOVER: Is that work, to your understanding, the LHD has joined in - that is, attempting to have the area reclassified?

MR KENNEDY: Without a doubt, they acknowledge the importance of that, particularly as it affects them directly. With the facility not being able to take the residents that they should be, and by all accounts there's another 30 that are at home that are also waiting, so if they become acutely ill during that time, they will be using hospital beds. So I suppose it's in the best interests of the local health district to ensure that all beds can be used in those facilities, and they are doing all they can to make sure that the system is changed to a Monash 6.

MR GLOVER: Thank you. I have no further questions of these witnesses.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

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

<THE WITNESSES WITHDREW

THE COMMISSIONER: So a break before the next witnesses?

MR GLOVER: Yes, 10 minutes, Commissioner.

THE COMMISSIONER: Let's make it - we will take a break for 15 minutes.

SHORT ADJOURNMENT

MR GLOVER: The next witnesses are Councillor Marsden and Ms Smith from the Cobar Shire Council. They're appearing via AVL from Cobar.

<KYLIE SMITH, sworn: [3.54pm]

<JARROD MARSDEN, sworn:

<EXAMINATION BY MR GLOVER:

MR GLOVER: Councillor Marsden, can I start with you. Could you state your full name, please.

MR MARSDEN: Jarrod Wayne Marsden.

MR GLOVER: You are the Mayor of Cobar Shire Council; correct?

MR MARSDEN: Yes, correct.

MR GLOVER: You were first elected to the council in 2006; is that right?

MR MARSDEN: As a councillor, yes.

MR GLOVER: You have been on the council continuously since that time?

MR MARSDEN: That's correct.

MR GLOVER: And you've been mayor of the shire since about October 2023; is that right?

MR MARSDEN: Correct.

MR GLOVER: And in anticipation of giving your evidence today, you have prepared a statement; correct?

MR MARSDEN: Yes.

MR GLOVER: Which you have signed. Do you have a copy of it there with you?

MR MARSDEN: Yes, I do.

MR GLOVER: I take it you read it before signing it.

MR MARSDEN: Yes, I did.

MR GLOVER: Are you satisfied that its contents are true and correct?

MR MARSDEN: Yes.

MR GLOVER: Ms Smith, if I can come to you, can you just tell us your role within the council?

MS SMITH: I am the director of corporate and community services for Cobar Shire Council.

MR GLOVER: In general terms, can you just tell the Commissioner what that role involves on a day-to-day basis?

MS SMITH: So on a day-to-day basis, that's managing the governance, finance and community services that are operated by the council, which includes the Lilliane Brady Aged Care Village that council operates.

MR GLOVER: Thank you. Councillor Marsden, if I can direct you to your statement, please. In paragraphs 3 to 5 you tell us a little bit about the shire. Can I ask you to tell us a little bit about the demographics of the population. Is the shire projecting a growth or decline in population going forward?

MR MARSDEN: Depending on which statistics from which organisation you like to listen to, most predict around - it is a flatlining population.

MR GLOVER: And what about the age demographic of the population? Is it ageing, for example?

MR MARSDEN: I don't have those exact numbers in my head or in front of me, but I believe, yeah, I would probably agree that it would be an ageing population.

MR GLOVER: In paragraphs 6 to 16 of the statement you tell us about the Lilliane Brady Village. That's the aged care facility owned and operated by the council; correct?

MR MARSDEN: Yes.

MR GLOVER: Can you tell us a little bit about how it came to be, to the extent you know, that the council came to own

and operate an aged care facility?

MR MARSDEN: The town reached a point where the residents strongly believed that an aged care facility was necessary for the town, was required by the town. Funding to build that, I believe, was co-contributed by local contributions and fundraising, combined with council funds.

MR GLOVER: And the council has operated it continuously since it opened in about 1982; is that right?

MR MARSDEN: Yes, that's correct.

MR GLOVER: Ms Smith, if I can turn to you, what the particular challenges that the council faces at present in operating that facility?

MS SMITH: I think one of the main challenges has been the introduction of new legislative requirements around the provision of aged care and actually meeting those requirements. Council is very concerned to ensure that we do meet our accreditation requirements as per our funding agreement, and to ensure that the residents of the village are provided with appropriate levels of care under that. That comes as a financial cost and we've seen that cost increasingly escalate as well with our regional inflation, so difficulty attracting staff and needing to move to an agency model, which we're trying to move away from, but that has been one of the major costs, I guess, is staffing of the centre due to changes in legislative requirements and the increased cost of staffing.

MR GLOVER: Councillor Marsden, in paragraph 12 of the statement, you tell us that the council projects that there will be a deficit of $1.3 million in the operation of the aged care facility for the current financial year; do you see that?

MR MARSDEN: Yes.

MR GLOVER: The operation of that facility at a deficit, is that something that has been a trend over recent years?

MR MARSDEN: No. Up until very recently, depending on the amount of high-care, high-dependency patients that were in the facility, some years council would make a little bit of money, some years council would lose a little bit of money.

All in all, as a long-term projection, the village was always sort of a break even and council was happy to operate under those sorts of - in that situation. It's only really been the last probably two years that we've seen the growth of the deficit to the point it is now.

MR GLOVER: Ms Smith, is there anything you would wish to add to the answer given by the mayor?

MS SMITH: I think, as we said, the operational deficit is the primary driver. That's fuelled by both location inflation, so increased costs of being so far away from the centre of population, in addition to the staffing cost that was mentioned.

MR GLOVER: Councillor Marsden, in paragraph 14 of the statement you refer to the challenges in attracting and retraining staff; do you see that?

MR MARSDEN: Yes.

MR GLOVER: Ms Smith has referred to some of those, but I just want to direct your attention about halfway down the paragraph to where you say:

> *The Council is unable to offer similar incentives to attract nurses and medical workforce that are offered by NSW Health.*

Do you see that?

MR MARSDEN: Yes.

MR GLOVER: Other than the Rural Health Workforce Initiative Scheme, was there any other incentive or initiative that you had in mind?

MR MARSDEN: Things like additional personal leave, family travel assistance, professional development, accommodation assistance, et cetera.

MR GLOVER: And when you say that the council is unable to offer incentives of that kind, is it unable to do so because of the financial burden that that would place on the council?

MR MARSDEN: Correct.

MR GLOVER: Ms Smith, did you wish to add anything to those answers?

MS SMITH: I think it is the financial benefit [sic], remembering that council also has a more broad local workforce, where we do actually have to provide equity in access and so there are considerations around offering such incentives for one service when we've got a broad-based service supervision across all council.

MR GLOVER: So the concern being that if you offered incentives of that kind for a workforce in the facility, there would be perhaps a need to offer them across the council's workforce more broadly; is that right?

MS SMITH: That is correct. We also currently do pay above award for some of those positions to try and minimise the - I guess try and balance out that cost. Agency staff are more expensive than paying our local staff at a higher rate, so we've certainly been trying to do that by putting in place all of the required increases for staff and a small increase as well to take - give consideration, I guess, that some of the staff we had at the village would have been paid less than some of our local console operators at service stations, had we not made that move.

MR GLOVER: Councillor Marsden, in paragraphs 17 to 21 of the statement --

THE COMMISSIONER: Sorry to interrupt, does that mean you have finished with the aged care facility?

MR GLOVER: For the moment, yes.

THE COMMISSIONER: Are you going back to it?

MR GLOVER: On one issue, yes.

THE COMMISSIONER: I will wait and see, then. You keep going.

MR GLOVER: In paragraphs 17 to 21 of the statement, Councillor Marsden, you refer to the Cobar Health Service.

MR MARSDEN: Correct, yes.

MR GLOVER: That's the facility operated by NSW Health in Cobar; is that right?

MR MARSDEN: Yes.

MR GLOVER: In paragraph 20 you refer to the frustrations of some community members on some issues. Do you see that?

MR MARSDEN: Yes.

MR GLOVER: What engagement do you have with community members about their concerns or issues with the delivery of health care in the region generally?

MR MARSDEN: I guess it's a very - in a very general sense, you know. For example, if I go down the street on a Saturday morning, you know, I'll be approached by a ratepayer who will tell me a horror story about their wife or their mother or their daughter being flown out to Dubbo and discharged at 2 o'clock in the morning and having to find their own way home, et cetera. I guess, unfortunately, I can't really talk in specifics, like I can't say, "On 20 April 2021 this happened", but they are the general stories that I get and it's just like, you know, "As mayor, as our representative, can you please see if you can do something about this to improve the situation so it doesn't happen to others."

MR GLOVER: Does the council engage in consultation with the Western NSW Local Health District about the services delivered in its local government area?

MR MARSDEN: There is certainly nothing organised. There have been ad hoc meetings. I haven't been to all of them, but I'm aware that they have occurred. We have a local health board chaired by Mr Gordon Hill. He's provided updates to council on what is happening locally, but certainly not really from a regional sense, from a Dubbo feedback point of view.

MR GLOVER: The local health board that you mentioned, is there a representative of council on that board?

MR MARSDEN: No, I don't believe there is, no.

MR GLOVER: Would you like to see any changes or improvements in the way that the council engages with the

local health district?

MR MARSDEN: Certainly not from a - not from a local point of view. This sort of becomes the point of frustration where, locally, our Cobar Hospital, it's staff, the way that it's run is generally very well accepted by the community and very highly thought of and at a very high standard. It's only really when it becomes patients being flown out and a regional situation where we seem to have issues, other than the limited services that can be provided locally, which kind of drive the amount of people being flown out.

MR GLOVER: When you say "it's only really when it becomes patients being flown out", that's the issue that you raise in the statement, is it, of patients being sent to larger centres and then having to find their way home; is that what you mean?

MR MARSDEN: When you are talking "flown out", I mean, you are automatically - Dubbo is our nearest point of fly-out so you are automatically 300 kilometres from home. So, you know, the tyranny of distance is there straightaway. That's without, you know, obviously if they are critical and flown on to Sydney, then you are nine hours from home.

MR GLOVER: What are the particular issues that members of the community have raised with you around that topic?

MR MARSDEN: Just how busy and overwhelmed the Dubbo hospital is, and they are so desperate for beds that, you know, you hear those horror stories of people being discharged at 2 o'clock in the morning to create another bed for someone else, and then, basically, you know, 2 o'clock on a Saturday morning, you are out on the street and you have got to try to find your own way back to Cobar, and if you have been flown out as an emergency, you are there in the clothes you are wearing. That's not a great situation when you are 300 kilometres from home with no train service, no - you know, you basically wait until 2 o'clock in the afternoon when the bus leaves.

MR GLOVER: So is the particular issue that you are referring to there the lack of support, as has been reported to you, in people being able to return to Cobar, for example, if they were transferred to Dubbo for treatment?

MR MARSDEN: Absolutely.

MR GLOVER: Are there any other particular issues that members of your community have raised with you surrounding the circumstances in which they may need to be transferred to another centre for treatment?

MR MARSDEN: No.

MR GLOVER: In paragraphs 22 to 25, Councillor Marsden, you tell us about the Cobar Primary Health Care Medical Centre; do you see that?

MR MARSDEN: Yes, I do.

MR GLOVER: That's a council-owned facility, is it?

MR MARSDEN: Yes, it is, yes.

MR GLOVER: The clinicians who operate from that facility run private practices, do they?

MR MARSDEN: It is through the Outback Division, which is based in Bourke, and they provide doctors into that centre.

MR GLOVER: Aside from making space available in the facility, does the council provide any other support to those delivering care through that centre?

MR MARSDEN: I believe there is accommodation in the form of housing for a doctor in town, yes.

MR GLOVER: Ms Smith, is this something that falls within your remit?

MS SMITH: Not specifically, but to confirm what the mayor says, there is income that comes from council - from those facilities, but they are targeted facilities below commercial rental, so there is a discount applied to those facilities, and we actually have two, as I understand, one is a medical practice which includes accommodation within that practice; the other is the practice centre that the Outback Division occupies, so we do support our other general practitioner that is not part - or not provided as part of the Outback Division services.

MR GLOVER: Ms Smith I might stay with you for this next series of questions and we will return to the aged care facility. Does the council receive any funding from either the Commonwealth or New South Wales Government for the purposes of operating that facility?

MS SMITH: Yes, from the Commonwealth Government.

MR GLOVER: And do we take it from the numbers that Councillor Marsden referred us to earlier that the funding received from the Commonwealth is insufficient to ensure that that facility operates at least at a break-even point?

MS SMITH: With the one caveat, that we are currently undertaking a review of the facility to ensure that there are no funding streams that we have missed. So at this point in time, the income that council is certainly receiving, that is correct, so there is a deficit on that. The challenge for us is whether or not we're availing ourselves of all of those opportunities that are provided through those funding streams. What I mean by that is, are we undertaking timely assessments of our residents to ensure that we're getting the appropriate payments.

MR GLOVER: What you are describing there is a review internally by the council to ensure it is operating the facility as efficiently as possible and maximising its revenue; is that right?

MS SMITH: That's correct.

MR GLOVER: Councillor Marsden, in paragraph 28 of --

THE COMMISSIONER: Sorry, can I ask a question about the aged care facility?

MR GLOVER: Yes.

THE COMMISSIONER: In paragraph 9, you tell us that the council approached multiple aged care providers who declined to run the service. Was one of the entities you approached the Western NSW LHD?

MR MARSDEN: No.

THE COMMISSIONER: To your knowledge, did they give any consideration as to whether they would take over that aged

care facility?

MR MARSDEN: No. When the new hospital was built, the original agreement with the state government was - obviously the new hospital was built right next door to the aged care facility and there is a corridor between the two, with two lovely doors that never get opened anymore. The original agreement with the state government was that they would take over that aged care facility. Unfortunately, very late in the piece, when the hospital was just about to be opened, they withdrew from that agreement.

But it was private - it was private enterprise that we went to the open market with expressions of interest, I believe that was around 2014. The feedback that we received was that the centre was just too small to make money on a commercial basis.

THE COMMISSIONER: I see. So would it be news to you that the Western NSW LHD did an evaluation about whether they were going to take over that aged care facility?

MR MARSDEN: Yes.

THE COMMISSIONER: Right. Okay. When you say in paragraph 9, also, that council approached multiple aged care providers who declined to run the service, what was the reason they declined to run the service?

MR MARSDEN: Because of its size. It was too small to be commercially viable. At the time, they said 50 beds was about as small as you could go to be commercially viable. We were 36 at the time, and 44 now, but, yeah, we're certainly still - still going to hit that number.

THE COMMISSIONER: The deficit of $1.3 million for the '23/'24 financial year, is that having an impact on rates yet?

MR MARSDEN: Certainly not rates, but at the moment we're in a position where if we can't secure extra funding federally to cover that number, council will have to either review its position of operating this facility or crunch the numbers, and other areas of the budget will have to suffer to cover the shortfall.

THE COMMISSIONER: All right. Okay, I understand.

MR GLOVER: Councillor Marsden, can I just take you back to an earlier answer you gave to the Commissioner, you said this:

> *When the new hospital was built, the original agreement with the state government was - obviously the new hospital was built right next door to the aged care facility and there is a corridor between the two ...*

And you then went on to say the original agreement with the state government was that they would take over the aged care facility. Do you remember giving that answer.

MR MARSDEN: Yes, I did.

MR GLOVER: Firstly, when was the new hospital built next door to the aged care facility?

MR MARSDEN: I believe it was around 2016.

MR GLOVER: And what is your understanding of the agreement with the state government that they would take over the aged care facility?

MR MARSDEN: Yeah, I've got a personal - I've got a little bit of a personal beef with this, because the agreement was never - it always verbal and it was never formalised. I actually - you will find me voting against the motion in amongst the council minutes, because I wanted it formalised so that the state government couldn't get out of it, but our council at the time really wanted a new hospital, so they decided to go ahead. It was never formalised into a memorandum of understanding, so I guess that opened the door for them to withdraw.

MR GLOVER: When you say "the state government", do you have a recollection of which part of the New South Wales Government you were dealing with, or the council was dealing with, in relation to this issue?

MR MARSDEN: No.

MR GLOVER: But from that earlier answer, do I take it it's something that would appear in the council minutes

from around that time?

MR MARSDEN: Absolutely. I would hope so.

MR GLOVER: And this is 2016, did you say?

MR MARSDEN: I believe so. That was around the time frame, yes.

MR GLOVER: Thank you.

THE COMMISSIONER: It doesn't matter for the witnesses, but for everyone else, there is something in Mr Spittal's evidence at page 2999 of the transcript about evaluating this.

MR GLOVER: Yes.

THE COMMISSIONER: And expecting it to lose about what it's losing at the moment.

MR GLOVER: Yes, there is a distinct correlation between the numbers referred to by Councillor Marsden and I think what Mr Spittal said last week.

Finally, Councillor Marsden, if I can direct this question to you, in paragraph 28 of your statement, you say:

There is little recognition across other levels of government of the role played by councils in supporting the delivery of health care.

Do you see that?

MR MARSDEN: Yes.

MR GLOVER: Later in paragraph 30 you refer to the need for some additional funding, and I will come to that in a moment, but in addition, or separately to the question of additional funding, is there any other recognition or support that you consider could be delivered to local government to assist them to support the delivery of health care within their regions?

MR MARSDEN: I guess just the - if we could have some

funding that would - we don't expect funding to cover what everyone else has to cover, but if we can get funding to cover the gap that we are now seeing, that is being driven both geographically and the tyranny of distance - and I use the specific example of we are required to provide eight hours of physiotherapy to our aged care facility patients. We don't have a physio in Cobar, so we have to get one out of Dubbo. Now, they spend a day travelling, they spend eight hours delivering the physiotherapy, and then they spend a day travelling home. So we're paying a physio three days a week. Now, at the aged care facility in Dubbo, they only have to pay the physio for the eight hours that they spend with the patients. So, you know, that gap that we have to pay for travel and accommodation - for travel and accommodation, that is the funding that we need, to cover that gap so that we can bring ourselves up.

MR GLOVER: Do a take it by "additional funding", you have in mind something other than additional rate revenue?

MR MARSDEN: Absolutely. We would be looking for separate and I guess special funding from either state or - probably federally, more to the point.

MR GLOVER: Is that something that your council has taken up with - let's confine it to the state government at the moment?

MR MARSDEN: We are trying to - we've initially gone through the local member, Mark Coulter, federally, who has approached the minister. We are now looking to get an audience with the minister to discuss that situation.

MR GLOVER: That's the federal member, is it?

MR MARSDEN: Yes, correct.

MR GLOVER: Is it an issue that's been raised with, for example, the Country Mayors Association or Local Government NSW?

MR MARSDEN: Not specifically.

MR GLOVER: Thank you. I have no further questions for these witnesses.

THE COMMISSIONER: Thank you.

Mr Cheney, do you have any questions?

MR CHENEY: No, thank you, Commissioner.

THE COMMISSIONER: Thank you both very much for your time. We're very grateful and you are excused, wherever you are.

MS SMITH: Thank you.

MR MARSDEN: Thank you very much.

<THE WITNESSES WITHDREW

MR GLOVER: That's the evidence for today. 9.30 tomorrow, Commissioner.

THE COMMISSIONER: All right. 9.30 tomorrow, is it? We will adjourn until 9.30 tomorrow morning.

AT 4.18PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 23 MAY 2024 AT 9.30AM

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