

**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

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

7
8 Yes, Mr Muston?
9

10 MR MUSTON: Commissioner, this marks the opening of our
11 public hearings in Broken Hill, focusing on the delivery of
12 health services to remote communities of the Far West LHD.
13 Over past two days we've had an opportunity to see and
14 speak to a number of people and services that make up the
15 patch work that come together in an attempt to meet the
16 health needs of the sparse but important community of
17 people that live across a very wide area within the LHD.
18

19 We visited the Royal Flying Doctor Service at Broken
20 Hill, spoke to many of the people involved in their
21 operations, two representatives of that organisation will
22 be giving evidence in a moment to tell us not only about
23 the emergency retrieval and patient transfer service for
24 which that organisation is very well known, but also about
25 the significant role that the organisation plays in the
26 delivery of primary care and dental care in many rural and
27 remote communities, and in many communities that people
28 might not still regard as truly remote. We have heard
29 increasingly as we have toured around the state of that
30 shift eastward of the line where the traditionally remote
31 forms of delivery of health care are becoming the norm.
32

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

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

3
4 Critically important in this region is the delivery of
5 health care to its First Nations communities, and we have
6 had the very great pleasure of visiting a number of
7 facilities and speaking to a number of people involved with
8 the local Aboriginal community controlled health
9 organisation, Maari Ma. They've been very generous with
10 their time in speaking to us, but equally in showing us
11 their facilities here in Broken Hill and the magnificent
12 new facility that they have in Wilcannia.

13
14 It is hoped that at some point in the future - perhaps
15 not this week - we will be able to capture some of what
16 they shared with us in an evidentiary form. But this week,
17 what we have been told will certainly inform questions
18 which we ask of other witnesses during the course of the
19 public hearings and will guide our inquiries in that
20 respect, as will information and experiences which were
21 shared with us during the Inquiry's community listening
22 sessions held on Monday and discussions we have had with
23 other individuals during our trip around a small part of
24 a very large LHD over the past couple of days.

25
26 Without further ado, I call Greg Sam and Associate
27 Professor Shannon Nott.

28
29 **<GREG SAM, affirmed: [9.34am]**

30
31 **<SHANNON NOTT, sworn:**

32
33 **<EXAMINATION BY MR MUSTON:**

34
35 MR MUSTON: Mr Sam, you are the chief executive officer of
36 the Royal Flying Doctor Service (South Eastern Section).

37
38 MR SAM: That's correct.

39
40 MR MUSTON: It's a role you have held since February 2014?

41
42 MR SAM: That's right.

43
44 MR MUSTON: And Associate Professor Nott, you are the
45 executive general manager, health and clinical services and
46 the chief medical officer of RFDS SE?

1 DR NOTT: Yes, I am.
2
3 MR MUSTON: Which is a role you have held I think since
4 March 2024?
5
6 DR NOTT: Correct.
7
8 MR MUSTON: Prior to that, you held a role in Western NSW
9 Local Health District?
10
11 DR NOTT: Correct.
12
13 MR MUSTON: Could you briefly explain to us or tell us
14 what that role was?
15
16 DR NOTT: Prior to coming into this new role with the
17 Royal Flying Doctor Service, I was the rural health
18 director of medical services for Western NSW Local Health
19 District. That role oversaw medical services, clinical
20 governance, safety and quality across 35 rural and remote
21 hospitals in the Western NSW LHD footprint.
22
23 MR MUSTON: How long did you hold that role for?
24
25 DR NOTT: Seven years.
26
27 MR MUSTON: Are there significant differences that you
28 have observed between the delivery - or issues associated
29 with the delivery of health care in Western New South Wales
30 as distinct to what you are experiencing now, albeit in a
31 different role, in the delivery of health care in Far West
32 New South Wales?
33
34 DR NOTT: I think when you consider the roles across both
35 health organisations, one being NSW Health and RFDS being
36 a not-for-profit, the principles in terms of delivery and
37 the challenges of delivery of high quality care are very
38 much the same. If you look at disadvantage and health
39 inequity across the Western LHD footprint, the Far West LHD
40 footprint and the organisations that are trying to bend the
41 curve in relation to that, we are all dealing with the same
42 quite sinister and longstanding challenges that exist
43 across rural and remote parts of New South Wales but more
44 broadly Australia.
45
46 One of the continual challenges for us all is that
47 within health care and the provision of health care, we

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

8
9 The other thing around that, and for us, ultimately,
10 to be able to deliver better outcomes for our communities,
11 we must consider two things, in my opinion: one is the
12 social determinants of health. We can address the access,
13 we can address models of care and work with community
14 around the health care provision at a place-based basis,
15 but without policy, without programs that appropriately
16 address the underlying social determinants of health care
17 or health more broadly, so things like housing, education,
18 what people eat, those preventative factors that we know
19 that support wellbeing in community, we will never change
20 outcomes for rural and remote communities. And when you
21 consider health prevention programs and high-quality,
22 I suppose, areas or policies to address underlying social
23 determinants, what we need to consider is the health in all
24 policies approach, that that is not the responsibility
25 solely of those people that operate in the health care
26 industry, it is a responsibility at a societal level.

27
28 The other big challenge across both roles that I have
29 been traversing is the fact that we need to find ways to
30 develop and run programs that are invested in terms of
31 community need and are underpinned by holistic,
32 longitudinal primary care. And that is one of the biggest
33 challenges for us to be able to deliver appropriate primary
34 care in a way that aligns with the principles of universal
35 health care access, so looking at health care need through
36 an equity lens that allows us to take into consideration
37 social disadvantage, resourcing, geography, First Nations
38 status and remoteness is incredibly important for us, and
39 what we need to be able to do in that primary care space is
40 look at how health partners can holistically plan around
41 what communities need at that local level and be,
42 I suppose, enabled to work collaboratively together to
43 design programs that allow us to actually achieve that.

44
45 MR MUSTON: We're repeatedly told in evidence that primary
46 health is a Commonwealth responsibility. Put to one side
47 the technicalities around how well that might work from

1 a funding and legislation point of view, the reality is, is
2 it not, that the Commonwealth doesn't actively engage in
3 service delivery in the primary health care space?
4

5 DR NOTT: I think if we take this back to a principle
6 level, there is irrefutable evidence that investment in
7 primary care is the best return on investment that we can
8 make for our health care dollar. That is irrefutable.
9 There is copious amounts of data and evidence globally in
10 that space. And so if our aim is to improve health
11 outcomes, we need to find solutions that invest
12 appropriately in that primary care space. For our
13 communities and the work that we do across communities with
14 Royal Flying Doctor Service, it is very clear to us also
15 that community members do not want to be drawn into the
16 politics, is this a state, federal or a local problem, the
17 reality is that people want and deserve to have access to
18 care in a way that actually meets their health care need.
19

20 If you look at a number of enablers around how do we
21 achieve universal health care access, which is underpinned
22 by quality primary care, the way that that should be done
23 is around pooled resourcing, and in this country that means
24 all levels of government being able to invest in strong
25 primary care that meets community need, and again is
26 applied through an equity of access lens that allows us to
27 take into account those factors that I mentioned before -
28 social disadvantage, health care need, burden of chronic
29 disease.
30

31 And so for us, as an operator that works both across
32 Commonwealth, state and alongside local councils and with
33 community to be able to deliver health care, the matter of
34 who is responsible or not is less of an issue; it's how do
35 we get dollars through a pipeline to frontline services.
36 We believe that pooled funding is a way of being able to do
37 that, but we need to ensure that pipelines see the flow of
38 that resourcing dollar directly to patients.
39

40 MR MUSTON: In the context of the stratified system that
41 we work in from a funding perspective, the pooling of those
42 resources requires in a practical sense a high level of
43 collaboration.
44

45 DR NOTT: Yes.

46 MR MUSTON: Starting with your experience in Western
47

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

5
6 DR NOTT: I think reflecting on my former roles, there is
7 every intent to be able to work collaboratively with
8 people, and there are great pockets of examples of that,
9 and I think some of my colleagues in Western talked to some
10 of those programs, so things like the Four Ts project,
11 working with community local councils to be able to deliver
12 care locally. But there are also examples of where that
13 can be done better.

14
15 I think if you look more broadly at a system level
16 around health planning, health needs assessments, the
17 richness of data that is provided between PHNs and LHDs
18 around health need assessment at a community level is
19 incredibly important for us to be able to plan services.

20
21 If we take that a step further, well, what do we need
22 to do when we recognise that there are significant gaps,
23 significant challenges in community? How do we
24 operationalise? How do we wrap around clinical services
25 for those communities? There needs to be an additional
26 step where the relevant players at a place-based and
27 community-based level can get together and utilise that
28 data to plan clinical services moving forward with the
29 community at the table and applying a patient-centred
30 approach.

31
32 This is something that we do and aspire to and aspire
33 to continuing to do within RFDS, is working with community,
34 understanding community, understanding the levers, the
35 motivations, the real challenges at a local level is
36 something that's built intrinsically as a rural and remote
37 organisation that we do.

38
39 Being able to build that trust - and trust is
40 incredibly important. You mentioned that the team here
41 have been travelling throughout Far West region. You will
42 note, just travelling and speaking with people, that trust
43 with healthcare providers is paramount in terms of actually
44 achieving health equity and health access.

45
46 For us, what we do as an organisation, we as the RFDS,
47 is actually working and building that trust at a local

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

15
16 So for us, I think, again going back to
17 a principle-based approach to this, is that community
18 trust, community understanding is an incredibly important
19 aspect around how do we translate and action the gaps that
20 we find through a health needs assessment into meaningful
21 programs, and that is something that we certainly see our
22 role as RFDS.

23
24 MR MUSTON: So in the local area, might that look
25 something like this: to the extent that health services
26 planning is happening, you would get your key players in a
27 room dealing community by community with the way in which
28 needs are identified in the health needs assessment are
29 potentially going to be met, which locally would mean by
30 the LHD, obviously enough, probably you and perhaps
31 Maari Ma, and then the PHN, potentially, at least as
32 a source of information if not potentially having some
33 input into how primary health might be dealt with, although
34 I gather that there is not a huge number of private primary
35 health providers distributed throughout the more remote
36 parts of your community, the human faces of the PHN are not
37 really there?

38
39 DR NOTT: For us, we have traditionally operated in a
40 space where traditional markets are not able to run. RFDS
41 has been built from that premise of there are communities
42 across Australia, and for us across New South Wales, that,
43 by the way that resources are distributed in a traditional
44 environment or an MBS-type model, there is no other
45 providers, and for us, our point of difference is being
46 able to operate in that way and deliver services in
47 innovative ways to be able to actually meet that community

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

3
4 The other thing I would add to your comments is that
5 the community absolutely need to be a key player there.
6 There is sometimes a disconnect between what can be done
7 and expectation, and what we need to be able to do is work
8 around a table, around how can we deliver the best care to
9 meet community need with the resources that we have; that
10 also, as I mentioned before, there needs to be an
11 understanding - and, as you have mentioned, there are
12 different levers of funding components that each of those
13 players can bring to a table - districts will have access
14 to different funding programs to PHNs.

15
16 One of the challenges for an organisation like ours to
17 be able to get those dollars coming out of the purse or
18 purses, we have to apply in multiple different ways to try
19 and get programs run and funded at a local level.

20
21 If you were able to have a forum that allowed us to
22 sit at a table, plan with those key players and streamline
23 the way in which money is filtered at a community level and
24 also made more efficient so that the money that is
25 delivered at a community level is streamlined and
26 synergistic, as opposed to fragmenting and causing
27 potential overlap - unintentionally - that would be better
28 overall for our vulnerable communities.

29
30 MR MUSTON: Might that potentially mean where there is,
31 say, some grant funding available as part of this
32 roundtable discussion, yourselves, the LHD, Maari Ma, at
33 least as the potential recipients of that funding, might
34 sit down before anyone's started to actively compete for it
35 and say, "There is a funding source. As a group, how could
36 we best use that to fill part of the patchwork of services
37 that we're delivering? This is the way we're going to do
38 it. You apply for that grant funding for that purpose; we
39 over here, we obviously won't do that, but we might have
40 something else that we are doing over here that as a group
41 we have collectively decided is the best way to utilise all
42 of the available funding sources that are out there."

43
44 DR NOTT: Yes, and collaborating together around how that
45 can work. Ideally, in an ideal world, we look at this
46 longitudinally, but the challenge with grants is that they
47 are time limited. For us to be able to recruit staff into

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

11

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

23

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

37

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

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

7
8 DR NOTT: Yes. So my experience in working with community
9 and certainly something that we've found as an organisation
10 is that data only tells part of the story, and particularly
11 in remote communities being able - and I think for - the
12 principle of co-design is empowering communities to be able
13 to help be part of the solution and be empowered to be able
14 to contribute to solutions. Part of that, as health
15 organisations and subject matter experts in this space -
16 health, I don't need to tell this Inquiry, is incredibly
17 complex - for people that are on the receiving end, the
18 complexities are not necessarily obvious.

19
20 So part of what we need to do for true co-design is,
21 yes, present this data, sense check it around is this
22 actually what you were seeing on the ground? Is this what
23 matters to people? Is this what people are chatting around
24 the cafe or the post office or whatever venue people gather
25 around? Is this the thing that keeps people up at night?

26
27 In some circumstances, people say "Yes", in others,
28 they will say, "Actually, you are missing out on X, Y and
29 Z." So there needs to be a marrying up of the data versus
30 patient community feedback and, then, also in terms of
31 improving that health system, literacy and knowledge around
32 how do we translate that knowledge into actionable models
33 of care.

34
35 Now, this is something that, for us, one of the most
36 important aspects of our organisation is the community
37 engagement team. The community engagement team go out to
38 community and have these conversations. They sense check
39 what we're delivering on the ground. They also work with
40 community around what we are offering, because you can
41 create services, but if people don't know about them or
42 know how to navigate them, then those services are not
43 meeting the mark. And so, for us, everything that we do,
44 particularly in that community primary care, dental, mental
45 health space, is grounded by our connection with community,
46 and that's where we see a real difference in terms of the
47 approach that we take to some other organisations.

1
2 MR MUSTON: So you mentioned a moment ago the importance
3 of evaluation. Does that work at two levels - evaluating
4 it from the point of view of assessing the health outcomes
5 longitudinally to the extent that you can, based on data,
6 amongst other things, but also, is there an important need
7 to continue to work collaboratively with the community that
8 is being served by these services to make sure that the way
9 in which they are being delivered is actually working and,
10 if not, what is it that they can tell you about how those
11 services need to be changed, for example, to make them more
12 accessible or more desirable from the perspective of the
13 end consumer?

14
15 DR NOTT: Absolutely. One of the key components that
16 I see as incredibly important around evaluation is actually
17 consideration of the quadruple aim, so the data in terms of
18 patient outcomes and then I think the key component that
19 sometimes we forget as we research or evaluate is that it's
20 not just patient outcomes that we perceive to be important;
21 the premise of the quadruple aim is that the patient
22 outcomes that matter to patients matter to community. And
23 so part of that design around how do we quantify outcomes
24 needs to be also a co-design process around, well, what
25 matters to you? Other aspects around patient experience.
26 So integrating within our evaluations the experience that
27 patients have within the system, clinician experience in
28 terms of delivering that care, and then looking at the
29 system-wide impacts, whether that's through an economic
30 lens, through a community lens, through the broader social
31 benefit that our health care programs bring.

32
33 Those four broad areas are what most, in my opinion -
34 and certainly in the experiences that we're progressing as
35 an organisation with RFDS - should be measured and reported
36 on and add value in terms of the evidence base that we are
37 providing in terms of rural and remote health care.

38
39 MR MUSTON: Measuring those things is very difficult, is
40 it not, if you have strictly siloed modes of delivering
41 health care - acute on the one hand, sitting in its own
42 silo, primary care sitting in the other, and allied health
43 potentially sitting in a third silo - working out what's
44 important to a community member who has received health
45 care, for example, someone who has had a knee replacement,
46 it may be important to them that they can go and do their
47 shopping independently, that might be the outcome that

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

5
6 DR NOTT: Correct. We need to - the reality is that
7 humans are not a conglomeration of diseases or individual
8 sort of systems. They are people. And for us, in terms of
9 health care, it is understanding that patient-centred
10 aspect of care; the community-centredness that many rural
11 and remote people see themselves fitting within; and how do
12 we actually make sure that we are gauging that.

13
14 There are systems around - complex systems around
15 patient reported outcome measures, but you are right, the
16 challenge in this space around how do we look at a sort of
17 system-wide or a community-wide wellness or health care
18 outcome scale is challenged because evaluations usually are
19 refined around a service, a program that has these imagined
20 or refined borders, but the reality is that health care or
21 health access, health outcomes, transcend programs, or go
22 beyond disease subsets.

23
24 MR SAM: If I may, I think what you are suggesting is what
25 we would see as the model, that what it requires, though,
26 is a resetting, I guess, of the priority of that approach
27 relative to the major driver still around episodic care, of
28 getting people into care, through care, out of care.

29
30 It speaks, as Dr Nott said, to the idea of how do
31 individuals and communities hold a health relationship over
32 time, and in failed and thin markets, it becomes even more
33 important that it's as much around the strength of that
34 relationship, exchange of information, exchange of being
35 able to manage with finite resources, and variable access
36 that will change over time.

37
38 In a rural context, and particularly in a remote
39 context, one can't make an assumption that you are going to
40 hold a treatment pathway or a care pathway consistently
41 over time for a variety of factors, whether that is the
42 availability of clinical resources or just trying to
43 prioritise demand, or in fact that individuals and
44 community needs will change quite rapidly. Holding some
45 form of overarching relationship with the community that
46 can help meter that change within a straight sort of
47 service provision model is also something that's quite

1 lacking here.

2

3

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

14

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

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

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

45

46

47

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

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

9
10 MR MUSTON: I will come back to that. It's probably
11 a useful segue, though, as we talk about bringing all the
12 pieces together, for me to ask you, Mr Sam, probably the
13 most appropriate person to answer this question, but
14 Dr Nott, jump in if you want to add to it or pick it up.
15 What are the services that the RFDS is delivering into the
16 community of the Far West? We all have childhood memories
17 of the television show where people who had suffered
18 a trauma on a farm or bitten by a snake were picked up and
19 taken by a fairly sophisticated airborne ambulance, but
20 what is it that the RFDS actually delivers into this
21 patchwork of services.

22
23 MR SAM: We still do that and still make television shows
24 about it, I might add. However, I think our core role as
25 an emergency service, the mantle of safety, is still very
26 much at the core of our purpose and mission. That speaks
27 to sort of locational presence and also extends to the fact
28 that part of our role is really breaching the access divide
29 to get people in to care and to get people - or care to
30 people.

31
32 So we have a primary role, still, in emergency
33 retrieval. We support the movement of patients across the
34 health system as well. So both in terms of moving patients
35 from the site of trauma or, indeed, the site of an
36 emergency event, but moving patients between hospitals,
37 particularly from sort of lower levels of hospital into
38 a higher acuity or a more tertiary context, so we fly a lot
39 of patients from rural areas into regional and metropolitan
40 services and back again.

41
42 We also move patients who have less acute
43 requirements - that is, a lower emergency level - again,
44 moving them into care, out of care, but also providing
45 support through that process.

46
47 However, in the last decade in particular, the

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

8
9 Perhaps the most significant driver of how our service
10 has evolved has been the shifting pattern of availability
11 and access to a broad range of services within community,
12 which this Inquiry will be well versed around, particularly
13 primary care, but also, I think, the rapid decline of what
14 was a longstanding model into rural communities of
15 a general practice and associated relationship with a small
16 hospital or a hospital within proximity, where the
17 relationship between primary care, general practice during
18 the day, and the hospital being able to provide some form
19 of acute care, serviced quite a need.

20
21 With, I guess, rationalisation of service and role
22 delineation amongst health facilities now, that is quite
23 dispersed. With the decline of general practice, again,
24 that relationship within communities about who holds
25 responsibility for care has declined, and we have
26 increasingly moved more and more into more communities
27 providing a broader range of services.

28
29 MR MUSTON: In relation to that, is the anecdotal sense
30 that we have, or that seems to be developing, that that
31 line beyond which primary care is traditionally met by
32 organisations like yours is creeping eastward. As
33 a deliverer of those services, is that something that you
34 have practically observed in terms of the way you are
35 delivering services?

36
37 MR SAM: Yes. So I think there is a definition issue, if
38 I may, around the concept of primary care. Often, it is
39 assigned to the MBS or Medicare-based system as an
40 insurance that drives a funding source for primary care in
41 a general practice context or a primary care setting.
42 There is also the definition that says it is where you
43 receive your care and from whom, and what is that care that
44 you are receiving, across a continuum of primary prevention
45 through to a range of subacute intervention. But as
46 a charity, our organisation fundamentally has grown and
47 evolved from being a failed market solution, that we were

1 able to invest through various funding sources into the
2 provision of services and grow, by attracting funding, but
3 importantly, 50 per cent of our funding comes from
4 fundraising and donations. So our appeal to the community
5 has broadened to say, "In supporting the RFDS, you are
6 supporting now a broader suite of services, particularly
7 primary care, in addition to those traditional emergency
8 services."
9

10 The challenge we have had is that as a failed market,
11 and increasingly now more into what I would call thin
12 market environments, that we often sit in the cracks
13 between the traditional funding lines for the provision of
14 health service and, like many for-purpose, and indeed for
15 many health organisations, now compete pretty much
16 exclusively for all services that we provide and over time
17 the level of investment we've had to make in our own
18 fundraising has not kept up with the cost of being able to
19 meet this increasing demand and the complexity of service
20 provision, which again will have been stated many times
21 through this hearing.
22

23 As a result of that, we've lost our capacity to see
24 a lot of growth and development into markets that have
25 failed, so we are responding now primarily to emergent
26 needs, and we are more reliant upon other systems for our
27 funding to provide care.
28

29 So our model has evolved but our ability to act and
30 self-determine and self-direct a lot of our own resource
31 has been diminished quite significantly over the last few
32 years.
33

34 MR MUSTON: In terms of - I just want to explore the
35 concept of a failed market that you have spoken of. Would
36 it be right to assume that, historically, there was
37 a primary care in the sense of GP based primary care or
38 care that would traditionally be GP based or community
39 dentist based, which was always delivered by the RFDS in
40 areas that were so remote that there was no market, failed
41 or otherwise, no doubt you have examples of towns over the
42 history or your organisation where it has always delivered
43 the dental care and GP based check-ups and primary care;
44 would that be right?
45

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

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

3
4 Whilst we were waiting - so the concept of if we're
5 not retrieving you, we could utilise resources to provide
6 some remote outreach clinics, and these were largely
7 fly-around or drive-around clinics using the resources
8 within the service that would have otherwise been used just
9 exclusively for emergency care. So that was, and still
10 remains, I guess, a core amount of our service. However --

11
12 MR MUSTON: Is that different to the failed markets that
13 you are talking about?

14
15 MR SAM: Well, markets are failing and I think what is
16 different is that that line, that geographic line and
17 demographic line, is now sort of moving eastwards, and so
18 what we're seeing now are communities that aren't
19 classified as the most remotest, without service, and we
20 are increasingly being sought by communities, and others,
21 to provide services into those.

22
23 So it's an expansion, I guess, of the failed market
24 concept, and what is now seen as a thinning market, that
25 once one or two threads start to disappear in community,
26 you see an inevitable decline in the availability of other
27 services.

28
29 THE COMMISSIONER: Can I just ask a question so
30 I understand this. We haven't mentioned this statement
31 yet, I don't think. Is that going to go into evidence?

32
33 MR MUSTON: I think it is probably not. It's a joint
34 outline, I think --

35
36 THE COMMISSIONER: Do you have the outline of evidence
37 that was prepared? Can you just look at paragraph 6 for me
38 and help me with - in paragraph 6 you talk about in the
39 last four years alone you have provided more than 300,000
40 occasions of care, and in (ii) and (iii) - (ii) there is
41 a mention of 28,700 GP medical practice consultations, and
42 in (iii), 30,000 primary health consultations. What's the
43 distinguishing factor between those?

44
45 DR NOTT: So the distinguishing factor between those is
46 that we wanted to highlight the difference between,
47 I suppose, the services that we've always provided in rural

1 and remote settings, so the 30,000 primary health care
2 consultations are a mix of both nurse-led primary care
3 clinics in incredibly remote locations and, as Greg
4 described, the fly-in fly-out or drive-in drive-out
5 communities that we've served for quite a long time.
6

7 The growing space is that point (ii) that you have
8 highlighted, the 28,000-plus GP medical practice
9 consultations, and this is to the point that is being made
10 around an increasing draw or requirement or pull from
11 communities for us to step into a traditionally MBS-run
12 primary care market, and I think there may have been
13 evidence already within this Inquiry that in our Western
14 New South Wales PHN footprint there are predictors of the
15 41 towns across its remit that may be without a GP practice
16 within - by the close of the decade.
17

18 Now, that should ring significant warning bells for
19 everyone across that geography. A number of practices are
20 sole GP practices. A number of them do not have succession
21 planning or clear lines of succession planning, and the
22 pipeline for GP workforce --
23

24 THE COMMISSIONER: There may be no-one willing to step
25 into the practice or buy the practice.
26

27 DR NOTT: Exactly. The pipeline we know nationally,
28 general practice - taking aside even the challenges of
29 rural/remote - nationally, metropolitan, rural/remote,
30 regional, there is a declining interest in medical students
31 wanting to enter general practice. So not only are we
32 seeing a gap, but that gap is widening. And so if you look
33 at compound annual growth rates of medical specialties
34 across this country, regional and rural are actually - we
35 are bending the curve in most sub-specialty areas except
36 for the specialty area of general practice.
37

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

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

3
4 So we do have a significant problem here, and what we
5 need to look at is actually also workforce solutions. The
6 pipeline needs to be fixed, and it needs to be fixed now.

7
8 The challenge with us, if we implement evidence-based
9 programs that allow us to promote rural health and rural GP
10 careers, we will have a gap of approximately 10 years
11 before we can start seeing the fruits of that. So in the
12 meantime, there needs to be considerable work done around
13 how do we maintain, one, the workforce that we have at the
14 moment, how do we support them; but also, how do we create
15 models where we know - and the numbers are suggesting that
16 we will have less people on the ground to do the work that
17 is likely going to grow as well.

18
19 THE COMMISSIONER: Can I just also while we're on this
20 before I go back to Mr Muston, just on this paragraph,
21 looking at (iv) and the 14,000 mental health, alcohol and
22 drugs consultations, is that also a growing area of
23 services that you are providing?

24
25 DR NOTT: Yes, and a significant one in terms of the
26 demand on our services, the extent and the programs that we
27 are growing in partnership with the local health district
28 but also off our own resources as well, that is a growing
29 space.

30
31 If you look at some of our traditional mental health
32 programs, they have been in that space of there is no other
33 provider. But - and I just met with our mental health team
34 yesterday - the work that they are doing is increasingly so
35 in town that is may have had some of these services
36 provided through other means, and also the services that we
37 are providing in that space are increasing in the diversity
38 of those. So through programs like We've Got Your Back,
39 where we're training up people within community to assist
40 in the sort of mental wellbeing of community members,
41 programs that allow us to get nurses or mental health
42 clinicians into communities where we can intersect with
43 existing service providers.

44
45 If you look across the PHN footprint in this part of
46 the world, our rates of mental health presentations are
47 significantly higher, it's around 50 to 60 per cent higher

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

7
8 And so that flow-on effect actually creates a much -
9 much more pressure on the system, and that again leads back
10 to some of the conversations we've had earlier around how
11 do we get in front of this, how do we keep people well in
12 community, how do we resource appropriately programs that
13 get out to community on the ground and are able to assure
14 that people don't end up in acute care facilities.

15
16 MR MUSTON: In terms of the GP medical practice
17 consultations that you have told us about, that distinction
18 between the more traditional primary health consultations
19 in remote areas and the GP medical practice consultations,
20 are they consultations which occurred in facilities like
21 the one that you operate now in Warren?

22
23 DR NOTT: Yes, correct.

24
25 MR MUSTON: Could I perhaps just ask you to give us a
26 little bit of history as to how that Warren project came to
27 be?

28
29 MR SAM: Yes. So, previously, the administration of that
30 practice had been managed by a workforce agency in
31 consultation with local government and the practice itself.

32
33 MR MUSTON: Just pausing there, the small town of Warren
34 in Western New South Wales had a GP practice which provided
35 primary care to the people of that town.

36
37 MR SAM: That's correct. It was, I guess, supported and
38 administered as a practice - supported by a workforce
39 agency as well. So it fundamentally operated as a small
40 private business, but supported in terms of how it, as
41 a quality practice, would have registrars, et cetera, pass
42 through.

43
44 MR MUSTON: Could I, just in terms of the support, just
45 unpack a little bit how that operated? We can imagine the
46 small private practice in a town has one or more GPs who
47 are the owners of that practice and deliver the medical

1 care whilst also dealing with the back-of-house side of
2 running a medical practice. What was the support that was
3 provided by the workforce agency?
4

5 MR SAM: It was largely to provide, I guess, corporate
6 type support services, but also to help with, I guess, the
7 management of workforce through it, so to enable continuity
8 of care in those small towns, to enable locum relief, for
9 example, and other types of support, with a combination of
10 I guess the ageing GP workforce, and we know that's another
11 major issue about general practitioners intent to want to
12 retire, and the declining financial viability of Medicare
13 billing, so that the economic viability of supporting those
14 practices all started to decline around the same time, and
15 with the withdrawal of the workforce agency support for
16 that, which was their decision, that town, in particular
17 local government, saw that the inevitability was that that
18 practice would close.
19

20 MR MUSTON: Pausing there, who was funding the workforce
21 agency to provide that support?
22

23 MR SAM: It is a combination, but largely there are both
24 sort of Commonwealth and a range of different
25 fee-for-service arrangements.
26

27 MR MUSTON: Sorry. I interrupted you.
28

29 MR SAM: It was the local government who first reached out
30 to us, because we provide some primary care services in and
31 around that district, so they were aware of our presence.
32 We had also operated general practice services out of
33 a clinic here in Broken Hill, which a lot of people in
34 Western and Far Western New South Wales were aware of. So
35 those discussions began largely with local government about
36 (a) their need and our interest, and it evolved from there.
37

38 MR MUSTON: When you say it evolved, what was the process
39 that led to --
40

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

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

7
8 MR MUSTON: In terms of the question that you ask
9 yourself, are we able to do this, there are at least two
10 considerations that feed into that, I assume. The first is
11 economically or financially, is it viable for us to do
12 this, having regard to the MBS billing that it might
13 generate coupled with other potential sources of income;
14 and, secondly, workforce considerations around the ability
15 to actually staff it. Going through them in turn, what was
16 the thought process or what is it that makes it viable for
17 you as an organisation to do that work?

18
19 MR SAM: The first thing is really we don't have a profit
20 motive, so there is not a specific economic threshold that
21 we test assessment against. It was really looked at in a
22 broader context of what is the value of us being able to
23 operate and not lose money as a charity. We were also
24 seeing that there were a number of reforms proposed within
25 the MBS system, the changes to MyMedicare, which hopefully
26 were going to increase the potential billing. And in terms
27 of the workforce consideration, we see a future very much
28 around being able to look at, I guess, integrating practice
29 based general practice - that is, fixed general practice in
30 community - with the way that we want to evolve our primary
31 care offering more generally, which is community based but
32 also remote based.

33
34 So it provides us with more infrastructure within
35 small rural communities with which, in the future, we can
36 use to grow and enhance, I guess, our ability to reach into
37 more remote areas.

38
39 So it fits more broadly with our aim to provide more
40 care in more areas that are under-serviced, and it also
41 enables us to evolve capacity and capability within the
42 Medicare system.

43
44 DR NOTT: If I may, in addition to what Greg has
45 mentioned, that capacity and capability piece, for us to
46 build - and Greg mentioned about the workforce side of
47 things - for us to be, I suppose, part of a solution, to be

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

9
10 The space in which we've found ourselves in this,
11 I suppose, more traditional GP practice environment allows
12 us to also support the training system. It will allow us
13 to be able to bring GP registrars through, so GP trainees
14 through, give them positive experiences in rural and
15 remote, but also working alongside the local health
16 district, so for instance in Warren, we could use the
17 example, but other places as well, we have arrangements in
18 place where we can work collaboratively with the LHD to be
19 able to utilise our workforce, as we grow it, to be able to
20 also support the local hospital. So the Warren Hospital
21 and Gilgandra don't necessarily have a full complement of
22 medical staff particularly to be able to service those
23 hospitals, but as we grow, we see our responsibility as not
24 just a not-for-profit that's going to look after our own
25 practice, but we've got a responsibility and an obligation
26 to be able to support the community need.

27
28 If you take the concept of rural generalism, so The
29 Collingrove Agreement, which essentially is that there are
30 specialist GPs in community that have advanced skills to
31 meet their community need and support the acute care
32 services as well as their primary care obligations, that is
33 a space that we, and the board, have very much an intent to
34 be able to work within.

35
36 If you expand that beyond the medical space, about how
37 do we have rural generalist nurses, allied health, we need
38 to be part of that solution, and for us to be able to have
39 the infrastructure, the spaces in terms of being able to
40 have safe and positive training environments, we'll be able
41 to continue to grow our workforce in partnership and
42 collaboration with local health districts.

43
44 MR MUSTON: Are there any particular challenges in terms
45 of the way in which those services are currently funded
46 which stand in the way of you achieving those objectives or
47 potentially even expanding your operations to pick up need

1 in other thin markets?

2

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

9

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

20

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

29

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

34

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

44

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

1 further, I suppose, inequity in terms of those that want to
2 enter a primary care space. So if, for instance, there was
3 a scholarship designed for only health staff, that puts us
4 behind the eight ball unless that is actually going to be
5 extended beyond, and that actually disadvantages these
6 small rural communities, because, as Greg said, there is
7 not the activity or space for us to sort of have this wall
8 up between what is state acute care and what is primary.
9

10 The more rural and remote you get, those spheres
11 essentially become one. It is the same workforce trying to
12 achieve the same things, and so we need to look at
13 incentives that work for the community and meet that
14 overarching aim that we are all working toward, which is
15 improvements in health care.
16

17 MR MUSTON: Is that really a facet of the place-based
18 pooling of resources that you opened with?
19

20 DR NOTT: Yes.
21

22 MR MUSTON: That indication that getting together all of
23 the resources, both financial and other resources, that are
24 available to meet the needs of the community and working
25 out the best way to distribute them is impacted adversely
26 if only part of those resources, in a workforce sense, have
27 access to certain incentives or at different levels of pay
28 or conditions because of awards being different and the
29 like, so all of these little issues can contribute to
30 making it more difficult to do that single place based
31 pooling of resources, planning of the way in which those
32 pooled resources will be used.
33

34 DR NOTT: Absolutely agree.
35

36 MR MUSTON: You told us. I think earlier on, Greg, that
37 something in excess of 50 per cent of your organisation's
38 total funding is derived from bequests and donations, and
39 I think presumably also the sale of bears and T-shirts and
40 all those other things that organisations like yours do as
41 part of their fundraising activities. Do we take it from
42 that that the moneys that you are receiving for the
43 delivery of your core business are not sufficient for that
44 purpose? Perhaps let's break that down into a few
45 components, and look at the primary care in Warren, for
46 example?
47

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

9
10 What we've seen increasingly, and certainly in the
11 last decade, major reforms to the way that funding into the
12 for-purpose sector is provided, so a big shift away from
13 block grant funding to, I guess, competitive based service
14 level agreements, which has, on one hand, I think,
15 increased the efficiency and the accountability of
16 services. However, the downside of that shift is it's
17 largely a model which suits high activity and high
18 population density. So a shift to activity-based
19 price-based services agreements has put additional pressure
20 on the fact that per capita, it costs a lot more to provide
21 that service in a remote context.

22
23 Secondly, our organisation and our board are quite
24 committed to the fact that we base and centre our services
25 in regional and rural, and hence our most populous bases
26 from a workforce point of view in New South Wales are in
27 Broken Hill and Dubbo, and that brings with it the set of
28 inflationary drivers that rural has generally. And we've
29 seen significant increases in our cost base, particularly
30 through COVID and emerging from COVID.

31
32 The third element is we are a highly regulated entity.
33 We operate in an aviation context, a health context, and we
34 are a charity, and we're rural and remote. Each of those
35 elements require us to commit more and more of our own
36 resource to maintaining standards compliance, et cetera.
37 That is not generally built into activity-based service
38 provision.

39
40 So in general, what I would say is that we have
41 transactional relationships with funders that put a lot of
42 emphasis on quality and accountability and efficiency.
43 However, it has come at the cost of, I guess, our core
44 funding into supporting our fixed costs, our infrastructure
45 costs, our compliance costs, et cetera, and as our service
46 has grown, the workforce has grown considerably, and that
47 has also been a major driver of cost escalation, because we

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

3
4 The power of the brand, if I can call it that, as
5 a charity still has a high level of attraction. However,
6 the idea that we can offer anything other than at least
7 parity in terms of employment, employment conditions now is
8 almost a standard. So we have to meet the same workforce,
9 employment, salary conditions as those services that are
10 operating around us. So that has been a major driver.

11
12 In terms of the cost for our Medicare billing GP
13 practices, we're very cautious to make sure that we don't,
14 I guess, diffuse our charity work into operating these
15 practices along commercial lines and they are accountable
16 along those commercial lines, hence my earlier comment
17 about we assess that before we make a decision to move into
18 that.

19
20 I think it's recognised that our cost base
21 fundamentally has just failed to - funding has failed to
22 keep up with that, and that's our single biggest issue,
23 which means we are now diverting the majority of our
24 fundraising money into sort of paying utility bills and
25 supporting keeping the lights on at both Broken Hill and
26 Dubbo bases, where previously we were operating surpluses
27 built around the fact that our fundraising was where we
28 could direct our services and determine to go into those
29 so-called failed market communities.

30
31 THE COMMISSIONER: Your fundraising, is most of it, of the
32 donations or bequests made to your organisation, just for
33 general use, or do some donors say, "I'm going to give you
34 X dollars but I want you to use it for this specific
35 purpose"?

36
37 MR SAM: Both, and increasingly, donors want to see us
38 providing service, not just sustaining, hence that idea
39 that increasingly --

40
41 THE COMMISSIONER: In other words "I'm going to give you
42 money, but I expect that it's not for the electricity bill;
43 it's for you doing some specific health care service".

44
45 MR SAM: That's correct, and particularly given our
46 fundraising in rural areas, it tends to reflect this issue
47 of how the community feels priorities sit, hence a large

1 growth in our mental health service has been enabled by
2 community saying "That's where we want to see our funds
3 being redirected".
4

5 DR NOTT: I might just add with that, there is significant
6 opportunity cost through us having to divert that funding
7 into some of the, I suppose, keeping the lights on, as Greg
8 has mentioned.
9

10 THE COMMISSIONER: By that, you mean you could be doing
11 things that you are not currently doing?
12

13 DR NOTT: We could be doing things that we're not
14 currently doing.
15

16 THE COMMISSIONER: Don't let me cut you off.
17

18 DR NOTT: Yes, absolutely. We could be doing things that
19 we know the community want, that if we had the freedom and
20 flexibility, as Greg mentioned before, around
21 self-determining alongside community where those dollars go
22 to, then we can be operating in areas that traditional
23 funding mechanisms would not allow us to and, also,
24 innovate in a way that perhaps some of the rigidity of
25 traditional funding mechanisms doesn't allow us to.
26

27 THE COMMISSIONER: Can you give some examples?
28

29 DR NOTT: So, for instance, there is increasing - even to
30 the points around the primary care space, there is
31 increasing request, even just last night I received some
32 messages from a doctor in a community requesting help. And
33 so if we had more freedom around our charitable dollars, we
34 would be able to look at where we can supplement existing
35 health services, where we know through our connections and
36 connection with community, we could be delivering more
37 primary care, more mental health, we could potentially be
38 looking at sub-specialist or specialty services that we
39 might bring into community.
40

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

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

3
4 MR MUSTON: Do you both have a copy of the statement or
5 the outline that was prepared in front of you?

6
7 THE COMMISSIONER: I think given I asked a question about
8 it, ultimately this should be tendered.

9
10 MR MUSTON: Yes, Commissioner, I am going to deal with it.
11 It's [SCI.0009.0110.0001] at 0005. I raised this with my
12 friend, and he is content for us to proceed on this basis.
13 Have you both had an opportunity to read and consider that
14 document?

15
16 DR NOTT: Yes, this document.

17
18 MR MUSTON: Are you both satisfied that it reflects or is
19 true and correct to the best of your respective knowledge?

20
21 MR SAM: Yes.

22
23 DR NOTT: Yes.

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

35
36 DR NOTT: Fragmentation is a real part of and a real
37 challenge across the health care system. For us, I think,
38 it goes down to some of those comments I made earlier
39 around collaborative planning and resourcing to be able to
40 do that. Some key enablers for us are health care is
41 increasingly becoming digitised. Digital systems are an
42 enabler to avoid fragmentation, but if designed
43 inappropriately, they can actually promote fragmentation of
44 system.

45
46 We need to find ways in which we can appropriately
47 share patient data between organisations in a way that

1 ensures patient privacy and the expectations of community
2 are met, but also promotes collaborative work together
3 around how do different organisations work in an
4 environment to treat the patient in the set-up.
5

6 So in health care, having knowledge is incredibly
7 powerful. If I saw, as a doctor, a patient who has complex
8 medical conditions, and they have seen multiple other
9 providers, in most settings today I wouldn't necessarily
10 have visibility, even with My Health Record, of what tests
11 have been ordered, what plans are of different
12 sub-specialty providers, and so on and so forth.
13

14 Digital systems will allow us to be able to close that
15 gap, but there needs to be, again, some focus around how do
16 we actually achieve it in an environment where the reality
17 is that with health care, there will be private
18 organisations, there will be not-for-profits or NGOs, there
19 will be state health systems, and so technically joining
20 the dots is actually quite a difficult one. But if, for
21 instance, in our space, there is willingness to
22 collaborate, it can be done. So I would take an example of
23 Wilcannia.
24

25 So we operate both primary care services within
26 Wilcannia as well as obviously our aero-medical retrieval
27 service. Far West LHD has an MPS there and Maari Ma also
28 support through a community-controlled health organisation.
29

30 Now, any individual in Wilcannia can traverse any one
31 of those organisations, and if you took a traditional lens
32 of it, we will all keep our data separate and the patient
33 is sort of stuck in between.
34

35 We've got agreements between ourselves and Maari Ma
36 around read-only access to each other's medical records,
37 recognising that our clients in that community will, at
38 times, sometimes see Royal Flying Doctor Service and
39 sometimes see Maari Ma.
40

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

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

7
8 Our doctors also, if they are prescribing into those
9 facilities when somebody has an acute episode, will chart
10 medication utilising the Far West systems. They will order
11 tests through the Far West systems. They will have access
12 to every hospital presentation that patient may have made
13 within the Far West network. So that transparency of data
14 is actually incredibly powerful. It can be done, and
15 certainly we work through workarounds as opposed to the
16 system enabling this sometimes, but we work through
17 workarounds because of goodwill and the reality is that out
18 here we all need to roll our sleeves up and do our best for
19 patients. So that digital component is one of the areas
20 that fragmentation can be addressed.

21
22 The collaborative planning and the remit, as
23 I mentioned before, around getting the providers in the
24 room regularly, as Greg discussed, and having
25 accountability of those providers to actually achieve the
26 outcomes that we set out for is also going to avoid that
27 fragmentation, and having that planned approach to going
28 "Okay, organisation X, this will be your role. We'll play
29 this role. We'll work together. We'll set up appropriate
30 governance and systems where we work as a team across
31 organisations to meet that community need".

32
33 MR MUSTON: We've talked about this collaborative planning
34 and delivery as a model that we should all be striving
35 toward. To what extent in the Far West do you feel that
36 that is happening at the moment, recognising that your time
37 here, Dr Nott, has not been long.

38
39 DR NOTT: So being new within a leadership role within the
40 RFDS - and Greg might want to comment as well - I see that
41 we do it well in pockets and, like any organisation, there
42 is always room to improve around the way in which we
43 interact with our partners. But, overall, the integration
44 of RFDS within LHD systems, I have not seen that degree of
45 collaboration in many other areas of the New South Wales
46 health system.

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

9
10 MR MUSTON: Viewed from the perspective of a participant
11 in that collaboration, do you have a sense that Maari Ma is
12 currently involved as a co-collaborator to the same extent
13 as you are?
14

15 DR NOTT: I wouldn't be able to comment due to my short
16 time within the organisation, but I am aware that with, for
17 instance, dental programs, where there is shared interest
18 between the entities, that we have been getting together to
19 plan. I'm not sure if you have got further comments there,
20 Greg?
21

22 MR SAM: There is and has been, certainly in my time,
23 a strong goodwill. I think the challenge is really the
24 system that supports us all, to convert a lot of that
25 intent to activity over time. So there will be
26 opportunities that will come from working with the LHD or
27 the PHN or Maari Ma or another organisation that might
28 centre around a particular initiative, or it might centre
29 around a particular funding opportunity, but the idea of,
30 I guess, a regular structured supported process still has
31 some ways to go.
32

33 MR MUSTON: When you say "supported", what is the support
34 that you had in mind? It may be many things.
35

36 MR SAM: I think it is a level, I guess, of responsibility
37 and accountability for that process. At the moment it does
38 require goodwill and timing and resource, and often that is
39 at each organisation's initiation, if you will. Certainly,
40 I think both the LHD and PHN have taken on, in Far West,
41 a greater role in trying to coordinate this, but that puts
42 pressure on their own organisations to a degree. So
43 I think we've spoken about it before, it's reframing the
44 priority around how services are planned, monitored and
45 delivered, and appropriately resourced.
46

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

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

11
12 Is that something that the RFDS has any visibility of,
13 or are you more just the air taxi that is booked by someone
14 else to make these trips?

15
16 DR NOTT: We certainly have visibility of that, and we see
17 it through nearly all of our health services. And it's
18 even more pronounced in the outpatient space where people
19 sometimes are expected to go on their own back both ways,
20 and yes, there are IPTAAS programs and those types of
21 things, but it is a real barrier to access.

22
23 A number of people will also forgo access to other
24 services that they need to go elsewhere for because of that
25 drive, because of the cost associated with travel and
26 accommodation, and even as you rightly pointed out, in
27 acute care environments, some people who absolutely need to
28 move between facilities because the acuity of their
29 condition is such that they are required to go to a higher
30 level of care will decide to not go or decide to leave
31 hospital. And so certainly that is an absolute barrier and
32 challenge that our clinicians deal with on a day-to-day
33 basis.

34
35 MR MUSTON: It is a barrier or a challenge which is
36 presumably manifesting itself in inferior health outcomes
37 for those people who face it.

38
39 DR NOTT: Yes. As I said, people - I personally, as
40 a doctor who has worked across both primary care branches
41 and retrieval branches, have numerous cases where
42 patients - I have had to have long conversations with
43 patients about their care, what I see through the lens of
44 a doctor in terms of the benefits of going versus the risks
45 of staying, and we do have to grapple with that in terms of
46 knowing that best or better care can be provided elsewhere,
47 but through the lens of that patient they would rather stay

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

4
5 MR MUSTON: Are there systemic changes that you think
6 could or should be made to try and remove or reduce some of
7 those barriers?

8
9 DR NOTT: Yes, the simple thing would be looking at
10 programs that allow us to ensure that those - particularly
11 those with significant socioeconomic disadvantage - are
12 able to access travel back home and are assisted in
13 coordinating that, because the challenge with a lot of
14 access schemes or programs is that often patients have to
15 apply for those themselves and particularly in our remote
16 areas, we need to recognise that many people do not have
17 the levels of education that would be expected to be able
18 to fill out or even know that these programs exist. Greg
19 mentioned that sort of health navigator role. That type of
20 role should transcend not just the travel issues but in
21 terms of access, how to access programs, how to access
22 support.

23
24 Even as a doctor that's worked within the system and
25 worked at a system level, I find it challenging daily to
26 know exactly what programs any individual or patient may be
27 able to access for their particular set of challenges.

28
29 MR MUSTON: If you as a doctor working in the system with
30 deep experience in the system find it challenging,
31 I presume the inference is that the patient who is sitting
32 on the other side of the desk may have absolutely no idea.

33
34 DR NOTT: Absolutely. I come from a farming family,
35 I grew up with farmers and people who work off farms and
36 I've always approached health care provision through the
37 lens that if my dad wouldn't know how to access a program,
38 a significant proportion of our community won't, and my
39 father, to be able to know - he wouldn't know that IPTAAS
40 programs exist, wouldn't know how to access them, and
41 managing complex and chronic disease is even more
42 challenging for people who don't know how to navigate the
43 system. It's hard enough for us to navigate it when we do
44 have that knowledge.

45
46 MR SAM: It is a problem. It is a challenge. It has,
47 I guess, continued to evolve as differentiation of

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

14
15 So I think we are very much aware of transportation as
16 a major restriction on access. Even getting in to a GP
17 practice from out of town can be a challenge for some
18 people.

19
20 MR MUSTON: Ultimately, it is right, isn't it, that if
21 there is a barrier that prevents access to that service, it
22 might be the best service in the world, but for that
23 particular consumer, it just doesn't exist.

24
25 (The witnesses nodded)

26
27 MR MUSTON: I have no further questions for these
28 witnesses, Commissioner.

29
30 THE COMMISSIONER: Mr Cheney, do you have any questions?

31
32 MR CHENEY: No, thank you.

33
34 THE COMMISSIONER: Thank you both very much for your time.
35 We're very grateful and you are excused.

36
37 DR NOTT: Thank you.

38
39 MR SAM: Thank you.

40
41 THE COMMISSIONER: You are excused.

42
43 <THE WITNESSES WITHDREW

44
45 THE COMMISSIONER: Is that a convenient time to take an
46 adjournment now? We'll adjourn until 11.30 then.

47

1 Q. There is nothing you want to change?

2 A. No, I don't believe any of it is incorrect.

3

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

5 A. Yes.

6

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

10 A. Yes, definitely.

11

12 Q. All funded, or many of them funded from different
13 sources?

14 A. Yes. Certainly. So a range of mental health, AOD and
15 support services, some of those being funded by the
16 Ministry of Health, some of these being funded by
17 Commonwealth, Western New South Wales PHN providing that
18 funding or contracting that funding to Mission Australia.
19 So the Enhanced Adult Community Living Support program --
20 do you want me to go through those programs?

21

22 Q. I will ask you about them briefly one by one. So the
23 Enhanced Adult Community Living Support program, that's
24 based in three locations; is that right?

25 A. Currently we're funded to provide that Dareton, Far
26 West New South Wales, Dubbo and Orange, Western New South
27 Wales. That program assists individuals with severe mental
28 health issues and highly complex needs in the community.
29 We receive clinical support to that program from the
30 Western NSW Local Health District and also Far West Local
31 Health District.

32

33 Q. When you say "clinical support", what do you mean by
34 that?

35 A. So the program is designed, Mission Australia is
36 contracted to provide the psychosocial support component of
37 the program. I would say one of the biggest - one of the
38 biggest things we support people in that program with is
39 connecting them to appropriate clinical supports within the
40 health system or whether that be with their GP or with
41 other local clinical support services such as, you know,
42 mental health support, psychiatry, psychologists, ongoing
43 care in that way.

44

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

1 delivery a day for that service.

2

3 Q. Just in terms of what you are providing, your
4 workers --

5 A. Yes.

6

7 Q. -- what discipline are the workers?

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

25

26 Q. And in terms of just how your workers provide that
27 service, so Dubbo and Orange I think you said that's
28 35 hours per week?

29 A. A day.

30

31 Q. Thank you. You have a number of workers providing
32 that?

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

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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

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

13

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

18 A. Yes.

19

20 Q. And you have to record every minute that that staff
21 member does during the day, every meeting, every email,
22 every break. What does that mean?

23 A. So basically our staffing model is based off what
24 we've been funded to provide hourly a day. So our support
25 hours that we must report on back to the ministry, so, for
26 example, for CLS in the western region, it's 35 hours
27 a day. So for us to report back on that, the only way you
28 could ever possibly meet that maximum target of the KPI is
29 to report every possible minute of a staff member's day.

30

31 Q. What does that actually - at a practical level, what
32 does that involve?

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

43

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

45 A. Yes.

46

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

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

8
9 Q. Mr Fraser asked you how many caseworkers does it take
10 to cover 35 hours a day, and you said divided by 8, so it's
11 4.4, but your answer was, "It's certainly not enough when
12 you look at it. When you look at what that includes, it's
13 not enough to be able to provide the support needed to
14 these consumers in the community." Can you explain to me
15 why it's not enough?

16 A. To me, I believe when you look at what the service
17 description is, so we're working with people with severe
18 mental health needs, with intensive - they have got highly
19 complex needs within the community, so we're not talking
20 about we're just going out doing a brief visit. Sometimes
21 these consumers require and deserve comprehensive case
22 plans and intensive support, and that may mean five hours
23 of support a day, it may - today, it might mean six hours
24 of support tomorrow, it might mean one hour of support the
25 next day, because mental health is not linear and it needs
26 to be flexible and innovative like that, and if we're
27 pushing staff into an hours based service model on
28 something that's so stringent like that, I believe that we
29 require more staff so we can say flexible, innovative and
30 responsive in nature to people's actual needs and remain
31 being a person-centred program.

32
33 MR FRASER: Q. Can I just ask you this, Ms Bottrell.
34 You are providing that service in the Western NSW Local
35 Health District out of those two locations, Dubbo and
36 Orange. Is that service provided in other locations within
37 that district by other NGOs?

38 A. The CLS service.

39
40 Q. The CLS service, to your knowledge?

41 A. Not within West and the Far West, no.

42
43 Q. So that service is effectively - that is the entirety
44 of the service for the entire district.

45 A. Western region.

46
47 Q. The western districts?

- 1 A. Yes.
- 2
- 3 Q. So for those based - those clients based --
- 4 A. Based out further.
- 5
- 6 Q. -- out further, say in Bourke, Brewarrina, long
- 7 distances from both Dubbo and Orange --
- 8 A. They would not be able to access the service that they
- 9 deserve.
- 10
- 11 Q. So no-one is providing that service, to your
- 12 knowledge?
- 13 A. Not CLS, to my knowledge. However, I do believe the
- 14 Housing Accommodation Support Initiative, currently
- 15 contracted to another NGO, does outreach to some of those
- 16 areas, but as said, it's - a lot of that is outreach
- 17 meaning travel there, they are not based there, which that
- 18 service model would look very different to what someone
- 19 would receive in a more metro or built-up community.
- 20
- 21 Q. And if I can just ask how those services came to be -
- 22 I think you have said that it's through the Ministry of
- 23 Health; is that right?
- 24 A. CLS is through --
- 25
- 26 Q. That particular service?
- 27 A. CLS is through the Ministry of Health, the mental
- 28 health branch, yes.
- 29
- 30 Q. Funded and contracted by them?
- 31 A. Yes.
- 32
- 33 Q. How is it that that service came to be delivered by
- 34 yourselves? Was there a tender process, or were you part
- 35 of some planning for that service to be established?
- 36 A. For CLS originally, we tendered for that program.
- 37 There has been consultations since most of those have been
- 38 initiated now.
- 39
- 40 Q. I just wish to ask you now about the Far West Local
- 41 Health District. You provide a service, you said, out of
- 42 Dareton?
- 43 A. Yes.
- 44
- 45 Q. In the southern --
- 46 A. The CLS.
- 47

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

4 A. Yes.

5

6 Q. Is it still, though, contracted on an hours-based
7 model?

8 A. Yes, it is.

9

10 Q. Again, is that service provided elsewhere within the
11 district by anybody else?

12 A. Not to my understanding, not the CLS program, no.

13

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

17 A. Definitely.

18

19 Q. But again, if you are elsewhere within the district,
20 you are only able to access that through Dareton?

21 A. Yes, that's correct. Dareton's funded for 15 hours of
22 support a week, so three hours a day.

23

24 Q. So for those places located close to Dareton, it may
25 be accessible?

26 A. Certainly not those ones far away, it wouldn't be
27 logistically possible, or be able to be safely delivered.

28

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

31 A. Yes.

32

33 Q. When you tendered for it, were you tendering for
34 a service that had been already identified to be provided
35 out of Dareton, or were you tendering for a service for the
36 district --

37 A. To be provided within the Far West.

38

39 Q. How was it identified that the service would be
40 provided out of Dareton as opposed to, say, Broken Hill?

41 A. So it was actually part of a conversation with the Far
42 West Local Health District about a service gap which had
43 been identified. So we are also actually funded in Far
44 West to provide the HASI service and, as I've mentioned,
45 they are similar services, HASI and CLS. So we're funded
46 in Far West to deliver HASI. When we were successful
47 receiving the CLS tender, we felt that it was best placed

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

8

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

11 A. Yes.

12

13 Q. -- as a product of Mission Australia giving thought to
14 how, between the two services that you then had been
15 contracted for, you could provide greatest coverage for the
16 district --

17 A. If we were to place that in Dareton, yes.

18

19 Q. I might come to the HASI service. Just remind us what
20 HASI stands for?

21 A. The Housing Accommodation Support Initiative.

22

23 Q. And is that being funded by the ministry?

24 A. Yes, the mental health branch.

25

26 Q. I think what you referred to in the outline is
27 a service that offers flexible support to people over
28 16 years, with a severe and persistent mental illness
29 through psychosocial recovery support within the community?

30 A. Yes, that's correct.

31

32 Q. Your workers, who are providing that service, do they
33 have similar qualifications as the other service?

34 A. Similar, yes, similar qualifications. Must have
35 a Cert IV in mental health or similar, and preferably
36 previous work experience in the area.

37

38 Q. How much - your funding for that service, how is that?
39 Are you funded for an hours per week model or a per day --

40 A. Hours a day. So HASI in the Far West is funded for
41 28 hours a day, so that's our maximum amount of support
42 hours. So we've actually placed, because - if I may, the
43 CLS program, as I mentioned, was 0.5 FTE, very hard and
44 almost impossible to recruit a part-time worker in the
45 Dareton area, so we also deliver partial HASI down there as
46 well, so then we're able to then call that a full-time
47 role. That also was being discussed with the Far West

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

3

4 Q. So you have a worker in Dareton who's effectively
5 providing four hours of the HASI service a day and four
6 hours of the CLS service per day. I presume it's not
7 necessarily specifically demarcated --

8 A. Certainly not as specifically as that, but it means
9 that community is able to access that service in a much
10 more, I guess, person-centred and accessible way.

11

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

14 A. Yes.

15

16 Q. By three and a half workers, if we do the divide by 8
17 process?

18 A. Yes, 3.5, yes.

19

20 Q. Just in terms of that, how do you factor in people who
21 have leave - and you mentioned that already.

22 A. Certainly difficult. People deserve to have leave.
23 We have to, I guess, do what we can with those positions
24 and, during periods of leave, back-fill those roles.
25 I guess we're in a position where we're a large
26 organisation, so we're able to support that somewhat, but
27 it's certainly not feasible ongoing.

28

29 Q. Does the funding cover leave provision, or --

30 A. No, it doesn't take into consideration when staff take
31 leave.

32

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

35 A. Yes.

36

37 Q. And paragraph 4 where some of these services are
38 outlined, (a), the housing accommodation support
39 initiative, what actually is it?

40 A. What actually is the HASI program?

41

42 Q. Yes.

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

1
2 Q. So in practical terms, what does that involve? What's
3 the support given to the individuals? It is to find
4 housing, is it?
5 A. Somewhat. Sometimes it's to maintain that housing and
6 build their own independence within our community and to be
7 able to maintain that long term without service
8 involvement, and certainly remaining engaged with their
9 clinical support, psychiatry, psychologists and maintaining
10 their wellbeing within our community.

11
12 The program certainly again, as I mentioned, is being
13 consulted over the coming two years. Particularly a lot of
14 that consultation will be around the introduction of the
15 NDIS and now where HASI fits in that as well.

16
17 Q. And how long - you mentioned you are funded 28 hours
18 per day for that program?

19 A. Mmm-hmm.

20
21 Q. How long does that funding agreement last?

22 A. How long do we currently have the funding agreement
23 to?

24
25 Q. Yes.

26 A. We've recently been given an extension until June
27 2026.

28
29 Q. How was the 28 hours per day arrived at? Was that the
30 result of a tender? What was it based on?

31 A. I'm assuming it would have been based on data within
32 the health system. We've had ongoing discussions with the
33 Ministry of Health where they, I believe, are aware that
34 the hours aren't truly reflective of, one, community need;
35 and --

36
37 Q. Stopping there, "community" being the Far Western NSW
38 LHD; is that what we're talking about?

39 A. Yes. But all LHDs, Far West LHD, Western LHD, the
40 hours based component and the hours KPI is not flexible and
41 too structured for a service of this nature.

42
43 Q. Sorry, I'm not following now, but all LHDs. When you
44 say "all", is it 28 hours per day for every LHD in the
45 state?

46 A. Oh, sorry, so it's 28 hours per day for the Far West,
47 yes.

- 1
2 Q. The Enhanced Adult Community Living Support program
3 that you've given some evidence about, CLS, which is the
4 program that you are funded for 35 hours per day; correct?
5 A. That's in Western NSW LHD.
6
7 Q. In Western NSW LHD, but not Far West?
8 A. No, for Far West LHD, the CLS program is funded for
9 three hours a day, so 15 hours a week.
10
11 Q. Three hours of the 35, or three hours additional to?
12 A. Three hours additional.
13
14 Q. And that program is funded through the Ministry of
15 Health?
16 A. Yes.
17
18 Q. And you said it was a tender?
19 A. Yes.
20
21 Q. The 35 hours and the three hours, what was that - how
22 was that arrived at, do you know?
23 A. I believe that those figures were created off data
24 through the Ministry of Health and the mental health
25 branch. They came to that conclusion.
26
27 Q. Was that then - was the tender, was it to provide
28 35 hours and three hours, or was it that you tendered and
29 said "We can provide this service in 35 hours or three
30 hours"?
31 A. No, that was their expectation, I understand.
32
33 Q. And precisely what is the Enhanced Adult Community
34 Living Support program, CLS? What do you do with that,
35 what is it exactly?
36 A. So it also assists people with severe mental health
37 issues providing individual support within each local
38 community, whether that be Dareton or Dubbo.
39
40 Q. Through the caseworkers you mentioned?
41 A. Through the caseworkers.
42
43 Q. The youth residential rehabilitation services in Dubbo
44 provided with the Department of Communities and Justice.
45 I assume that means it's funded through DCJ not Health?
46 A. Yes.
47

1 Q. Safe Haven provided in partnership with Far West LHD.
2 One, what is Safe Haven and what do you mean by
3 "partnership" with Far West LHD?

4 A. Sure. So the Safe Haven is part of the Towards Zero
5 Suicides initiative through NSW Health. The Far West Local
6 Health District have - we were successful in a grant to
7 deliver the Safe Haven service within Far West, and when
8 I say Far West, just to be clear, I'm speaking the service
9 is available in Broken Hill. So the Safe Haven provides an
10 alternative to the emergency department, particularly when
11 people are in suicidal crisis. When I say --

12
13 Q. Sorry, tell me how it works?

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

34
35 Q. Is your organisation's involvement in Safe Haven
36 funded by the Far West LHD?

37 A. Yes.

38

39 Q. The AOD, alcohol and other drugs coordinated care
40 programs?

41 A. Yes.

42

43 Q. What are they?

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

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

9
10 MR FRASER: Q. Is that a product of what you tendered
11 for?

12 A. Yes, so --

13
14 Q. In terms of the service that you tendered - was it
15 a tender process for that service as well?

16 A. Yes. Yes, it was a tender process.

17
18 Q. And when you tendered for it, the funding was of a set
19 amount?

20 A. Yes, a set amount.

21
22 Q. Is that service in Dubbo and Orange that you have
23 described there in Western, in a similar --

24
25 (Audio interference)

26
27 THE COMMISSIONER: Keep going.

28
29 MR FRASER: Q. In terms of each of - it's very
30 distracting - those services, again, the same in Dubbo and
31 Orange, you are just funded effectively --

32 A. Yes, so the AOD CCC contract is one contract for
33 Mission Australia for Far West and Western New South Wales,
34 and we're funded for 1 FTE in Far West, Broken Hill; 1 FTE
35 in Dubbo and 0.8 FTE in Orange.

36
37 Q. The only other one that I hadn't covered is The Way
38 Back service. That's provided here in Broken Hill; is that
39 right?

40 A. The Way Back service is funded by the PHN, the Western
41 New South Wales PHN and yes, we are funded to provide the
42 service here in Broken Hill. However, last year in March,
43 the service was decommissioned and we were then
44 recommissioned several weeks later. Half of that funding
45 was then placed into Orange, New South Wales, so now we
46 deliver The Way Back in Broken Hill and in Orange,
47 New South Wales.

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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

1 for dinner - all of those sorts of things, which is
2 supported by people who have lived experience of loneliness
3 and mental health distress.
4

5 Q. This is probably a little simplistic, but you are
6 providing a number of services which cover those with
7 mental health issues, suicidality?

8 A. Mmm-hmm.
9

10 Q. And alcohol and other drug problems?

11 A. Yes.
12

13 Q. Would you agree there is a significant degree of
14 overlap of the clientele of those different services at
15 different times?

16 A. Yes, I would agree.
17

18 Q. Or at least some?

19 A. I would agree that there is some overlap. However,
20 I also believe that, when working closely, if the
21 collaboration and the governance is there for those
22 services, you are able to - we've been able to provide
23 quite an effective continuum of care for people locally.
24

25 Q. In the places where you are able to provide the
26 service or services?

27 A. Definitely.
28

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

34 A. Yes.
35

36 Q. But there seems to be, in effect, something of
37 a patchwork of services in different locations as a result
38 of the limited funding in different locations at different
39 times; is that fair?

40 A. Yes, I think that would be fair to say. I think that
41 there is a lot of overlap from those services, but without
42 some of them it would create significant service gaps.
43

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

1 HASI and the CLS programs?

2 A. Yes.

3

4 Q. Are you involved in - is your organisation involved in
5 regional assessments of service needs?

6 A. Yes, so we are invited to be involved in several
7 consultation processes.

8

9 Q. Could you describe those? Who invites you to these
10 processes?

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

25

26 Q. Are you involved in, say, any planning for or invited
27 to play a part in planning for, say, alcohol and other drug
28 service delivery throughout the district? Does the local
29 health district sit down with you and maybe other NGOs and
30 say "What services are you able to provide? Do you see the
31 services you currently provide as meeting the needs of the
32 client base"?

33 A. I wouldn't say that's done as often on a local level,
34 I would say that's more done on a state level from
35 a New South Wales-wide level.

36

37 Q. By the ministry?

38 A. Yes.

39

40 Q. Is that a regular process, annual?

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

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

7
8 Q. In terms of the coverage of your services, however,
9 they are limited in their nature by virtue of the funding
10 that is available --

11 A. Most certainly.

12
13 Q. -- to you under the tenders that you have been
14 awarded?

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

33
34 Q. In terms of planning for that service or
35 identification of that service gap, presumably, in your
36 meetings with those funding it, you indicate that you are
37 not able to provide the service outside of Broken Hill, for
38 instance?

39 A. Yes.

40
41 Q. If that's where you are able to provide it?

42 A. Certainly we do voice that, and that has been taken on
43 board. However, when you look at state-based funded - if
44 they're a state-based funded services, the time it takes to
45 implement these changes and then, you know, like
46 I mentioned, we've been extended for HASI and CLS for
47 another two years while there is a consultation process,

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

10
11 Q. In terms of what you have said about funding the full
12 cost of service delivery --

13 A. Yes.

14
15 Q. -- you've set out some of those at paragraph 13(a) of
16 your outline. Generally, when you have tendered - and
17 I think you answered a question to this effect from the
18 Commissioner - the level of the service has been determined
19 prior to your involvement in many of these cases - I'm not
20 saying every, but in many of them?

21 A. Yes, in many of the cases.

22
23 Q. So the tender is for 35 hours a week?

24 A. Yes.

25
26 Q. Or 35 hours a day, for instance, in one case?

27 A. Yes, there will be set metrics or KPIs that you must
28 deliver within that service, yes.

29
30 Q. Indeed. And do you have the opportunity, for
31 instance, in your ongoing communication during the
32 process - during the course of those tenders, to feed back
33 that that does not reflect the full cost?

34 A. During the course of the tender process?

35
36 Q. Yes.

37 A. Yes, we do.

38
39 Q. Or at any time?

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

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

7
8 Q. And how might that be achieved to get the voice back
9 to the community?

10 A. It is a good question, isn't it. I think for - to
11 reduce the impact of competitive tendering processes, we
12 really need to look at what we're asking people to deliver
13 and really setting out what a service must have to be able
14 to deliver that service. I think it's about
15 accountability, ensuring there is accountability but
16 ensuring that a service best placed to deliver that service
17 in the community - that they are the ones that are
18 supported to apply for that. So if that is an Aboriginal
19 community controlled health organisation, then it should be
20 them supported to apply for that tender. If that is an NGO
21 that is based in Broken Hill or Dareton or Wilcannia,
22 Menindee, they should be supported in that process to
23 tender. I think there is a better way that we could do it
24 because there are people that are better placed to deliver
25 some services in rural communities.

26
27 Q. Presumably, that involves an understanding of what the
28 community wants?

29 A. Definitely, I think, and as I said, when I say
30 "consultation and co-design", I mean doing that genuinely
31 and effectively. I think sometimes, like I said, we
32 promote "We need to do a consultation and we need
33 to co-design and we need to ask the community" - if we're
34 going ask them, we need to make sure that we're going to do
35 something with that information and be responsive and do it
36 in a timely manner, because sometimes we spend so much time
37 asking and so much time, you know, promising change, and
38 communities don't see that and that can be really
39 disheartening and it can be really hard to inspire hope in
40 communities when they may feel let down at times.

41
42 Q. The other matter in terms of improving service
43 provision that you raised is funding cycles.

44 A. Yes.

45
46 Q. Some of your services, they may be on a one- or
47 two-year funding cycle; is that right?

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

8
9 Quite often we might not find out if that program is
10 going to continue to be funded until quite late in the
11 financial year. So we may find out in the end of March
12 whether a service will continue past June, and by then we
13 may have already lost our workforce within that service.

14
15 Recruitment is already a challenge in these areas.
16 That then just adds another level of complexity and another
17 complication in recruitment and retention of staff. To me,
18 if services are appropriately implemented, we should be
19 looking at longer-term contracts for seven years at least,
20 possibly longer in communities that have long-term
21 disadvantage or in particular Aboriginal and Torres Strait
22 Islander communities. I believe that they should have
23 longer -term funded programs to ensure they are able to be
24 designed and implemented in communities effectively.

25
26 Q. Just lastly, like most organisations providing
27 services in rural and regional Australia, you identify
28 staff recruitment and retention --

29 A. Yes.

30
31 Q. -- and training, professional development, as
32 a particular challenge?

33 A. Yes.

34
35 Q. You raised that just a moment ago in the context of
36 your funding cycles. But in terms of the broader supply of
37 workforce for your services --

38 A. Yes.

39
40 Q. -- can you outline the challenge and how you overcome
41 it, to the extent you are able to?

42 A. So there is a lot of challenges with workforce
43 recruitment and retention, some of that being the ability -
44 well, be able to recruit to the roles with particular
45 qualifications. So at times we, I think, Mission Australia
46 does well to invest time and finances into training and
47 recruiting staff to be able to deliver the services that we

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

11
12 Also, with training opportunities, whilst online
13 training has certain - is certainly available to us,
14 I don't feel that people should have less of - have
15 a disadvantage to accessing education and training because
16 of where we live. They should be able to, you know, access
17 face-to-face training and learning opportunities and
18 development opportunities in Sydney, where they may be held
19 and, for that, we would need to be funded for staff to be
20 able to access that.

21
22 Q. So in terms of the training aspect, that presumably
23 feeds into that funding aspect that you referred to earlier
24 of being funded for the full cost of providing the service,
25 so recognising the cost of training and developing your
26 staff as part of that cost?

27 A. Yes.

28
29 Q. Is that right?

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

42
43 Q. And in terms of supply of sufficiently qualified
44 staff, are you involved in any partnerships with any
45 training organisations to train staff in your relevant
46 disciplines?

47 A. Yes, we are partnered with a number. So we often,

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

20
21 MR FRASER: Commissioner, those are the questions that
22 I have for this witness.

23
24 THE COMMISSIONER: Q. Can I just ask, in paragraph 10
25 where you're talking about having annual funding
26 agreements, does that apply to all of the services you
27 provide that you have outlined in paragraph 8? Is that all
28 of them?

29 A. Yes. So then - they are annual funding agreements or
30 they are - the majority of the time they are only extended
31 for 12 months to two years at this stage.

32
33 THE COMMISSIONER: Thank you. Do you have any questions,
34 Mr Cheney?

35
36 MR CHENEY: No, thank you, Commissioner.

37
38 THE COMMISSIONER: Thank you very much for your time.
39 We're very grateful.

40
41 THE WITNESS: Thank you.

42
43 <THE WITNESS WITHDREW

44
45 THE COMMISSIONER: All right. Professor Jones?

46
47 MR MUSTON: We might be able to finish this witness before

1 lunch.

2

3 <DEBRA MAREE JONES, affirmed: [12.27pm]

4

5 <EXAMINATION BY MR MUSTON:

6

7 MR MUSTON: Q. Could you state your full name for the
8 record, please?

9 A. I'm Professor Debra Maree Jones.

10

11 Q. And you are the head of rural clinical school, Broken
12 Hill University, Department of Rural Health?

13 A. I am.

14

15 Q. That's a mouthful.

16 A. Very much.

17

18 Q. Which we understand sits within the University of
19 Sydney Nursing School and Faculty of Medicine and Health?

20 A. Yes, it does.

21

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

24 A. Yes.

25

26 Q. Have you had an opportunity to read that before today?

27 A. Yes, I have. Like a good academic, I edited.

28

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

32 A. Yes, it is.

33

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

36

37 THE COMMISSIONER: Sure.

38

39 MR MUSTON: Q. Whilst you tell us in that document that
40 the rural clinical school sits within the University of
41 Sydney's Nursing School and Faculty of Medicine and Health,
42 could you actually just give us a slightly broader picture
43 of what the rural clinical school at Broken Hill is?

44 A. Yes, I can. We're one of about 19 university partners
45 for rural health, even though we are termed a rural
46 clinical school. That's an organisational structure term
47 that makes sense of the other Commonwealth funded programs.

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

10
11 So in the recent restructure that was done through the
12 University of Sydney, the three rural clinical schools
13 previously sat in the School of Medicine at Sydney
14 University, but have now been distributed to ensure that
15 the large schools all have carriage and have an embedded
16 rural academic department in them. So we now sit with
17 Sydney Nursing School, Lismore sits in the School of Health
18 Sciences and our Dubbo and Orange colleagues sit with
19 Sydney Medical School. Collectively we form the rural
20 precinct.

21
22 Q. While you have got that formal connection with the
23 University of Sydney, do you regard yourself as an outpost
24 of the University of Sydney, or are you a separate entity?

25 A. No, we are part of the University of Sydney and
26 extremely proud of that alignment. In saying that, as part
27 of the University Department of Rural Health Commonwealth
28 program parameters, we do engage with over 25 Australian
29 universities in the placement of students from across
30 multiple disciplines.

31
32 Q. Is that something that you do in Far West LHD?

33 A. We - I - our campus, our school, has three campuses,
34 so we have a campus at Broken Hill, which is the main
35 campus. We then have a campus in Bourke and a campus
36 which - new offices hopefully, will be developed in
37 Wentworth in the South West footprint. So we cover two
38 LHDs, Western New South Wales and Far West LHD.

39
40 Q. You have told us about the collaboration that you have
41 with a wide range of different universities. How does that
42 actually work in terms of what you do in an organisation?

43 A. They are two approaches when we engage with additional
44 universities. One is that through the ClinConnect system,
45 which is a New South Wales health system around student
46 placement allocations, universities can come in and
47 allocate students to placement availability, so that's one

1 stream of activity. Through our partnership with Far West
2 Local Health District, we actually coordinate the
3 ClinConnect system on their behalf so we become the
4 one-stop shop for student activity, accommodation, pastoral
5 support, education programs.
6

7 The other approach we take is actually working
8 collaboratively with like minded universities across
9 different disciplines to design programs of relevance for
10 student activity. An example would be we have
11 a tripartisan university relationship around extended
12 duration medical student placements, which brings
13 University of Adelaide, Wollongong University and Sydney
14 Medical School, and that has actually been designed to be
15 fit for context in place through those levels of
16 collaboration.
17

18 We also have similar collaborative approaches to these
19 models for nursing and now a growing one around allied
20 health extended duration placements.
21

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

31 A. And that's done in collaboration with our host sites
32 because we not only place students in our LHD facilities
33 but we also place them in our social care services, our
34 schools, Aboriginal community controlled health
35 organisations, NDIS and the RFDS are some examples of where
36 we place them. But this enables the repository to come in
37 for student applications for placements where universities
38 will say, "We would like to send X number of students from
39 this discipline to placements in semester 1 or semester 2
40 of student program."
41

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

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

5
6 We also have student accommodation. So that enables
7 us, then, when students are accepted to undertake their
8 placements, to allocate those students directly into
9 student accommodation as well.

10
11 Q. That student accommodation presumably is not only
12 available to Sydney University students --

13 A. No.

14
15 Q. -- but also Monash, Wollongong?

16 A. A host of universities.

17
18 Q. Anyone who wants to come?

19 A. Yes.

20
21 Q. You mentioned a moment ago that placements went beyond
22 the LHD facilities. Does that suggest that your one-stop
23 shop arrangement is not only with the LHD but, also, say
24 with organisations like Maari Ma and various other
25 providers of health care throughout the Far West; is that
26 right?

27 A. Yes. Yes, that's correct. We don't impose that on
28 key stakeholders and partners, but if that is their
29 preference, that is what we would do. So we then also work
30 on student compliance, so ensuring students have the right
31 immunisation, the right clearance checks, so will we cover
32 off all of those I suppose operational components of
33 student placements which releases the burden on those host
34 sites.

35
36 We then provide an overarching level of pastoral care
37 and supervision for students whilst they're also on site
38 and engage closely with those sites just to make sure, and
39 it's always better for us to identify issues earlier
40 through that close engagement than finding out later that
41 something may have gone wrong and we haven't had a chance
42 to respond.

43
44 Q. You say you don't force a participation in that
45 program on organisations providing health care in the Far
46 West but is it the sense you have that almost all of
47 them actually --

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

11
12 So we will work very closely not only with our partner
13 universities but with our host sites in designing up those
14 placements so they make sense in context.

15
16 Q. You have told us about the student accommodation,
17 which is reasonably self-explanatory. But the pastoral
18 care services that you provide to students who are out here
19 on placement, what does that look like in a practical
20 sense?

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

35
36 Q. What do you see as the importance and value of
37 clinical placements for university students in areas like
38 the Far West?

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

1 Q. How do you deal with that second aspect?

2 A. The community embeddedness? We do a lot of work
3 promoting student engagement in social events, footy clubs,
4 soccer clubs, netball clubs, hiking clubs, so the students
5 are given a whole array. Most of the students, I will
6 speak Broken Hill, for example, are encouraged to
7 participate in the Broken Hill festival, they all go to the
8 races.

9

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

20

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

32

33 Q. I might have interrupted you earlier, you were talking
34 about two different cohorts or streams, the metro based
35 student who comes and has a rural experience embedded in a
36 way that hopefully makes it a meaningful experience for
37 them. The second stream is what?

38 A. Rural origin. So the two streams that the evidence
39 tells us that are critically important are the metropolitan
40 or larger regional exposure to rural and remote practice,
41 plus then also embedding activities around rural origin
42 peoples. The evidence tells us that rural origin people
43 are more likely to return to their community or like
44 communities to practise once they are registered. So it is
45 about providing both pathways of engagement so we're trying
46 to get the best we can out of both streams. So we invest
47 in health career academies in our secondary schools from

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

9

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

14 A. Uptake of practice --

15

16 Q. -- having had one of those experiences come back?

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

30

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

40

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

45

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

1 the extent to which those who come through those programs
2 have been observed to stay?

3 A. It can be age related. We can find that our younger
4 rural origins may want to go off and have grand adventures,
5 like any other young person may once they actually have
6 a qualification and profession they can use. I think for
7 our more mature aged, those who are making that sea change
8 in their careers later in life, if they are embedded, if
9 their family are here, if they own the house, it makes
10 sense working here.

11
12 Q. For those who are off on adventures, have you been in
13 the system long enough to see them come back at a slightly
14 later stage in their lives?

15 A. Yes, and I was one of those as well. I went off and
16 had eight to 10 years of adventuring in rural remote
17 locations in Australia and then returned home.

18
19 Q. There is no shortage of adventures in Broken Hill --

20 A. No.

21
22 Q. -- we've discovered over the last two days.

23 A. Yeah.

24
25 Q. In terms of the school, the way in which you work with
26 local schools, you told us a little bit about the efforts
27 that you are making to attract school-aged students into
28 medicine. Could you just talk through that a little bit in
29 more detail?

30 A. It is across the health disciplines. So we
31 established health career academies back in about 2008/2009
32 as a pathway. That was based on we were working on another
33 initiative with our high schools, and we were actually
34 approached by our primary schools saying "Where is the
35 career pathway for our kids?" So the health career academy
36 program was established.

37
38 It was specifically to focus in on, in the first
39 instance, nursing given that nurses are the biggest
40 workforce in our rural/remote communities. Feedback from
41 those initial pilots was really positive and it also spoke
42 to a desire for exposure to other disciplines, which then
43 led to us responding to that, bringing in the medicine
44 academy, mental health academies, allied health academies,
45 to try and give students, I suppose, a taster across
46 multiple disciplines so they could get a sense of whether
47 one actually resonated more with them or another.

1
2 So we are seeing some uptake from those programs, but
3 another component of those programs is also around
4 elevating health knowledge and understanding for our kids.
5 It's not only about saying "Here is a pathway"; it is about
6 saying "What information and knowledge can we share which
7 may help you make healthy decisions in your own life as you
8 move forward into adulthood?"
9

10 Q. If you don't know the exact number, ballpark would be
11 fine. How many high schools are there in the Far West LHD?

12 A. Well, we engage with two in Broken Hill, so that's
13 Willyama and Broken Hill High School. We also engage with
14 Coomealla High around health career academies in that
15 south-west footprint, so that's the Dareton-Wentworth
16 communities, and we also have levels of engagement in our
17 Bourke community as well.
18

19 So annually we would probably see more students
20 transitioning into the TAFE-based pathways to some degree,
21 which is their assistant in nursing, assistant in allied
22 health. That's potentially linked to the school-based
23 apprenticeship and traineeship programs that the Far West
24 Local Health District run as well. So students can see
25 a direct in-community pathway to that. So the LHD offer
26 about 14 to 18 of those school-based traineeship pathways
27 annually for locals.
28

29 Q. Do you know where geographically those pathways are
30 offered?

31 A. The SBA/Ts? Yeah, basically in Broken Hill but they
32 can also be offered in Menindee or Wilcannia. The LHD put
33 a significant amount of effort in trying to make sure where
34 they have students who are expressing that transition into
35 those SBA/T programs that they can be delivered in site. I
36 know that in Balranald, they can also be offered in
37 Balranald. So I think there is a sense to try to
38 distribute them so there is not just a focus on Broken Hill
39 as the primary site.
40

41 Q. The academy programs that you run, do they give you an
42 insight into the importance of actively engaging with
43 schools and students in terms of the extent to which
44 training opportunities like that are taken up?

45 A. I think that's critically important. Once again,
46 being an academic, the evidence will tell us and theory
47 tells us that our little people can start making career

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

13

14 Q. Do you think, recognising that there is resourcing
15 issues that would be associated with it, there would be
16 benefit in having that slightly more intensive engagement
17 with careers teachers and students in high schools in
18 particular across the LHD?

19 A. Yes. We recently published a paper - health career
20 academies in some way shape or form delivered across the
21 three rural clinical schools, that the University of Sydney
22 has carriage of, and it was about lessons learned from
23 trying to implement grow your own sorts of initiatives.
24 I think some of the critical component of having that
25 funded specifically is how do you contextualise that and
26 how do you sustain that.

27

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

40

41 Q. Did the studies that you have done arising out of this
42 give you any indication as to the extent to which a program
43 delivered in that way increases the uptake in training
44 places and ultimately workforce positions by First Nations
45 community members?

46 A. This becomes very difficult as well, trying to track
47 where your past participants go, especially if they leave

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

11
12 Q. So these - just so we understand it, those programs
13 there are the programs in which a school student might be
14 finishing year 11 and 12 as part of a mix of subjects they
15 are doing, it will include some vocational training and
16 some placement within hospital settings or non-hospital
17 settings operated by the LHD?

18 A. And I think the critical thing, too, is that it's not
19 only about the training pathways, it's about the employment
20 that comes with it. So I know that Brad and colleagues
21 working at the LHD are investing heavily in trying to
22 ensure that every young person that engages in a
23 school-based traineeship pathway has an employment outcome.
24

25 Q. Is there scope to extend that, perhaps facilitated by
26 the LHD, into non-LHD providers of health care within
27 region, for example, and ACCHOs?

28 A. Look, I think there is great capacity. In most of our
29 communities our ACCHOs are partners in delivering this
30 program, so that may mean that they open the doors so that
31 we can take these students directly into their health
32 services and they can engage. When we run our First
33 Nations specific academies, we will take them to Coomealla
34 Health Aboriginal Corporation, we will engage with Maari Ma
35 to see if we can get them there. We will also try and take
36 them, as they mature, out to the RFDS and other places. So
37 they can understand that there is a scope of employment
38 opportunity if this is a pathway that they choose, that it
39 is not only working in an LHD or a hospital facility, that
40 there is a broad career opportunity available.
41

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

1 one-stop shop arrangement that you operate. Are there
2 other aspects of that collaboration?

3 A. Look, there are significant aspects to this
4 collaboration. So we work collaboratively with the Far
5 West Local Health District, for example, on designing up
6 fit for purpose health career pathway frameworks, so
7 actually looking at using theory and evidence to inform the
8 career pathways that we establish in this space. We've
9 looked very closely at research and how we are undertaking
10 our research and what are the drivers for that research.
11 So part of our mandate under our parameters that we're
12 funded is to undertake research of relevance to our context
13 and regions which is critically important.

14
15 We also know that if we're not working collaboratively
16 in this space to understand what's happening with our
17 workforce investments and the impacts and outcomes we're
18 having, we can actually be fragmenting individuals' career
19 pathways. We can be, you know, duplicating and resource
20 wasting.

21
22 So part of working collaboratively is us being clever
23 with the resources we do have, because none of us have
24 endless buckets of funds. So it's very much can we co-fund
25 positions, can we co-fund programs, can we co-fund projects
26 to be able to give us I think the greatest efficiency and
27 effectiveness that we can within the resources we have.

28
29 Q. You mentioned the slightly longer clinical placements.

30 A. Extended durations, yes.

31
32 Q. Could you tell us a little bit about them and what the
33 benefits that you see they carry?

34 A. All right. So extended duration placements are very
35 much embedded in medical workforce education. So six to
36 12 months to two-year placements as part of your degree in
37 medicine is quite normal. For nursing, it's really
38 atypical to have an extended duration placement. Most of
39 our nursing placements are somewhere between two to six
40 weeks. You might get eight to 10 at a push. The evidence
41 tells us that it's about 18 weeks if you want to see an
42 uptake of rural practice as part of a placement.

43
44 So we've been working collaboratively with a number of
45 key regional stakeholders and universities in designing
46 extended duration nursing placements, so we're now in
47 I think about our fourth semester of a 20-week duration

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

11
12 So we've used the evidence both from medicine and what
13 is now emerging from nursing in our footprint, and I would
14 highlight that we're probably the only footprint nationally
15 who are pushing the boundaries on nursing duration of
16 placements, but we're now engaged with a number of other
17 universities who are interested in understanding how you
18 co-design those models and make them work in your remote
19 context. And we've just come out of a co-design workshop
20 in April with three universities and a number of regional
21 stakeholders around extended duration allied health
22 placements based on that same theoretical proposition that
23 the longer we can keep students in situ learning, the more
24 embeddedness we bring, the more sense of accountability,
25 and the more sense of knowing they can thrive and survive
26 in rural remote contexts we're seeing.

27
28 Q. So these are programs where university students who
29 are studying nursing or allied health will be brought out
30 and they will do a placement for 20 to 24 weeks instead of
31 the more conventional shorter placement. Does that mean
32 that part of their non-practical education is needing to be
33 delivered to them while they are out doing the placement,
34 or is the placement being seen as --

35 A. A clinical placement in isolation to their theoretical
36 learning?

37
38 Q. Yes.

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

1 in that pre-placement process in the orientation period to
2 providing those students with curriculum of relevance to
3 rural and remote communities and populations.
4

5 So for our nursing students in the program, they do
6 five days intensive orientation and education with us on
7 site, so that will include, you know, an understanding of
8 primary health care, what does a rural nurse look like,
9 where can we work, what do we do; an understanding of
10 cultural safety and competence in the way that we do our
11 work; health care complexity and what does it mean when
12 you're actually - because rural and remote health care is
13 complex, but I think we fail to teach any health students
14 about the realities of what complexity is, what it looks
15 like and then how do you navigate through it.
16

17 We also spend significant investments in community
18 engagement. So how do you engage authentically and
19 respectfully with communities in deciding what health care
20 needs are and how services should be delivered, and we also
21 present sessions around what we term to be community
22 literate health care and what does that mean for health
23 professionals who are engaging in rural remote contexts.
24

25 So that is our platform to springboard them,
26 hopefully, and prepare them for success in working through
27 the complexities they may confront as they grow into the
28 placement and then we build in critical reflection sessions
29 which enable the students to talk to their experiences and
30 reflect on some of the why do we think that's happening.
31 What is our role as health professionals in addressing
32 those concerns that you are seeing. But we are also highly
33 sensitive that the more sense of belonging these students
34 have, the more sense of feeling valued by their host sites
35 and communities, the more sense of responsibility they can
36 carry for the inequity and disadvantage that they see in
37 real life.
38

39 It's different to learning about inequity and
40 disadvantage from journal articles and in a university
41 setting versus actually coming out and seeing the
42 authenticity of disadvantage and inequity as it is
43 experienced in the real world of rural remote and First
44 Nations health.
45

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

1 by you or by whichever university they happen to have come
2 from?

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

14
15 So the universities have to do a significant amount of
16 curriculum juggling at this stage, and I will acknowledge,
17 for a small number of students, because these are pilot
18 models and we are trying to prove efficacy, that these
19 models work for students, and not only for students, for
20 our host sites. That was one of the big catalysts as to
21 why we're very much on this pathway to extended duration.

22
23 Our host sites, who are informing us, they were tired
24 and fatigued. They were tired and fatigued pre-COVID.
25 COVID just amplified that tiredness and that fatigue and,
26 then, to have multiple students churning through these
27 systems for placements of short duration, you have to
28 question where the value is, not only for students but for
29 our host sites who are meant to supervise, engage,
30 socialise and support students on that learning journey.

31
32 So that was one of the big catalysts. Our host sites
33 said to us "We want this to stop. We need the students
34 here for longer if we're going to feel like the
35 contribution we're making is equally as valued as the
36 students coming out to us feel".

37
38 Q. In terms of that theoretical learning, when you get to
39 your Thursday or Friday, assuming the juggle has happened
40 at the other end, one young man on placement might log on
41 and do his university tutorials in Adelaide --

42 A. Yes:

43
44 Q. -- at the university down there, whereas another young
45 woman might be logging on --

46 A. To Western Sydney, to University of Sydney --

47

1 Q. -- to Wollongong --

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

8

9 Q. Acknowledging what seem to be the great benefits of
10 the extended placements, how do they sit in a landscape
11 where we are repeatedly told placement poverty is a real
12 challenge that a lot of students face?

13 A. I think that is probably one of the biggest deterrents
14 for students being able to participate in these extended
15 placements, it was with interest that the Commonwealth
16 Government has now made a commitment to cost of living
17 support for specifically nursing and social work students
18 I think commencing in June/July 2025, which will give
19 students access to I think about \$320 a week for the
20 placements they undertake.

21

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

32

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

42

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

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

17
18 Q. In relation to that scholarship, do you also operate
19 as a one-stop shop for students in terms of informing them
20 of and helping them to navigate their way through
21 scholarships and bursaries?

22 A. Yes, we try to link students to scholarships
23 routinely. The other challenge can be that students can
24 apply for a scholarship, be successful, but not receive
25 that scholarship until they have completed their placement.
26 So they have to still carry a financial burden, or their
27 families carry that financial burden of supporting that
28 student until that scholarship is actually released. So
29 timing of release can be a challenge.

30
31 Q. One last question. In paragraph 21 of your outline
32 you tell us that you regard our rural/remote and First
33 Nations communities as the local scholars who hold the deep
34 understanding of the needs of their communities and can
35 contribute to the solutions required to meet the challenges
36 confronted. In practice, how do you, as an organisation,
37 really seek to harness that well of knowledge that lies
38 with those or within those local scholars?

39 A. Can I say, this isn't easy. I think people talk about
40 community engagement and they think it is something we all
41 do routinely. It is extremely complex. It requires
42 a really deep level of authentic and sincere caring for
43 your communities and a sense of who are we accountable to.
44 The one thing we say as a department, yes, we're
45 accountable to our university, we are accountable to our
46 Commonwealth funders, but primarily we're accountable to
47 our communities.

1
2 We cannot progress any of the work that we do without
3 communities engaging with us and knowing that we will
4 respect them in that level of engagement.
5

6 So the language we use is - and because most of my -
7 well, all of my team live in our regions, whether they are
8 in Bourke, whether they are down south or whether they are
9 in Broken Hill, so not only are we employees, we are
10 community members, you know, we are mums, we are daughters,
11 we are son, wives, family members. So I'm very privileged
12 in the fact that a lot of my staff have deep connections
13 across communities and across a number of different
14 agencies. So we're very receptive to sitting and talking
15 and listening.
16

17 I think one of the things that the local people we
18 employ are great at is in being able to interpret what they
19 are hearing, because we know we have to try and take the
20 language of community and translate that into a way that
21 our universities understand the message we're trying to
22 give, or policymakers or health providers, because the way
23 we need to message needs to resonate not only with our
24 communities but with those we're trying to influence and
25 impact and leverage into. So I think being able to
26 interpret that and ensure that we're interpreting that
27 correctly is a critical component.
28

29 I think the language we use to define our communities
30 can actually act to undermine that. You know, they can be
31 our patients, they can be our consumers - they are actually
32 the owners of our healthcare systems and we need to use
33 that language if we're to show a deep respect.
34

35 We need to also understand and acknowledge knowledge
36 sovereignty and leadership of that knowledge sovereignty.
37 The language of decolonising our perspectives on what is
38 good health care and what is not and from whose perspective
39 I think we need to deeply reflect on, and I would say that
40 the privilege we have is that we sit in that unique
41 position where we can draw on that capacity, because we're
42 not driven by the same KPIs as an LHD or an ACCHO, so we
43 have greater flexibility and expectation that we will
44 engage in ways that are respectful and meaningful to get
45 the outcomes we need.
46

47 An example of how this plays out in the authentic

1 world is, through that deep engagement with a number of our
2 key stakeholders and communities we've been working for
3 12 months to establish what we're calling our Cross-Sector
4 First Nations Research Collaboration where through
5 a partnership between ourselves and four key agencies,
6 we're launching the First Nations Research Network
7 tomorrow. That is very much around decolonising
8 traditional Westernised, you know, paradigms of who
9 controls research, can do research on who. This is about
10 giving knowledge sovereignty, knowledge production and
11 knowledge leadership back to our First Nations peoples.
12

13 So to me, you know, something that's been 12 months in
14 negotiation and discussion and getting clarity comes to
15 fruition tomorrow. So these are the things that we can do.
16 But I think the other thing, you know, is that deep
17 connection to our communities, you know? This is my home.
18 I've watched for a number of decades, you know, past harms
19 being perpetrated by individuals or agencies against each
20 other, you know, untruths being told. So you don't want to
21 find yourself in that position. Your creditability is
22 shot. People's trust in you is shot if you don't engage in
23 those ways and we can't be effective if we don't engage in
24 those ways, as we say, community literate behaviours - have
25 a deep understanding, have a deep level of respect and
26 engagement. Commit to what you are going to do and then
27 deliver on it and do it in a way that engages your
28 community partners in not only designing what we want to
29 do, implementing what we do, but evaluating the impacts of
30 what we do.
31

32 Q. By evaluating you mean constantly checking in with the
33 community to make sure that it's actually doing what
34 everyone hopes it would do and, if not, why no?

35 A. Yes, and that can be a formal evaluation where we will
36 have robust research frameworks wrapped around these
37 initiatives to understand impact and outcomes, or it can be
38 as much as sitting down and saying, "Now, how did that work
39 for you", and if it didn't work well, and, see, that's
40 those multiple feedback loops, that different perspectives
41 inform how you polish - you know, you can start with a lump
42 of coal and hopefully, over time, you can polish it up to
43 a diamond.
44

45 MR MUSTON: Commissioner, I have no further questions.
46

47 THE COMMISSIONER: Q. The First Nations Research Network

1 that you are launching you said was a partnership between
2 yourselves and four key agencies. Who are the other
3 agencies?

4 A. The Far West Local Health District is one of those key
5 agencies, the Royal Flying Doctor Service is another key
6 agency, Coomealla Health Aboriginal Corporation, and we
7 have a cross-border partnership with Monash Rural Health in
8 Mildura, so they will be coming to the table as well. So
9 their First Nations representatives will be leading that
10 network and they will be supported by the University of
11 Sydney's Poche Centre for Indigenous Health Research.

12
13 Q. What does it involve and what do you hope to achieve
14 through it?

15 A. I haven't determined that, because I'm not a First
16 Nations woman. So part of the intent is that group will
17 come together and they will talk about what initially will
18 be a 12-month pathway and journey of learning, hopefully,
19 very much research methodologies that are embedded in First
20 Nations ways of knowing, being and doing. They will also
21 be determining as a group their governance structure and
22 the terms of reference to which they will work and my role
23 is to help facilitate that and to keep that space safe for
24 those First Nations representatives.

25
26 Q. So despite it being launched, it is fairly embryonic?

27 A. It is very embryonic and it is not prescriptive. That
28 would be totally inappropriate and go against the whole
29 sense of Firsts Nation sovereignty and leadership.

30
31 THE COMMISSIONER: Mr Cheney, do you have any questions?

32
33 MR CHENEY: No, Commissioner.

34
35 THE COMMISSIONER: Thank you very much, Professor, for
36 your time. We're very grateful. You are excused and we
37 will adjourn until 10 past 2, I think.

38
39 <THE WITNESS WITHDREW

40
41 LUNCHEON ADJOURNMENT

42
43 MR FRASER: Commissioner, we have in the witness box David
44 Green. I call Mr Green.

1 <DAVID GRAHAM GREEN, sworn: [2.10pm]

2

3 <EXAMINATION BY MR FRASER:

4

5 MR FRASER: Q. Mr Green, would you give your full name,
6 please?

7 A. David Graham Green.

8

9 Q. Mr Green, you are currently the director of people and
10 culture at the Far West Local Health District; is that
11 right?

12 A. That's correct.

13

14 Q. And we understand that you have held that position
15 since April of 2022; is that correct?

16 A. That's correct.

17

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

20 A. Correct.

21

22 Q. I think from looking at your CV, this position is your
23 first position working for the strictly public health
24 system --

25 A. That's correct.

26

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

28 A. Yes.

29

30 Q. You prepared an outline of evidence; is that right?

31 A. That's correct.

32

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

35 A. I have.

36

37 Q. Are you content that it is accurate and correct, as
38 far as you can tell?

39 A. As far as I can tell, yes.

40

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

43

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

1 to list a number of specific programs; is that right?

2 A. That's correct.

3

4 Q. Can I just ask you about some of those. Attraction
5 and retention, is that of staff generally to the district?

6 A. Generally, but more specifically because I'm not
7 directly responsible for nursing graduates and medical
8 services, we tend to focus on the roles outside those
9 areas. However, we do provide support in the
10 administration of the systems that allow the applications
11 to apply, the processing of the application, the
12 interviewing process and also the letters of offer and so
13 forth generally.

14

15 Q. I will ask you then, you have said you are not
16 responsible for nursing graduates --

17 A. Mmm-hmm.

18

19 Q. -- directly. Who is?

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

28

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

32 A. Correct.

33

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

35 A. Yes.

36

37 Q. And that's in terms of graduate nurses. What about
38 experienced nurses? Does that fall within your --

39 A. We support the recruitment of non-graduate nurses. We
40 are responsible for fulfilling the recruitment requisitions
41 that are triggered by the nurse manager and their relevant
42 directors.

43

44 Q. And in terms of medical staff, is it a similar
45 situation - you provide the back-end support?

46 A. At a much lower level. It tends to be centralised
47 within the medical services directorate purely because of

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

5
6 Q. I will come back to some of those matters as we
7 progress in terms of some of the particular areas that you
8 touch upon. You have also referred in paragraph 4 to being
9 responsible for learning and development. Again, is that
10 across staff and the district?

11 A. It is across the district, but it varies in terms of
12 your definition of "learning and development". There is
13 professional development, and if I could use, for example,
14 nursing, the clinical development, you have clinical nurse
15 educators, you have a team of CNEs that operate under the
16 director of nursing midwifery and clinical governance who
17 provide specific professional training. We're not involved
18 in that. We provide, again, back-end support in some of
19 the systems that are used, My Health Learning, for example,
20 which is the learning database which sits across all roles
21 in the district, and most of NSW Health. We do the
22 onboarding, we do the mandatory training, the compliance
23 training, but again, we administer it, we don't necessarily
24 develop the training. Much of it is driven from selected
25 modules and driven out of the Ministry of Health.

26
27 Q. Largely coordinated through HETI?

28 A. Yes.

29
30 Q. You also said you are responsible for organisational
31 development. Can you explain what that means?

32 A. It's a fairly broad topic area. Where we are focusing
33 is fairly embryonic. We're focusing more on employee
34 engagement. Our major focus is - and I refer to it in my
35 statement - people matters engagement score and then the
36 action plan that drops out of that which is designed to
37 improve the working environment for people and provide an
38 opportunity for staff to meet with their managers and work
39 out how to work, to bring the best out of them and what
40 changes can be made at the local level, ie in the work
41 unit, at the service level and potentially across the
42 directorate or the district.

43
44 Q. Can you give an example of that in action, so as to
45 say?

46 A. I refer to the example in my statement of evidence
47 where I talk about the decision that was made to

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

12

13 Q. From what you just said, another program that may be
14 somewhat related that you are responsible for is workplace
15 health?

16 A. To a degree, yes.

17

18 Q. Can you explain what workplace health means?

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

32

33 Q. I think it's safe to say, then, some of the other
34 parameters you are responsible for fall under the umbrella
35 of traditional what might be termed HR functions, employee
36 relations, business partnering, payroll, those kind of
37 functions?

38 A. They are what are considered the traditional HR
39 functions. Payroll is outsourced to HealthShare.
40 Rostering is outsourced to HealthShare and the two go hand
41 and hand in the health environment generally. But in terms
42 of the general - what's generally considered to be HR, yes,
43 you are correct.

44

45 Q. I think what you have said in your statement is you
46 had five staff members when you commenced?

47 A. Mmm-hmm.

1
2 Q. You now have 11; is that right?
3 A. Yes.
4
5 Q. Is it 11 FTE?
6 A. Yes.
7
8 Q. And you are currently seeking to recruit to another
9 position that is vacant; is that right?
10 A. That is correct.
11
12 Q. Which is the manager of Aboriginal workforce
13 development?
14 A. Correct.
15
16 Q. Is that a new position?
17 A. It is a newly created position, yes.
18
19 Q. That's a newly created position. We might return to
20 that in a moment. Just in terms of the general growth in
21 the team, is that growth from five to 11 the result of
22 newly created - generally the product of newly created
23 positions, or is it the product of filling previously
24 vacant positions?
25 A. No, it is the creation of - it is newly created
26 positions. To give you context, part of the remit that
27 I was recruited for was to assess the people and culture
28 needs, so broader than just HR, the needs of the LHD, and
29 then make a recommendation to the chief executive about the
30 resources that were required by the LHD to provide
31 a modern, up-to-date, or as up-to-date as we can get, HR
32 people and culture function. Those roles, the newly
33 created roles, or the ones created in the last two years,
34 reflect that.
35
36 Q. Presumably your advice to the chief executive was that
37 there were insufficient staff to provide such a modern
38 up-to-date service?
39 A. Yes.
40
41 Q. Can I ask you, I'd like to focus now - and I should
42 have touched on it, I don't mean to overlook it - I think
43 the welcoming service, which is provided by the Department
44 of Regional New South Wales, or funded by, is coordinated
45 via your directorate; is that right?
46 A. Correct.
47

1 Q. And a statement has been put into evidence from the
2 individual who provides that service. But that generally
3 aims to assist new staff members coming to the area with
4 their integration into the community generally; is that
5 right?

6 A. It's designed to make them feel as welcome as possible
7 in the community and as welcome as possible in the
8 organisation, with the intention that the sooner they feel
9 welcome and settled, the more effective they will be in the
10 workplace and, over time, potentially less likely to wish
11 to move to another service or out of the district.
12

13 Q. That brings me to the topic I wanted to come to, which
14 was recruitment and retention of workforce.

15 A. Mmm-hmm.
16

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

20 A. Yes.
21

22 Q. But that during that month, effectively, there were
23 788 FTE being utilised and a staffing deficit of 88, doing
24 the maths.

25 A. Mmm.
26

27 Q. Can I just ask you about those figures. That 88
28 staffing FTE deficit, is that firstly distributed across
29 the district, or is it particularly acute in certain parts
30 of the district?

31 A. As a general observation, and not having the data in
32 front of me, because the vast proportion of the FTE in the
33 district resides in Broken Hill and in the hospital, it is
34 generally within Broken Hill. The next area would be what
35 we call the Lower Western Sector which is Baronga,
36 Wentworth, Balranald, Dareton, and then you have the remote
37 services Tibooburra, Wilcannia, Menindee and so forth,
38 where the vacancy rate is probably less, but a single
39 vacant position in those smaller services is far more
40 impactful than in a larger service.
41

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

44 A. Correct, yes.
45

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

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

10

11 Q. Just taking now as a snapshot in time, and I'm not
12 asking you to have the up-to-date figures at your
13 fingertips, but are there any particular disciplines that
14 are posing a challenge as of now?

15 A. It depends how you define "challenge".

16

17 Q. Are there any particular disciplines where there is
18 a particular difficulty in obtaining sufficient staff?

19 A. The - I will answer that question conversely, if
20 I may. The roles that we do not have difficulty in
21 recruiting tend to be your low to semiskilled roles that we
22 can draw immediately from the local labour market, okay?
23 Therefore, any other role that we can't draw from our local
24 labour market, which is upper semiskilled to highly
25 skilled, we tend to have to recruit externally, and they
26 are more problematic.

27

28 Q. So ongoing difficulty with sufficient nurses; is that
29 right?

30 A. Well, there has been an ongoing difficulty with
31 sufficient nurses globally for 20 years.

32

33 Q. Just to ask you in relation to your - you have also
34 provided some figures in relation to what you have termed
35 your processing of recruitment requisitions.

36 A. Mmm, yes.

37

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

41 A. Effectively.

42

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

1 that were initially sought, generally? In other words, are
2 there a significant number of cases where the employment
3 outcome that was sought by the requisition has been
4 a permanent staff member, but due to being unable to obtain
5 a permanent staff member, the result has been an agency
6 staff member?

7 A. It can be, but to make a general statement in relation
8 to those - I would be loath to make a general statement in
9 relation to those figures because it would require
10 a case-by-case analysis of each of those. You will find
11 that managers - because the hiring manager is the manager
12 that triggers the recruitment decision. My directorate
13 doesn't oversee that. It's up to the hiring manager. So
14 the hiring manager can make a decision as to whether they
15 wish to replace the role, whether there is sufficient
16 activity, so sufficient demand, whether they have someone
17 coming through the ranks or someone coming back from leave
18 that they are aware of who would be suitable, and they can
19 then choose to use another alternative, secondment,
20 internal secondment, or secondment from another LHD or
21 agency. So it's almost specific context to the roles.

22
23 Q. Do you have a sense of how successful people are being
24 at filling permanent roles and having to resort to agency
25 roles, without going into numbers?

26 A. My general comment will be that we tend to be
27 relatively successful in attracting permanent roles when we
28 set our mind to it. Now, what I mean by setting our mind
29 to it is actually applying effective recruitment practices.
30 That, for example, can include advertising out of district,
31 advertising interstate, effectively managing the applicant
32 pool, moving people through the recruitment process and the
33 system effectively, efficiently and in a timely manner.
34 That can make it very impactful. And then you made earlier
35 a reference to the welcome experience, and then landing
36 them properly, embedding them into the organisation and the
37 community effectively. That's effective recruitment.

38
39 Q. Can I ask you what you mean, just looking at those
40 things that you have said - what you mean by effectively
41 managing the applicant pool?

42 A. Mmm. The recruitment system that all LHDs are
43 required to use, and they call it - it is ROB, recruitment
44 onboarding, it is an applicant tracking system. It is
45 designed for much larger organisations and it tends to be
46 sequential and cumbersome. The way it is currently
47 configured is that it is almost totally up to the hiring

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

11
12 The other side of the process is that applicants
13 generally, particularly in nursing, just using the nursing
14 cohort as an example, tend to apply for multiple positions
15 at the same time. They will then take the best offer that
16 they get. So we will find instances where they keep us on
17 the hook, "Yes I'm interested, yes I'm interested", only to
18 find weeks later that they've gone somewhere else, and that
19 was their intention all along. So it depends on whether
20 the candidate wants to come to us, and that's where early
21 intervention, early handling, for want of a better phrase,
22 massaging communication contact with a candidate, actually
23 brings them on the journey to land here and become a valid
24 employee or a valuable employee of the local health
25 district.

26
27 Q. That what you have termed as "skilled capable people
28 to manage applicants", is that something that your
29 directorate is becoming involved in?

30 A. We are responsible for it. The issue that we have as
31 a directorate within a small LHD is that the beast that is
32 ROB - and that's the internal jargon - is very labour
33 intensive and requires a large recruitment team to move
34 people through the system quickly - through the applicant
35 pool quickly. We don't have the resources for that and ROB
36 has been designed for much larger organisations. It's
37 effective in larger organisations. It becomes burdensome
38 for smaller organisations and smaller services.

39
40 Q. What is it about ROB that requires such a large team,
41 as you say?

42 A. It's the configuration. I'm not an expert in ROB or
43 applicant tracking systems, but it's the configuration, the
44 fact that it is sequential, you cannot move outside the
45 system, we have checks and balances that are required by
46 relevant pieces of legislation, we have checks and balances
47 built into the system that come out of ministry, so

1 vaccination guidelines, Working With Children Checks,
2 police checks, reference checks, all those have to be
3 stepped through sequentially and in hopefully a timely
4 manner, but they are all dependent upon human intervention
5 into the step.
6

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

17 A. Technically, they can be, yes.
18

19 Q. Technically they can be?

20 A. You have to reapply and run them through the system
21 every time. Each LHD is a separate employing entity. Even
22 though we're effectively a wholly owned subsidiary of NSW
23 Health, because we're an separate employing entity, we have
24 to run through the same probity checks, which is what we're
25 talking about, each time they apply across LHDs. So the
26 short answer to your question is yes.
27

28 Q. Yes, about the centralised - by HealthShare or whoever
29 it might be - do you think that could streamline the
30 process?

31 A. If you take the notion that we're all employed
32 ultimately by NSW Health, then a single database that
33 captured the common detail that is required across
34 NSW Health would make it much easier for not only the Far
35 West Local Health District but all local health districts
36 to move people through the systems.
37

38 Q. Quicker?

39 A. Quicker.
40

41 Q. And more efficiently?

42 A. Yes.
43

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

1 size, then those individual steps that need to be repeated
2 each time are particularly emphasised in your ability to
3 move people through the system?

4 A. There are clear diseconomies of scale for smaller
5 services and smaller LHDs, yes.
6

7 THE COMMISSIONER: Q. Whatever ROB is, you can't - if
8 someone's applied for a job at Sydney LHD and done all
9 these police checks, et cetera, you can't - if they apply
10 for a job with you, you can't just log into the system and
11 say they've got all the checks done?

12 A. No, and we also have to issue them with a new letter
13 of offer. So even on a secondment basis, and we currently
14 have staff seconded out of Sydney LHD, we have to raise
15 a requisition, then raise a letter - have their requisition
16 approved, then raise a letter of offer, get that accepted
17 by the employee, so we can actually put them into the
18 rostering system so we can pay them.
19

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

25 A. Yes.
26

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

28 A. Correct.
29

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

32 A. Yes. Yes.
33

34 Q. And can you just explain how - as you have said in the
35 outline, the intent was to improve the capability building
36 of existing staff and to improve the capability of
37 recruitment of staff to the district. How is it that those
38 roles achieve that, just explain.

39 A. Sure. The intent behind those roles, given that they
40 have only been in place for 18 months or so, so it's still
41 early days, the talent acquisition lead, by way of title,
42 it was a change from a recruitment manager, so it reflects
43 modern day practice and acceptance that applicants are not
44 just people - people filling a role, they are actually
45 talent and you want to be very specific about the sort of
46 person - talent - that you want to acquire. That then
47 leads into things like your employee value proposition, how

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

13
14 Q. Is there any other advantage about them being located
15 in Sydney? Are they able to engage with professional
16 bodies or other agencies in a way by being based in Sydney?

17 A. If you find, and we did, a career talent acquisition
18 person, they are already plugged into a network of talent
19 acquisition people which is superior in breadth and depth
20 by virtue of scale in your metro areas in comparison to
21 your rural locations.

22
23 Q. We'll come to techniques in a moment, and similarly
24 your learning and development lead, presumably responsible
25 for learning and development - does that include strategies
26 for the retention of staff?

27 A. Not specifically at this stage. That is the intent.
28 The focus of the learning and development lead is more on
29 aligning our training, identifying what are foundational
30 levels of training for employees and, in particular, our
31 team leaders and lower managers, so people management
32 skills is a clear area of focus; developing and coaching
33 those staff and the team leaders so we can bring people
34 through. It is all well and good to bring in calibre
35 candidates, but you need to give them a pathway and
36 a reason to stay. Money is not the be all and end all for
37 most people.

38
39 If you look at any sort of engagement data and you
40 look at the top 10 drivers of why people come to work,
41 remuneration is normally around 7, it is about
42 self-actualisation, career development pathways, culture,
43 working environment. Those are the things that the
44 learning and development lead will focus on once we move
45 past what are the more foundational elements, and by
46 "foundational" I mean how to have a performance management
47 conversation with a team member; how to call out behaviour;

- 1 how to create clear expectations for your teams.
2
- 3 Q. So skills building in those --
4 A. Frontline skills, yes.
5
- 6 Q. Just going back to those factors that you were
7 referring to in relation to attracting people to stay, when
8 you say "culture" - you said "culture and working
9 environment". What do you mean by those two?
10 A. Well, culture is, for me, for want of a better phrase,
11 the vibe of where you work, I mean your values, your team
12 ethos, your unwritten ground rules, how you interact as
13 team members and your capacity to work effectively as
14 a team. Your working environment encompasses that, but it
15 also goes beyond that to include communication from senior
16 management, communication from service managers, how the
17 individual directorates integrate, so, for example, how
18 your maintenance team work with your nursing staff to make
19 sure that the equipment is working, that the configuration,
20 the lighting is up to speed, that problems are fixed
21 quickly. That's part of your working environment.
22
- 23 Q. They go hand in hand, presumably?
24 A. Yes, pretty much.
25
- 26 Q. Two aspects of similar things for an employee.
27 A. Almost two sides of the same coin.
28
- 29 Q. Can I just ask you about some of your strategies
30 available for recruiting and retaining staff. Not one
31 initiated by the local health district but one that you
32 refer to in your outline is the Rural Health Worker
33 Incentive Scheme --
34 A. Mmm-hmm.
35
- 36 Q. -- paragraph 15 onwards, introduced at a similar time
37 to you taking up your post, it would seem?
38 A. Mmm.
39
- 40 Q. And just to confirm, whose scheme is that? Is that
41 a ministry scheme?
42 A. It was developed by ministry, yes, and handed out to
43 the rural LHDs.
44
- 45 Q. And as you have set out there, it offers a maximum of
46 \$20,000 per FTE that can be used in a variety of ways?
47 A. Mmm-hmm.

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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.

1 Q. On the basis that if they left, you'd have to --

2 A. Advertise twice unsuccessfully, yes.

3

4 Q. I understand that. You have set out the current
5 distribution in a table.

6 A. Mmm.

7

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

12 A. Mmm-hmm.

13

14 Q. Not eligible for the scheme. There are some
15 semiskilled positions here. Extrapolating from your
16 statement earlier, presumably those positions are generally
17 ones located outside of Broken Hill, for instance,
18 administration or hospital property and maintenance?

19 A. Mmm, they are not necessarily located outside of
20 Broken Hill, those roles. They are on the upper level of
21 semiskilled or trades. By way of example, your trades
22 roles tend to be hard to recruit to just by virtue of the
23 nature of the labour market in Broken Hill. So they can
24 become eligible for the incentive.

25

26 Q. But just moving back to what you said about
27 semiskilled roles in Broken Hill, what about semiskilled
28 roles outside of Broken Hill?

29 A. In the smaller services, the labour market is much
30 smaller, therefore, it is more likely that you will
31 advertise twice unsuccessfully, which makes them eligible.
32 You then - and you then also have to the ability to map
33 those positions in the local - similar positions in the
34 smaller services, by virtue of the extrapolation you just
35 articulated where you go, "If I lose a clerk" - I've got
36 two clerks, say, in Wilcannia, just by example, "if I lose
37 one, I'm recruiting for one, I might as well give it to the
38 other, because if they resign, I'm in the same position".
39 So it's the same extrapolation.

40

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

45 A. It's both.

46

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

1 in your outline is that the number of retention initiatives
2 were predominantly issued to staff already employed in the
3 district prior to the commencement of the scheme. 297 were
4 on a retention basis and 148 were on a recruitment basis;
5 is that right?

6 A. At the time that we extracted the data for the
7 statement. It is a moving feast.

8
9 Q. Of course. Those figures will have moved since then?

10 A. Yes.

11
12 Q. This is relatively recently though, certainly in the
13 last three or four weeks, I would have thought. But in
14 terms of the 148 recruitment positions, do you have a sense
15 that you would have been able to fill those positions
16 without the scheme, or --

17 A. The Rural Health Workforce Incentive Scheme replaced
18 an earlier scheme where we did have capacity to assist
19 people to relocate without a wage incentive, so it was
20 a one-off payment. So that was already in existence.

21
22 Without the application of the Rural Health Workforce
23 Incentive Scheme at all in New South Wales, we would have
24 been competing on a level playing field, as level as it
25 gets, okay, with all the disadvantages as a remote location
26 we have. We had to step into the rural health workforce
27 incentive scheme, because if we didn't, we would have been
28 left even further behind. So it is a bit hard to say
29 whether this may - whether the 148 that we have here,
30 whether they would have come. I take the view that most of
31 the 148 would have come here anyway, because that's the
32 intention. The incentive just assisted their relocation or
33 made it a little bit more attractive.

34
35 Q. So is the point that you were seeking to make by
36 saying that it hasn't had a material impact to date is that
37 it hasn't really improved things from the previous
38 iteration as opposed to the alternative of having no -
39 nothing to incentivise staff?

40 A. The Rural Health Workforce Incentive Scheme in
41 comparison to the previous scheme is much more
42 sophisticated, there are larger amounts of money attached
43 to it. But it's had no measurable impact on our capacity -
44 we haven't gone from five applicants to 50 applicants, as
45 simple anecdotal evidence. I would suggest, and in talking
46 to people and in talking to the recruitment team, the
47 applicants who receive the money - and we apply the

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

3
4 Q. Do you know if the scheme has been formally evaluated
5 across the state?

6 A. Not to my knowledge.

7
8 Q. I appreciate you don't administer it.

9 A. No, no, nor more specifically to the LHD, I've not
10 been approached by ministry to provide that sort of
11 feedback.

12
13 Q. And have you provided any feedback on the scheme to
14 the ministry?

15 A. Not formally, no. There's been informal conversations
16 with those who are overseeing the program, but not in terms
17 of "What do you think, how could we improve it", not along
18 those lines.

19
20 Q. Can I ask you: how could you improve it, or how could
21 it be improved, I should say?

22 A. That's almost a question of how long is a piece of
23 string. The incentive is a good idea at intervening in the
24 labour market to improve the ability of rural and remote
25 health services to attract calibre staff. Where it
26 struggles is a whole host of reasons. We operate in a
27 tightly controlled environment, both jurisdictionally and
28 industrial relations. We were effectively trying to go
29 outside the award-making scheme. We are competing against
30 other jurisdictions who offer far more money. We are in a
31 wages war and I would suggest, without knowing officially,
32 that the increase from \$10,000 to \$20,000 was in relation
33 to the fact that other players just upped the money as
34 well.

35
36 THE COMMISSIONER: Q. By "other jurisdictions", you are
37 talking about other states --

38 A. Queensland, Victoria, and WA to an extent as well.

39
40 The money is effectively insufficient. \$10,000 or
41 even \$20,000, if you put it on the table in front of
42 someone, it is a big sum of money. But then you take at
43 least a third out in tax, you then ask them to pay for
44 their relocation expenses. You then look at how much they
45 can earn on an annualised basis by the time - if they are
46 a nurse or a doctor, all the other allowances that get
47 tacked in, you go "It's actually not that much money".

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

7
8 MR FRASER: Q. In terms of strategies if not monetary
9 incentives, are there other strategies that you think may
10 assist the challenges at least for areas such as the Far
11 West Local Health District?

12 A. I think we need to be more innovative and more lateral
13 thinking in our approach. I reflect on the experiences
14 I've had in other states and in other organisations of
15 where we've looked at some of the structures. By way of
16 example, when I was in Queensland as the director of HR for
17 PresCare and I was negotiating the enterprise agreement, we
18 were speaking to the Queensland nurses union and we
19 couldn't afford to give them the pay increase that they
20 wanted. It is a not-for-profit organisation. So they came
21 back to us and said, "Well, for our nurses" - they had an
22 increment based on hours of service, or every annual they
23 go up an increment. They went from 1 to 8. They said,
24 "Why can't you shorten the number of hours to make the
25 grade". There is logic sitting in behind that, because if
26 you look at a registered nurse level 1, increment 5 or 6,
27 the logic behind it is that you pick up experience by
28 on-the-job experience, so you become more valuable as
29 a nurse or a clinician. But by the time you get to 5, 6, 7
30 or 8, the question of the return on that - what skills you
31 pick up, there is a question of: well, are we just making
32 them wait 12 months?

33
34 So we agreed to shorten the number of hours. It also
35 then ratcheted into the fact that you have part-time
36 employees working 50 per cent of the ordinary hours who
37 have to wait two years for an increment increase as opposed
38 to 12 months, and there is an equity issue. So that's one
39 example.

40
41 I would look at - I think we are too tightly
42 controlled, and this is just an opinion, I'm not a clinical
43 professional, so I will caveat what I'm about to say.
44 I think we're too tightly controlled by professional
45 associations who, respectfully, it is in their best
46 interest to restrict supply. A labour movement runs on
47 controlling labour. If you restrict supply, you then have

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

9
10 But there was a massive push to do it. It was very
11 effective for aged care. We didn't need to hire registered
12 nurses in the numbers that we needed, because we knew the
13 endorsed nurses with the medication endorsement could do
14 it. They are just examples of things we should be looking
15 at particularly in the rural/remotes. I'm not saying we
16 have to do it in the metros and, in fact, I wouldn't
17 encourage to do it in the metros because we need to have
18 a competitive advantage, and if we can say to our staff
19 "You can get accelerated professional development because
20 we do things a little bit differently out here, but still
21 safely", that's attractive to them.

22
23 Q. Something else you have raised in your outline that
24 may be related to that is flexibility in conditions of
25 employment that you can offer. I think, if we go to
26 paragraph 24, the fact that awards and conditions are
27 determined at the state level?

28 A. Mmm.

29
30 Q. With very few conditions discrete to remote services?

31 A. Correct.

32
33 Q. Are there any conditions discrete to remote services?

34 A. In the nursing award, we have an additional week of
35 leave, if I recall totally correctly, for Ivanhoe and
36 Tibooburra because of their remote location and also, as
37 I understand it, because of their size, their staff are
38 effectively on call 24/7 and their reward or the recompense
39 for that is an additional week's leave.

40
41 Q. That's really the limit of it, is it, off the top of
42 your head?

43 A. Staff who are based in Broken Hill, for Far West, and
44 I think it's for all of Broken Hill but I will reference
45 the local health district - we all get an additional week's
46 leave. So we get five weeks of leave. There is also for
47 some staff an allowance under the Broken Hill Health

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

11
12 Q. Is there the flexibility to offer bespoke incentives
13 to staff?

14 A. Not currently, but I'd love it if there was.

15
16 Q. So, for instance, staff relocating from - junior staff
17 whose family may be on the eastern seaboard, to take an
18 example, are you able to offer assistance with travel
19 home --

20 A. Under the rural health workers incentive scheme we
21 can, it is bespoke, but the problem with it is it is capped
22 at \$10,000 and trips home from here, family, to the eastern
23 seaboard, on the two carriers that operate out of the
24 Broken Hill airport, are expensive.

25
26 Q. Indeed. And also require other criteria to that
27 scheme being met?

28 A. Correct.

29
30 Q. You are not able to offer that as a matter of course
31 when advertising a position?

32 A. No, we need to meet the criteria of the incentive. So
33 if the criteria were broadened or we were provided with
34 another set of criteria that we could apply on a - in a
35 bespoke manner, that would give us greater flexibility.

36
37 MR FRASER: Those are the questions that I have for
38 Mr Green.

39
40 THE COMMISSIONER: Thank you.

41
42 Q. Can I just ask one further thing just so I understand
43 what you are telling us. It is partly in your statement
44 and partly in the evidence you gave today. If you look at
45 27 and 28 of your outline, I understand what you are
46 telling me in 28 about the lack of a single database. But
47 in 27, how should I understand where you say - when you are

1 talking about ROB, in the second-last sentence:

2

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

5

6 I understand that --

7

8 *and cannot be bypassed.*

9

10 I get that the system doesn't allow you to bypass a step.
11 But why would it be useful for you to bypass a step in
12 terms of agility of recruitment? It would have to be
13 a step that's not absolutely crucial, I imagine. You tell
14 me what you mean by that anyway?

15 A. It is the sequential nature of the steps. The way the
16 system has been configured, they've just said "This is the
17 way it is", and probably for very good reason. But you can
18 look at the steps and say "Well, we could probably do two
19 at the same time", or, "Can we take --

20

21 Q. Or out of order?

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

26

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

29

30 A. Correct.

31

32 THE COMMISSIONER: Got it, thank you.

33

34 Mr Cheney, do you have any questions?

35

36 MR CHENEY: No, Commissioner.

37

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

40

41 THE WITNESS: Thank you.

42

43 <THE WITNESS WITHDREW

44

45 MR FRASER: Mr Glover will take the next witnesses.

46

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

1
2 MR GLOVER: Yes, if convenient.
3
4 THE COMMISSIONER: Whatever you tell me, thank you.
5
6 MR GLOVER: The next witnesses are Mr Nankivell and
7 Councillor Kennedy. They will be giving evidence together.
8
9 <THOMAS KENNEDY, sworn: [3.04pm]
10
11 <JAY NANKIVELL, sworn:
12
13 <EXAMINATION BY MR GLOVER:
14
15 MR GLOVER: Q. Mr Nankivell, could I start with you.
16 Could you state your full name, please?
17
18 MR NANKIVELL: Jay Nankivell.
19
20 MR GLOVER: You are the general manager of Broken Hill
21 City Council; correct?
22
23 MR NANKIVELL: Correct.
24
25 MR GLOVER: You have held that role since March 2021?
26
27 MR NANKIVELL: Yes.
28
29 MR GLOVER: Prior to that, you held a series of other
30 roles with the council, including chief financial officer
31 and manager of finance; is that right?
32
33 MR NANKIVELL: That's correct.
34
35 MR GLOVER: You first were employed at the council in
36 about June 2016; correct?
37
38 MR NANKIVELL: Yes, that's right.
39
40 MR GLOVER: For the purposes of giving your evidence today,
41 you prepared what's described as an outline of anticipated
42 evidence, although I think you've signed it, it's on the
43 screen there. Do you have a copy of it with you as well?
44
45 MS NANKIVELL: Yes, I have a copy.
46
47 MR GLOVER: I take it, prior to signing it, you read it?

1
2 MR NANKIVELL: Yes.
3
4 MR GLOVER: You are satisfied that its contents are true
5 and correct?
6
7 MR NANKIVELL: Yes.
8
9 MR GLOVER: Councillor Kennedy, if I can come to you, can
10 you state your full name, please?
11
12 MR KENNEDY: Thomas Kennedy.
13
14 MR GLOVER: You are the Mayor of Broken Hill City Council;
15 correct?
16
17 MR KENNEDY: I am.
18
19 MR GLOVER: When were you first elected mayor?
20
21 MR KENNEDY: Elected mayor in 2021, December.
22
23 MR GLOVER: How long have you been on the council?
24
25 MR KENNEDY: Since first elected in 1999.
26
27 MR GLOVER: And you have been on the council continuously
28 since 1999?
29
30 MR KENNEDY: Except for a four-year period and a two-year
31 period.
32
33 MR GLOVER: Mr Nankivell, if we start with you, in
34 paragraph 3 of what I will call the statement, you refer to
35 a number of challenges facing the delivery of health care
36 in Broken Hill. Before we go to those, can I ask you to
37 tell us a little bit about the local government area, its
38 size and population?
39
40 MR NANKIVELL: Yes. So the local government for Broken
41 Hill City Council is just Broken Hill itself. We don't go
42 out into the unincorporated area, so around 30 square
43 kilometres. The population currently is 18,000 people,
44 with an expected growth over the coming years. Contrary to
45 the Department of Planning's estimations around population
46 decline, it will be actually a gradual increase over the
47 next five years due to a number of mining and renewable

1 projects that are coming online.
2
3 MR GLOVER: In terms of growth, just in ballpark figures,
4 what's the projected numbers?
5
6 MR NANKIVELL: We're expecting an increase in the
7 residential workforce of between 1,500 to 2,000 workers and
8 estimating that to be around a 3,500 to 5,000 increase in
9 population.
10
11 MR GLOVER: Can you tell us a little about the
12 demographics of the population? Is it an ageing
13 population, for example?
14
15 MR NANKIVELL: It is an ageing population, with a high
16 percentage of our population over 65, a lot of the younger
17 generation will leave at the end of high school for further
18 education, we have a bit of a spike in those 30s, in that
19 30 age bracket, this is a good place to raise a family, but
20 then we see that transition again, of that age group
21 leaving, and then retirees being our largest proportion.
22
23 MR GLOVER: What about members of First Nations
24 communities? Are they a significant portion of the
25 population within Broken Hill?
26
27 MR NANKIVELL: Yes, we have about 10 per cent - from the
28 recent ABS data, around 10 per cent of our population is
29 Indigenous and that is continuing to grow relative to our
30 population.
31
32 MR GLOVER: Councillor Kennedy, is there anything you
33 would wish to add to Mr Nankivell's description of the
34 local government's area and its demographics?
35
36 MR KENNEDY: No, though we do have a considerable amount
37 of people that do fly into the city, most of them are
38 residential-based workforce for mines, but we still do have
39 some fly-in fly-out people.
40
41 MR GLOVER: Is mining the main industry within Broken
42 Hill?
43
44 MR KENNEDY: Mining would be the biggest earner, followed
45 by tourism.
46
47 MR GLOVER: Mr Nankivell, if we go back to paragraphs 3

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

5
6 MR NANKIVELL: Yes.

7
8 MR GLOVER: How does the council engage with its community
9 about those matters?

10
11 MR NANKIVELL: So we do a four-year community strategic
12 plan where we go out and engage with the entire community
13 around what the residents would like to see in 20 years'
14 time for that area, for our city, it includes aged care, it
15 includes the health care sector, and there is a number of
16 priorities within those community strategic plans we're
17 working towards.

18
19 The concerns that have been highlighted around that is
20 that continual ageing population of Broken Hill with
21 a reduction in our current aged care beds and the strain
22 that is putting on the general health care sector. Sorry,
23 I'm probably answering more than I need to there. That's
24 how we engage. We do community consultation every
25 12 months and every four years for the future 20 years.

26
27 MR GLOVER: Thank you. We will break up some of the
28 things you mentioned in that answer. So, firstly, we'll
29 come to aged care in a moment, but other than concerns
30 about the availability and accessibility of aged care, what
31 other concerns are you aware of within the community in
32 relation to the availability and accessibility of
33 healthcare services within your local government area?

34
35 MR NANKIVELL: Yes, it is probably exactly that. It is
36 the accessibility of those healthcare services. There is
37 a strain on our current public health system for access to
38 those services, some people can be waiting up to 365 days
39 for elective surgery. And then going outside of Broken
40 Hill for those services due to our remoteness and the costs
41 of travel, it just becomes not possible for many people in
42 regards to the time it takes to travel outside of Broken
43 Hill. Adelaide is our closest capital city and that's
44 where most of our health services would come from, and the
45 number of specialties that come to the city as well is
46 obviously starting - I believe is starting to reduce access
47 is still there via alternate means into the cities but we

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

3

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

7

8 MR NANKIVELL: That's correct.

9

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

14

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

21

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

25

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

28

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

31

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

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

10
11 MR GLOVER: Mr Nankivell, if you can turn to paragraph 8,
12 please there you tell us that the council is aware of
13 a concern within the community that members of the board of
14 the Far West Local Health District are not well known or
15 visible. Can you just describe to us first how you have
16 become aware of that concern?

17
18 MR NANKIVELL: That is just from general feedback. When
19 we are discussing the general health care sector for Broken
20 Hill, sometimes people are unaware that there is actually
21 a local board that sits above the Far West Local Health
22 District. They expect that it just reports straight to
23 Sydney without any local involvement, which obviously is
24 a concern there, and then just with the local
25 representation, they are unaware that there is actual local
26 representatives for Broken Hill on that board as well.

27
28 MR GLOVER: When you say there is a bit of a concern as to
29 the lack of awareness of the existence of the board, what's
30 the particular concern that you were referring to?

31
32 MR NANKIVELL: The local input, ensuring that there is
33 that listening voice of what the Broken Hill residents, and
34 I guess the broader Far West Local Health District, to make
35 sure that the concerns of the people living in this area
36 are actually taken on board in regards to the development
37 of their services and the continuity of services for the
38 city.

39
40 MR GLOVER: Tell me if I have understood you correctly.
41 The concern is that if people don't know the board exists,
42 they may not be aware of potential mechanisms for them to
43 provide input and feedback into the work of that board. Is
44 that what you are referring to?

45
46 MR NANKIVELL: Yes, that's correct.
47

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

3

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

9

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

17

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

20

21 MR KENNEDY: Yes, it is.

22

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

25

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

30

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

38

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

45

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

1 there something that you consider could be done differently
2 to improve the engagement between the LHD board and the
3 community within the area?
4

5 MR KENNEDY: Yes, I think if it was known just who the
6 board were and a mechanism for people to have direct input
7 with that board, I think it would improve outcomes in the
8 hospital significantly. As a council, if it was based on
9 similar to what the council has with our council meetings,
10 for example, people know where to go if they do have
11 a complaint or, in addition to a complaint, even to say how
12 well things are going. So you don't always want to hear
13 complaints, you also want to get positive feedback. So
14 I think there is a real opportunity there to have a similar
15 set-up to what the council has in allowing people to have
16 that direct input to the board itself.
17

18 THE COMMISSIONER: I don't know how important these things
19 are, perhaps very important, but in terms - there is
20 a website, obviously, that has the board members on it, but
21 it has photos, it doesn't seem to have a bio to describe
22 who they are. That might be useful. It's got the board
23 minutes, but I can't imagine many members of the community
24 accessing them.
25

26 MR GLOVER: Perhaps I might explore that with Councillor
27 Kennedy. So do I take it that - tell me if I have
28 misunderstood you in any way, but the concern is to the
29 extent that there might be processes for community to
30 engage with members of the board, to your observation, they
31 are not well known within the community; is that right?
32

33 MR KENNEDY: Yes, not well known at all. A lot - if
34 you've got people that have concerns about health coming to
35 the mayor as opposed to the board in the first instances,
36 or the hospital themselves, there is definitely a breakdown
37 in communication or a way for those people to communicate
38 directly. People would feel a lot more confidence if they
39 could go and speak directly or put their concerns directly
40 to people. That's not happening. So what generally
41 happens in a community of our size, the rumour mill spreads
42 pretty quickly if something goes wrong. There is no real
43 way to address that for people immediately, or they don't
44 think there is a real way to address it. Perception is
45 more important than reality when it comes to that ability
46 to have a direct access there.
47

1 THE COMMISSIONER: Can I just ask you this, you are the
2 elected representatives - or you are, Mr Mayor - of the
3 local community. Have you, or to your knowledge, any of
4 your fellow councillors ever been asked for input as to who
5 might be a good candidate to be on the board?
6

7 MR KENNEDY: No. So a lot of the people that are on the
8 board are people that we do know, people that I do know or
9 people that I have had dealings with. Good people. But
10 no, no official input into those people. I'm not sure how
11 much input the general public has into any of those
12 appointees to the committee anyway.
13

14 THE COMMISSIONER: I should just point out in the question
15 I just asked, it shouldn't be taken as any indication that
16 the board members aren't very diligent and appropriate
17 members. It's just I wanted to know whether the council's
18 been asked.
19

20 MR GLOVER: Councillor Kennedy, in an earlier answer you
21 told the Commissioner that you meet fairly regularly with
22 Mr Astill; correct?
23

24 MR KENNEDY: Yes.
25

26 MR GLOVER: How frequently do you have those meetings?
27

28 MR KENNEDY: On an official basis, probably quarterly, but
29 social functions probably monthly. They are usually some
30 sort of council function that he often will attend as - in
31 a social setting but still be available to talk about any
32 concerns that the council may have in regards to health, or
33 any concerns they may have or help that the council can
34 give him in those regards.
35

36 MR GLOVER: I take it from that answer and the answer you
37 gave earlier that, at least from your perspective, you feel
38 you have access as you need it to Mr Astill?
39

40 MR KENNEDY: Yes.
41

42 MR GLOVER: What are the sort of matters you discuss in
43 those meetings?
44

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

1 that early child care, birth to two years old, long day
2 care. Mr Astill made it clear that there's probably 40 to
3 70 spots that could be filled at the hospital if there
4 was - or increase in hours if there was an increase in
5 child care services in the city.

6
7 MR GLOVER: Just pausing there, 40 to 70 staffing
8 positions?

9
10 MR KENNEDY: Yes, yes. A lot of those are nurses. So
11 those nurses would be able to return sooner or increase
12 hours. Council has established that there is only one spot
13 for every seven children that are required at that
14 age group. The other thing that has been made really clear
15 is the opportunity for nurses, for example, to be able to
16 go home for a weekend. Flight prices are extremely
17 expensive, up to \$900 one way. Nurses themselves, as well
18 as Mr Astill, have told me that a lot of them will get
19 homesick and leave before they should.

20
21 The opportunity, if they could go home on weekends,
22 would make a significant increase in the ability to attract
23 them, firstly, but also retain them. One thing that these
24 young people do is if they have a good experience, they
25 will go back to where they come from and say how good it
26 is. One of the things that they do like in Broken Hill is
27 the access to sports. So sport, they get involved really
28 early with all forms of sport, which makes it a lot easier,
29 because they then have that social network which gives them
30 some form of company, but they still often will miss their
31 family and friends from away and, if that could be
32 addressed, that would definitely improve the retention rate
33 at the hospital.

34
35 MR GLOVER: There is probably not much that the council
36 can do about the prices set by the airlines, but is there
37 some work being done within the council in relation to the
38 child care issue?

39
40 MR KENNEDY: Yes, both really strong. So one thing that
41 council is working on is trying to get an upgrade to the
42 runway, that's about \$15 million to reinforce the runway,
43 which would allow 737 jets to land. That would bring down
44 the price of air fares. The other thing that we are
45 pushing is - and have met with a number of politicians - is
46 to implement a scheme that's similar to what is in Western
47 Australia, where it is subsidised flights for locals,

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

7
8 With child care, we're trying to free up land through
9 Crown lands to existing child care facilities that would
10 increase their numbers by up to 80 to 100 additional spots,
11 which would then, without a doubt, have significant impacts
12 on returning of medical staff back to the hospital.

13
14 MR GLOVER: Mr Nankivell, did you wish to add anything to
15 the councillor's response to that series of questions?

16
17 MR NANKIVELL: I think that's covered it off.

18
19 MR GLOVER: Mr Nankivell, if you just go to paragraph 9 of
20 your statement, there you tell us that there has been less
21 consultation with the council than there may have
22 previously been. Can you just - you give one particular
23 example there, but can you just describe in general terms
24 the concern that you are highlighting in that paragraph?

25
26 MR NANKIVELL: Yes. So the concern there is the
27 consultation, and I'm going off on the basis of what
28 happened prior to myself taking on the role as general
29 manager and prior to Mr Astill. If there was any
30 consultation around their service delivery and subsequent
31 issues that they are experiencing at that point in time, we
32 aren't consulted on a regular basis around the issues that
33 they are potentially facing, whether that be bed blocks or
34 reduction in specialty services or new programs they are
35 bringing in. We do have very good consultation around
36 obviously their infrastructure projects and how they are
37 looking to expand the capacity there through those areas
38 there with their recent grant funding and those broader
39 issues how we can have a collaborative approach around
40 transport in and out of the city to attract essential
41 workers, the child care issues and, then, in general, how
42 you can actually attract people into work into Broken Hill.

43
44 So those broader concepts we have good consultation
45 and collaboration with, but on the basis of knowing that
46 there is going to be an upcoming issue potentially due to
47 aged care beds, for example, stopping elective surgery, or

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

5
6 MR GLOVER: So what would you like to see done differently
7 in relation to those issues?

8
9 MR NANKIVELL: It's probably just in general just the
10 heads-up that this is an issue so that we can provide that
11 support before it becomes an issue, as opposed to the mayor
12 regularly hearing it from concerned residents, which
13 obviously then passes across to the operational side of
14 council.

15
16 MR GLOVER: So when you use "consultation" in that
17 context, it's a flow of information that you are looking to
18 improve; is that right?

19
20 MR NANKIVELL: Yes, and not - and not so much in the
21 formal meetings, this is probably having that more regular
22 contact, that if there is a foreseen issue that's happening
23 at that point in time or in that - you know, coming up on
24 that afternoon that there are going to be issues for the
25 residents of the city, that we know about it.

26
27 MR GLOVER: Mr Nankivell, you heard Councillor Kennedy
28 describe some of the initiatives that are being pursued by
29 the council to alleviate some of the stress in relation to
30 transport and child care. Are there any other initiatives
31 being undertaken by the council to support the delivery of
32 health care within the region?

33
34 MR NANKIVELL: Probably just to add further to Mayor
35 Kennedy's comments about the airport, in addition to the
36 upgrade that's required for the funding, \$15 million
37 funding for the upgrade to the runway, we are in the
38 process of actually reconstructing our apron and taxiways
39 which will allow for an increased capacity in the number of
40 aircraft that currently can land in the city, so that
41 includes the Qantas services and REX services. At the
42 moment, we are locked into two aircraft bays at one point,
43 at any given point in time, to actually expand that to
44 allow greater capacity to come into the city, which would
45 hopefully, at a point in time, reduce the costs in the
46 market.

47

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

12
13 MR GLOVER: That's the project, for want of a better term,
14 you describe in paragraph 20 of your statement; is that
15 right?

16
17 MR NANKIVELL: Yes, paragraph 20.

18
19 MR GLOVER: If that project continues, what is it - what
20 will be the council's role in planning and delivering that
21 project?

22
23 MR NANKIVELL: Council's role will be the planning and the
24 delivery of that project, to take on that role in
25 partnership, and then what that end model looks like in
26 regards to ownership and who has access to it is yet to be
27 determined, but from council's housing audit that it
28 completed in 2022, along with our strategic housing review,
29 it was nominated within that, that the majority of
30 essential workers, being health care workers, are looking
31 for those easy maintenance, one- to two-bedroom apartments
32 close to the CBD for that social life as well. So trying
33 to increase that liveability factor to attract people from
34 metropolitan Sydney out into Broken Hill.

35
36 MR GLOVER: Is there, to your knowledge currently,
37 a shortage of housing available within the local government
38 area?

39
40 MR NANKIVELL: Yes, there is currently a shortage. With
41 our expected increases, as mentioned earlier, with the
42 mining operations, renewable operations, we are estimated
43 to be around 700 houses - 700 quality houses short by 2025.
44 So that's - and the majority of that will obviously be
45 taken up by essential workers that will need to come to the
46 city, so we have got a housing shortage and a housing
47 crisis.

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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.

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

5
6 MR GLOVER: Mr Nankivell, in paragraphs 11 to 17 you
7 describe some of the challenges in aged care within the
8 region. Do you see that?

9
10 MR NANKIVELL: Yes.

11
12 MR GLOVER: Firstly, in general terms, how are you aware
13 of the matters set out in those paragraphs?

14
15 MR NANKIVELL: That is through consultation with both
16 Southern Cross Care, the only aged care - residential aged
17 care provider in the city, as well as the Far West Local
18 Health District, around their constraints and concerns and
19 then, beyond that, it is the continuous number of phone
20 calls for help that council - the mayor in particular -
21 receives around finding an aged care place for their
22 elderly parents or either their husband or wife as well,
23 with the issue that they potentially will be transferred
24 out of Broken Hill to an alternate facility if a place
25 can't be found locally.

26
27 MR GLOVER: Is there any work being undertaken by the
28 council to support the delivery of aged care services
29 within the local government area?

30
31 MR NANKIVELL: Yes, not in regards to actually delivering
32 those aged care services, but certainly continuous
33 advocating with the state and federal government, primarily
34 the federal government, around assistance for Broken Hill
35 to have its Modified Monash Model reclassified to allow for
36 some further funding for Southern Cross Care to be able to
37 obtain the nurses, registered nurses that are required,
38 into the city, but furthermore, some of the stringent
39 requirements that were introduced as a part of that review
40 in 2023 would potentially be relaxed as well around the
41 registered nursing hours required per resident.

42
43 MR GLOVER: Just dealing with the Modified Monash Model
44 for a moment, is that an issue that you also discussed with
45 Mr Astill?

46
47 MR NANKIVELL: Yes, it is.

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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

1 engaging with to attempt to secure that reclassification?

2

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

9

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

13

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

25

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

28

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

31

32 MR CHENEY: No, Commissioner.

33

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

36

37 **<THE WITNESSES WITHDREW**

38

39 THE COMMISSIONER: So a break before the next witnesses?

40

41 MR GLOVER: Yes, 10 minutes, Commissioner.

42

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

45

46 **SHORT ADJOURNMENT**

47

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

4
5 <KYLIE SMITH, sworn: [3.54pm]

6
7 <JARROD MARSDEN, sworn:

8
9 <EXAMINATION BY MR GLOVER:

10
11 MR GLOVER: Councillor Marsden, can I start with you.
12 Could you state your full name, please.

13
14 MR MARSDEN: Jarrod Wayne Marsden.

15
16 MR GLOVER: You are the Mayor of Cobar Shire Council;
17 correct?

18
19 MR MARSDEN: Yes, correct.

20
21 MR GLOVER: You were first elected to the council in 2006;
22 is that right?

23
24 MR MARSDEN: As a councillor, yes.

25
26 MR GLOVER: You have been on the council continuously
27 since that time?

28
29 MR MARSDEN: That's correct.

30
31 MR GLOVER: And you've been mayor of the shire since
32 about October 2023; is that right?

33
34 MR MARSDEN: Correct.

35
36 MR GLOVER: And in anticipation of giving your evidence
37 today, you have prepared a statement; correct?

38
39 MR MARSDEN: Yes.

40
41 MR GLOVER: Which you have signed. Do you have a copy of
42 it there with you?

43
44 MR MARSDEN: Yes, I do.

45
46 MR GLOVER: I take it you read it before signing it.

47

1 MR MARSDEN: Yes, I did.
2
3 MR GLOVER: Are you satisfied that its contents are true
4 and correct?
5
6 MR MARSDEN: Yes.
7
8 MR GLOVER: Ms Smith, if I can come to you, can you just
9 tell us your role within the council?
10
11 MS SMITH: I am the director of corporate and community
12 services for Cobar Shire Council.
13
14 MR GLOVER: In general terms, can you just tell the
15 Commissioner what that role involves on a day-to-day basis?
16
17 MS SMITH: So on a day-to-day basis, that's managing the
18 governance, finance and community services that are
19 operated by the council, which includes the Lilliane Brady
20 Aged Care Village that council operates.
21
22 MR GLOVER: Thank you. Councillor Marsden, if I can
23 direct you to your statement, please. In paragraphs 3 to 5
24 you tell us a little bit about the shire. Can I ask you to
25 tell us a little bit about the demographics of the
26 population. Is the shire projecting a growth or decline in
27 population going forward?
28
29 MR MARSDEN: Depending on which statistics from which
30 organisation you like to listen to, most predict around -
31 it is a flatlining population.
32
33 MR GLOVER: And what about the age demographic of the
34 population? Is it ageing, for example?
35
36 MR MARSDEN: I don't have those exact numbers in my head
37 or in front of me, but I believe, yeah, I would probably
38 agree that it would be an ageing population.
39
40 MR GLOVER: In paragraphs 6 to 16 of the statement you
41 tell us about the Lilliane Brady Village. That's the aged
42 care facility owned and operated by the council; correct?
43
44 MR MARSDEN: Yes.
45
46 MR GLOVER: Can you tell us a little bit about how it came
47 to be, to the extent you know, that the council came to own

1 and operate an aged care facility?

2

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

8

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

11

12 MR MARSDEN: Yes, that's correct.

13

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

17

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

32

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

38

39 MR MARSDEN: Yes.

40

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

43

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

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

6
7 MR GLOVER: Ms Smith, is there anything you would wish to
8 add to the answer given by the mayor?

9
10 MS SMITH: I think, as we said, the operational deficit is
11 the primary driver. That's fuelled by both location
12 inflation, so increased costs of being so far away from the
13 centre of population, in addition to the staffing cost that
14 was mentioned.

15
16 MR GLOVER: Councillor Marsden, in paragraph 14 of the
17 statement you refer to the challenges in attracting and
18 retraining staff; do you see that?

19
20 MR MARSDEN: Yes.

21
22 MR GLOVER: Ms Smith has referred to some of those, but
23 I just want to direct your attention about halfway down the
24 paragraph to where you say:

25
26 *The Council is unable to offer similar*
27 *incentives to attract nurses and medical*
28 *workforce that are offered by NSW Health.*

29
30 Do you see that?

31
32 MR MARSDEN: Yes.

33
34 MR GLOVER: Other than the Rural Health Workforce
35 Initiative Scheme, was there any other incentive or
36 initiative that you had in mind?

37
38 MR MARSDEN: Things like additional personal leave, family
39 travel assistance, professional development, accommodation
40 assistance, et cetera.

41
42 MR GLOVER: And when you say that the council is unable to
43 offer incentives of that kind, is it unable to do so
44 because of the financial burden that that would place on
45 the council?

46
47 MR MARSDEN: Correct.

1
2 MR GLOVER: Ms Smith, did you wish to add anything to
3 those answers?
4
5 MS SMITH: I think it is the financial benefit [sic],
6 remembering that council also has a more broad local
7 workforce, where we do actually have to provide equity in
8 access and so there are considerations around offering such
9 incentives for one service when we've got a broad-based
10 service supervision across all council.
11
12 MR GLOVER: So the concern being that if you offered
13 incentives of that kind for a workforce in the facility,
14 there would be perhaps a need to offer them across the
15 council's workforce more broadly; is that right?
16
17 MS SMITH: That is correct. We also currently do pay
18 above award for some of those positions to try and minimise
19 the - I guess try and balance out that cost. Agency staff
20 are more expensive than paying our local staff at a higher
21 rate, so we've certainly been trying to do that by putting
22 in place all of the required increases for staff and
23 a small increase as well to take - give consideration,
24 I guess, that some of the staff we had at the village would
25 have been paid less than some of our local console
26 operators at service stations, had we not made that move.
27
28 MR GLOVER: Councillor Marsden, in paragraphs 17 to 21 of
29 the statement --
30
31 THE COMMISSIONER: Sorry to interrupt, does that mean you
32 have finished with the aged care facility?
33
34 MR GLOVER: For the moment, yes.
35
36 THE COMMISSIONER: Are you going back to it?
37
38 MR GLOVER: On one issue, yes.
39
40 THE COMMISSIONER: I will wait and see, then. You keep
41 going.
42
43 MR GLOVER: In paragraphs 17 to 21 of the statement,
44 Councillor Marsden, you refer to the Cobar Health Service.
45
46 MR MARSDEN: Correct, yes.
47

1 MR GLOVER: That's the facility operated by NSW Health in
2 Cobar; is that right?
3
4 MR MARSDEN: Yes.
5
6 MR GLOVER: In paragraph 20 you refer to the frustrations
7 of some community members on some issues. Do you see that?
8
9 MR MARSDEN: Yes.
10
11 MR GLOVER: What engagement do you have with community
12 members about their concerns or issues with the delivery of
13 health care in the region generally?
14
15 MR MARSDEN: I guess it's a very - in a very general
16 sense, you know. For example, if I go down the street on
17 a Saturday morning, you know, I'll be approached by
18 a ratepayer who will tell me a horror story about their
19 wife or their mother or their daughter being flown out to
20 Dubbo and discharged at 2 o'clock in the morning and having
21 to find their own way home, et cetera. I guess,
22 unfortunately, I can't really talk in specifics, like
23 I can't say, "On 20 April 2021 this happened", but they are
24 the general stories that I get and it's just like, you
25 know, "As mayor, as our representative, can you please see
26 if you can do something about this to improve the situation
27 so it doesn't happen to others."
28
29 MR GLOVER: Does the council engage in consultation with
30 the Western NSW Local Health District about the services
31 delivered in its local government area?
32
33 MR MARSDEN: There is certainly nothing organised. There
34 have been ad hoc meetings. I haven't been to all of them,
35 but I'm aware that they have occurred. We have a local
36 health board chaired by Mr Gordon Hill. He's provided
37 updates to council on what is happening locally, but
38 certainly not really from a regional sense, from a Dubbo
39 feedback point of view.
40
41 MR GLOVER: The local health board that you mentioned, is
42 there a representative of council on that board?
43
44 MR MARSDEN: No, I don't believe there is, no.
45
46 MR GLOVER: Would you like to see any changes or
47 improvements in the way that the council engages with the

1 local health district?

2

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

13

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

19

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

26

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

29

30 MR MARSDEN: Just how busy and overwhelmed the Dubbo
31 hospital is, and they are so desperate for beds that, you
32 know, you hear those horror stories of people being
33 discharged at 2 o'clock in the morning to create another
34 bed for someone else, and then, basically, you know,
35 2 o'clock on a Saturday morning, you are out on the street
36 and you have got to try to find your own way back to Cobar,
37 and if you have been flown out as an emergency, you are
38 there in the clothes you are wearing. That's not a great
39 situation when you are 300 kilometres from home with no
40 train service, no - you know, you basically wait until
41 2 o'clock in the afternoon when the bus leaves.

42

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

1
2 MR MARSDEN: Absolutely.
3
4 MR GLOVER: Are there any other particular issues that
5 members of your community have raised with you surrounding
6 the circumstances in which they may need to be transferred
7 to another centre for treatment?
8
9 MR MARSDEN: No.
10
11 MR GLOVER: In paragraphs 22 to 25, Councillor Marsden,
12 you tell us about the Cobar Primary Health Care Medical
13 Centre; do you see that?
14
15 MR MARSDEN: Yes, I do.
16
17 MR GLOVER: That's a council-owned facility, is it?
18
19 MR MARSDEN: Yes, it is, yes.
20
21 MR GLOVER: The clinicians who operate from that facility
22 run private practices, do they?
23
24 MR MARSDEN: It is through the Outback Division, which is
25 based in Bourke, and they provide doctors into that centre.
26
27 MR GLOVER: Aside from making space available in the
28 facility, does the council provide any other support to
29 those delivering care through that centre?
30
31 MR MARSDEN: I believe there is accommodation in the form
32 of housing for a doctor in town, yes.
33
34 MR GLOVER: Ms Smith, is this something that falls within
35 your remit?
36
37 MS SMITH: Not specifically, but to confirm what the mayor
38 says, there is income that comes from council - from those
39 facilities, but they are targeted facilities below
40 commercial rental, so there is a discount applied to those
41 facilities, and we actually have two, as I understand, one
42 is a medical practice which includes accommodation within
43 that practice; the other is the practice centre that the
44 Outback Division occupies, so we do support our other
45 general practitioner that is not part - or not provided as
46 part of the Outback Division services.
47

1 MR GLOVER: Ms Smith I might stay with you for this next
2 series of questions and we will return to the aged care
3 facility. Does the council receive any funding from either
4 the Commonwealth or New South Wales Government for the
5 purposes of operating that facility?
6

7 MS SMITH: Yes, from the Commonwealth Government.
8

9 MR GLOVER: And do we take it from the numbers that
10 Councillor Marsden referred us to earlier that the funding
11 received from the Commonwealth is insufficient to ensure
12 that that facility operates at least at a break-even point?
13

14 MS SMITH: With the one caveat, that we are currently
15 undertaking a review of the facility to ensure that there
16 are no funding streams that we have missed. So at this
17 point in time, the income that council is certainly
18 receiving, that is correct, so there is a deficit on that.
19 The challenge for us is whether or not we're availing
20 ourselves of all of those opportunities that are provided
21 through those funding streams. What I mean by that is, are
22 we undertaking timely assessments of our residents to
23 ensure that we're getting the appropriate payments.
24

25 MR GLOVER: What you are describing there is a review
26 internally by the council to ensure it is operating the
27 facility as efficiently as possible and maximising its
28 revenue; is that right?
29

30 MS SMITH: That's correct.
31

32 MR GLOVER: Councillor Marsden, in paragraph 28 of --
33

34 THE COMMISSIONER: Sorry, can I ask a question about the
35 aged care facility?
36

37 MR GLOVER: Yes.
38

39 THE COMMISSIONER: In paragraph 9, you tell us that the
40 council approached multiple aged care providers who
41 declined to run the service. Was one of the entities you
42 approached the Western NSW LHD?
43

44 MR MARSDEN: No.
45

46 THE COMMISSIONER: To your knowledge, did they give any
47 consideration as to whether they would take over that aged

1 care facility?

2

3 MR MARSDEN: No. When the new hospital was built, the
4 original agreement with the state government was -
5 obviously the new hospital was built right next door to the
6 aged care facility and there is a corridor between the two,
7 with two lovely doors that never get opened anymore. The
8 original agreement with the state government was that they
9 would take over that aged care facility. Unfortunately,
10 very late in the piece, when the hospital was just about to
11 be opened, they withdrew from that agreement.

12

13 But it was private - it was private enterprise that we
14 went to the open market with expressions of interest,
15 I believe that was around 2014. The feedback that we
16 received was that the centre was just too small to make
17 money on a commercial basis.

18

19 THE COMMISSIONER: I see. So would it be news to you that
20 the Western NSW LHD did an evaluation about whether they
21 were going to take over that aged care facility?

22

23 MR MARSDEN: Yes.

24

25 THE COMMISSIONER: Right. Okay. When you say in
26 paragraph 9, also, that council approached multiple aged
27 care providers who declined to run the service, what was
28 the reason they declined to run the service?

29

30 MR MARSDEN: Because of its size. It was too small to be
31 commercially viable. At the time, they said 50 beds was
32 about as small as you could go to be commercially viable.
33 We were 36 at the time, and 44 now, but, yeah, we're
34 certainly still - still going to hit that number.

35

36 THE COMMISSIONER: The deficit of \$1.3 million for the
37 '23/'24 financial year, is that having an impact on rates
38 yet?

39

40 MR MARSDEN: Certainly not rates, but at the moment we're
41 in a position where if we can't secure extra funding
42 federally to cover that number, council will have to either
43 review its position of operating this facility or crunch
44 the numbers, and other areas of the budget will have to
45 suffer to cover the shortfall.

46

47 THE COMMISSIONER: All right. Okay, I understand.

1
2 MR GLOVER: Councillor Marsden, can I just take you back
3 to an earlier answer you gave to the Commissioner, you said
4 this:

5
6 *When the new hospital was built, the*
7 *original agreement with the state*
8 *government was - obviously the new hospital*
9 *was built right next door to the aged care*
10 *facility and there is a corridor between*
11 *the two ...*

12
13 And you then went on to say the original agreement with the
14 state government was that they would take over the aged
15 care facility. Do you remember giving that answer.

16
17 MR MARSDEN: Yes, I did.

18
19 MR GLOVER: Firstly, when was the new hospital built next
20 door to the aged care facility?

21
22 MR MARSDEN: I believe it was around 2016.

23
24 MR GLOVER: And what is your understanding of the
25 agreement with the state government that they would take
26 over the aged care facility?

27
28 MR MARSDEN: Yeah, I've got a personal - I've got a little
29 bit of a personal beef with this, because the agreement was
30 never - it always verbal and it was never formalised. I
31 actually - you will find me voting against the motion in
32 amongst the council minutes, because I wanted it formalised
33 so that the state government couldn't get out of it, but
34 our council at the time really wanted a new hospital, so
35 they decided to go ahead. It was never formalised into
36 a memorandum of understanding, so I guess that opened the
37 door for them to withdraw.

38
39 MR GLOVER: When you say "the state government", do you
40 have a recollection of which part of the New South Wales
41 Government you were dealing with, or the council was
42 dealing with, in relation to this issue?

43
44 MR MARSDEN: No.

45
46 MR GLOVER: But from that earlier answer, do I take it
47 it's something that would appear in the council minutes

1 from around that time?
2
3 MR MARSDEN: Absolutely. I would hope so.
4
5 MR GLOVER: And this is 2016, did you say?
6
7 MR MARSDEN: I believe so. That was around the time
8 frame, yes.
9
10 MR GLOVER: Thank you.
11
12 THE COMMISSIONER: It doesn't matter for the witnesses,
13 but for everyone else, there is something in Mr Spittal's
14 evidence at page 2999 of the transcript about evaluating
15 this.
16
17 MR GLOVER: Yes.
18
19 THE COMMISSIONER: And expecting it to lose about what
20 it's losing at the moment.
21
22 MR GLOVER: Yes, there is a distinct correlation between
23 the numbers referred to by Councillor Marsden and I think
24 what Mr Spittal said last week.
25
26 Finally, Councillor Marsden, if I can direct this
27 question to you, in paragraph 28 of your statement, you
28 say:
29
30 *There is little recognition across other*
31 *levels of government of the role played by*
32 *councils in supporting the delivery of*
33 *health care.*
34
35 Do you see that?
36
37 MR MARSDEN: Yes.
38
39 MR GLOVER: Later in paragraph 30 you refer to the need
40 for some additional funding, and I will come to that in a
41 moment, but in addition, or separately to the question of
42 additional funding, is there any other recognition or
43 support that you consider could be delivered to local
44 government to assist them to support the delivery of health
45 care within their regions?
46
47 MR MARSDEN: I guess just the - if we could have some

1 funding that would - we don't expect funding to cover what
2 everyone else has to cover, but if we can get funding to
3 cover the gap that we are now seeing, that is being driven
4 both geographically and the tyranny of distance - and I use
5 the specific example of we are required to provide eight
6 hours of physiotherapy to our aged care facility patients.
7 We don't have a physio in Cobar, so we have to get one out
8 of Dubbo. Now, they spend a day travelling, they spend
9 eight hours delivering the physiotherapy, and then they
10 spend a day travelling home. So we're paying a physio
11 three days a week. Now, at the aged care facility in
12 Dubbo, they only have to pay the physio for the eight hours
13 that they spend with the patients. So, you know, that gap
14 that we have to pay for travel and accommodation - for
15 travel and accommodation, that is the funding that we need,
16 to cover that gap so that we can bring ourselves up.

17
18 MR GLOVER: Do you take it by "additional funding", you have
19 in mind something other than additional rate revenue?

20
21 MR MARSDEN: Absolutely. We would be looking for separate
22 and I guess special funding from either state or - probably
23 federally, more to the point.

24
25 MR GLOVER: Is that something that your council has taken
26 up with - let's confine it to the state government at the
27 moment?

28
29 MR MARSDEN: We are trying to - we've initially gone
30 through the local member, Mark Coulter, federally, who has
31 approached the minister. We are now looking to get an
32 audience with the minister to discuss that situation.

33
34 MR GLOVER: That's the federal member, is it?

35
36 MR MARSDEN: Yes, correct.

37
38 MR GLOVER: Is it an issue that's been raised with, for
39 example, the Country Mayors Association or Local Government
40 NSW?

41
42 MR MARSDEN: Not specifically.

43
44 MR GLOVER: Thank you. I have no further questions for
45 these witnesses.

46
47 THE COMMISSIONER: Thank you.

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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

\$

\$1,500 [1] - 3177:12
\$10,000 [4] - 3194:4,
 3197:32, 3197:40,
 3200:22
\$15 [2] - 3211:42,
 3213:36
\$20,000 [4] - 3193:46,
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