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

Thursday, 23 May 2024 at 9.30am

(Day 031)

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: When you are ready, Mr Glover.
2
3 MR GLOVER: Yes, Commissioner. The first two witnesses
4 today are Sally Pearce and Justin Files. They will be
5 called together. Before we proceed, I understand Mr Files
6 would wish to give an acknowledgment of country and
7 I invite him to do so.
8
9 MR FILES: Thank you. I guess, first of all, my name is
10 Justin Files. I'm a Barkindji man. Country Barkindji is
11 my dialect of the Nation of the Barkindji. We meet on
12 Wilyakali dialect of the Barkindji Nation today and the
13 reason for our welcomes for any gatherings where many minds
14 come together to make things better and lean towards
15 solutions and better outcomes for the whole.
16
17 Traditionally, what we would do in this part of the
18 world, we would gather at Mootwingee, which was our
19 traditional parliament, which is 100 kilometres north of
20 Broken Hill, and the ambassadors from the surrounding clan
21 groups would go out to all dialect groups. Dialects are
22 only what we would refer to in modern terms as states, like
23 New South Wales, Victoria, so they were dialect groups, and
24 they could roam anywhere within the nation and, then, when
25 they came to specific landmarks for neighbouring tribal
26 groups or neighbouring nations, they would wait for their
27 law persons from those neighbouring nations to come forth
28 and receive the message sticks, and the message sticks
29 would inform those nations of how many people could attend
30 traditional parliament.
31
32 Traditional parliaments were where we made our laws
33 and, of course, customs were the responsibility of dialect
34 groups, but the laws that we followed within the nation and
35 with our neighbouring nations, they were made to bring as
36 much harmony to the people as possible, so wellbeing is
37 what you could call that.
38
39 With that, I would like to welcome you all here to
40 Wilyakali country of the Barkindji nation and I wish
41 everyone a very beneficial discussion through the
42 processes. Thank you.
43
44 THE COMMISSIONER: Thank you very much for that.
45
46 MR GLOVER: I am told both will take an affirmation,
47 Commissioner.

1
2 **<JUSTIN JOSEPH FILES, affirmed: [9.33am]**
3
4 **<SALLY JOY PEARCE, affirmed:**
5
6 **<EXAMINATION BY MR GLOVER:**
7
8 MR GLOVER: Q. Ms Pearce, if I could start with you,
9 could you state your full name, please?
10
11 MS PEARCE: Sally Joy Pearce.
12
13 MR GLOVER: You are the chair of the board of the Far West
14 Local Health District; correct?
15
16 MS PEARCE: Yes.
17
18 MR GLOVER: When were you appointed to that role?
19
20 MS PEARCE: I was appointed as acting chair in July last
21 year and formally appointed from January.
22
23 MR GLOVER: And you have been on the board since
24 about September 2019; is that correct?
25
26 MS PEARCE: That's correct.
27
28 MR GLOVER: For the purpose of giving your evidence today,
29 an outline of your evidence has been prepared?
30
31 MS PEARCE: That's correct.
32
33 MR GLOVER: That's [MOH.9999.1245.0001]. There is
34 a screen to your left. If you have a hard copy with you,
35 feel free to use that.
36
37 MS PEARCE: Yes.
38
39 MR GLOVER: Have you had a chance to read the outline
40 again before giving your evidence today?
41
42 MS PEARCE: I have.
43
44 MR GLOVER: Are you satisfied it is true and correct?
45
46 MS PEARCE: Yes.
47

1 MR GLOVER: Mr Files, can you state your full name,
2 please?
3
4 MR FILES: Justin Joseph Files.
5
6 MR GLOVER: You are a member of the board of the Far West
7 Local Health District; correct?
8
9 MR FILES: Yes.
10
11 MR GLOVER: Been on the board for about two years; is that
12 right?
13
14 MR FILES: A little over.
15
16 MR GLOVER: An outline of your anticipated evidence has
17 also been prepared; is that right?
18
19 MR FILES: Yes.
20
21 MR GLOVER: I will have that brought up on the screen,
22 please, operator. I understand there are one or two
23 corrections you would wish to make?
24
25 MR FILES: Yes, please. Only - under "Partnerships",
26 point 14, I have said that we "regularly meet". It's our
27 intent to regularly meet with the ACCHO board of the
28 region, Maari Ma Health, and also Coomealla Health
29 Aboriginal Corporation.
30
31 MR GLOVER: Other than that change, are there any others?
32
33 MR FILES: And in relation to our local health councils, we
34 are not responsible for those health councils. We are
35 allocated and sit on those health councils.
36
37 MR GLOVER: Which paragraph are you referring to?
38
39 MR FILES: Sorry, under "Community engagement", point 18.
40
41 MR GLOVER: So where it says each board member is
42 responsible, the change you would wish to make is to make
43 clear that each board member is allocated to sit with those
44 councils; is that right?
45
46 MR FILES: That's correct.
47

1 MR GLOVER: Are there any other changes you would wish to
2 make?
3
4 MR FILES: No.
5
6 MR GLOVER: Subject to those two changes, are you
7 satisfied that the outline is true and correct?
8
9 MR FILES: I am.
10
11 MR GLOVER: Thank you. Ms Pearce, if I can turn to you
12 first. In addition to your role as chair, you also sit on
13 some committees of the board; is that right?
14
15 MS PEARCE: That's correct.
16
17 MR GLOVER: Which are those?
18
19 MS PEARCE: I sit on the finance, performance and
20 workforce committee and also the Aboriginal health and
21 workforce committee.
22
23 MR GLOVER: Mr Files, you are also on the latter of those
24 two committees; is that right?
25
26 MR FILES: That's correct.
27
28 MR GLOVER: And you sit as co-chair of that committee?
29
30 MR FILES: Co-chair.
31
32 MR GLOVER: We will return to that shortly. Ms Pearce, in
33 paragraph 5 of your outline, you tell us about the
34 composition of the board. Currently it has eight members,
35 four of whom live in Broken Hill.
36
37 MS PEARCE: That's correct.
38
39 MR GLOVER: And four outside of Broken Hill. You yourself
40 are based in Sydney; correct?
41
42 MS PEARCE: Correct.
43
44 MR GLOVER: Where are the other three members who are not
45 based in Broken Hill?
46
47 MS PEARCE: So two of the other members are based in

1 Sydney. One of them, Dr Bandler, worked for many years as
2 a GP with the Royal Flying Doctor Service and still has
3 patients out in the community here. And another member
4 lives in the Tweed area.
5
6 THE COMMISSIONER: I'm sorry, I'm just having trouble
7 hearing you. It could be the microphone is not close
8 enough.
9
10 MS PEARCE: Apologies.
11
12 MR GLOVER: I think you said two of the other members are
13 based in Sydney, although Dr Bandler had worked with the
14 RFDS in the community?
15
16 MS PEARCE: Yes.
17
18 MR GLOVER: And another is in the Tweed?
19
20 MS PEARCE: Yes, she was a resident with her family in
21 Broken Hill and, for health reasons, she had to move out of
22 Broken Hill to be closer to a tertiary hospital.
23
24 MR GLOVER: Prior to your appointment to the board, did
25 you have any connection with the region?
26
27 MS PEARCE: No. I've been out here a number of times, but
28 I don't have a family connection, and haven't lived in this
29 area.
30
31 MR GLOVER: Can I ask you about the operation of the board
32 when four of its members are not resident within the
33 district?
34
35 MS PEARCE: Yes.
36
37 MR GLOVER: How does the board go about ensuring then that
38 each of its members, including those who are not resident
39 within the region, have a strong and detailed knowledge and
40 understanding of the community that is served by the
41 district on an ongoing basis?
42
43 MS PEARCE: So I think I would say that we are
44 a skills-based board and one of those really important
45 areas is knowledge and understanding of the community.
46 I think six of the board members do actually have very -
47 quite deep connections to the local area. Myself and one

1 of the other Sydney-based members, we - I've been coming
2 out - aside from when I was prohibited during COVID, I've
3 been coming out on about a monthly basis for nearly five
4 years. I talk to the staff, I talk to the community.
5 I spend a lot of time getting to know the different
6 facilities we have out here, the services they provide, the
7 focus, and what's important to those communities.
8
9 One of the things that really helped me when I first
10 joined the board was sitting on the health council for the
11 Two Rivers area, and that covers Buronga, Dareton and
12 Wentworth, and being on that health council, which is made
13 up of community representatives and attended by the local
14 health managers of the facilities, really gives you quite
15 a deep understanding of what's happening in those
16 communities, what their priorities are, and what they are
17 looking for from their health service.
18
19 Our community members are very generous in giving
20 their time to the health service and ensuring that we are
21 pretty clear about how they feel about the services we
22 deliver, and they want to be engaged in improving the
23 health services, so they're very frank and forthright in
24 our conversations.
25
26 MR GLOVER: Did you happen to follow any of the evidence
27 given yesterday?
28
29 MS PEARCE: I did.
30
31 MR GLOVER: You would have been aware of a concern that
32 has come to the attention of the Broken Hill City Council
33 that members, or the board as a whole, is not visible and
34 accessible to the community?
35
36 MS PEARCE: Yeah, and I think the four resident board
37 members we have are very well known in the community, so
38 our deputy board chair is a former lord mayor; another
39 board member is the treasurer of the Country Women's
40 Association and also sits on Foundation Broken Hill, which
41 is quite a well-known organisation within the town.
42 I think we currently have a little bit of a gap in having
43 a board member from outside of Broken Hill. I think that's
44 something we will be looking to encourage people from
45 outside of Broken Hill to join the board. It's not -
46 I don't - as a board, we don't select the members, that's
47 a decision for the minister.

1
2 I was appointed in January permanently, and since that
3 time I've actually been working hard to get out and meet
4 the chairs and the CEs of all the relevant organisations we
5 work closely with. I started with the organisations where
6 we're jointly providing health care, so I've met with
7 Maari Ma, the RFDS, Mildura Health a couple of times, the
8 PHN where we've set up a new joint committee, and I think
9 over the coming months my focus will broaden to meeting
10 with all of the council mayors and general managers, if
11 they wish to meet with me, as well as some other
12 organisations.
13
14 MR GLOVER: If we come, then --
15
16 THE COMMISSIONER: When you come out monthly, how long is
17 that trip? Is it a day, a couple of days or --
18
19 MS PEARCE: It could be overnight, it could be a couple of
20 days, but this year I've been out twice a month.
21
22 THE COMMISSIONER: Twice a month?
23
24 MS PEARCE: Yes, I'm out for a week at the moment.
25
26 THE COMMISSIONER: And when you say you talk to the
27 communities, what does that involve?
28
29 MS PEARCE: So when we - during my time on the board,
30 we've gone out and visited our facilities, except during
31 COVID when that was limited, and so we will go --
32
33 THE COMMISSIONER: That would involve talking to staff
34 there?
35
36 MS PEARCE: Talking to staff, talking to the health
37 council, stopping at the local cafe to get some lunch and
38 asking them what they think. It really is anyone that
39 wants to talk to us, we'll talk to about the issues we
40 have.
41
42 I think another element that is a little unusual for
43 Far West compared to some of the larger metropolitan health
44 districts is that our staff also represent a large portion
45 of our community, and so we get significant feedback from
46 staff, as well, of how they have found our health
47 facilities, as members of the public using the facilities.

1 I mean, as an example, yesterday afternoon two of our board
2 members contacted me about specific issues raised with
3 them. One was to praise a diabetes education session that
4 was held with the community and he had really positive
5 feedback about that. Another was a concern raised about
6 some of the fees that the hospital charges for some things,
7 and we'll be having a discussion about that at the board
8 meeting. So technology, really, you know - even though
9 I may be in Sydney, I'm not that far away.
10
11 THE COMMISSIONER: I'm not sure about that. The other
12 three non-locally based board members, do they also come
13 out and stay? They stay overnight?
14
15 MS PEARCE: Two of them do. One board member, it depends
16 on - she has regular treatment in a tertiary hospital and
17 if there is a clash, then she is unable to come.
18
19 THE COMMISSIONER: Does she appear at board meetings via
20 Teams or some platform?
21
22 MS PEARCE: Yes, and she has family and a broad circle of
23 friends in the community out here as well.
24
25 THE COMMISSIONER: Okay.
26
27 MR GLOVER: What about committee meetings --
28
29 MS PEARCE: Yes.
30
31 MR GLOVER: -- for those members who are not resident in
32 Broken Hill, do they travel to Broken Hill for those
33 meetings?
34
35 MS PEARCE: We would do it virtually, predominantly.
36
37 MR GLOVER: We will come to the issue of community
38 engagement more broadly shortly, but in the answer you gave
39 to the Commissioner, you described some ad hoc ways of
40 engaging with the community like in a cafe.
41
42 MS PEARCE: Yes.
43
44 MR GLOVER: Obviously that can only happen when you and
45 the other board members who are resident away from Broken
46 Hill are in the region; is that correct?
47

1 MS PEARCE: That's correct.
2
3 MR GLOVER: Are there any other structured mechanisms
4 whereby the board as a whole can engage with its community?
5
6 MS PEARCE: Each year we do have an annual public meeting
7 that we advertise quite broadly, and invite the community
8 to attend, but to date that's really been done - it's
9 really just the media that show up, so it's not something
10 where we've had significant community attendance.
11
12 I think there is a lot of engagement that happens at
13 the organisational level as well and, quite rightly, they
14 are doing continual engagement with our partner
15 organisations in the community more broadly.
16
17 I think next year we'll start the strategic planning
18 process, and that will be an opportunity for us to
19 undertake a more structured engagement with the community
20 on where they see the future of the health service.
21
22 MR GLOVER: One of the functions of the board is to seek
23 the views of providers and consumers of health services and
24 members of the community served by the district; correct?
25
26 MS PEARCE: Yes.
27
28 MR GLOVER: How does a board in practice achieve that?
29
30 MS PEARCE: I think I have described some of the ways we
31 do that through our health councils, which are all
32 community representatives. We also have a patient story,
33 which starts and grounds each of our board meetings, and
34 that's an anonymous story where a patient is able to
35 describe their experience of our health service. We
36 usually get both positive and negative feedback from that.
37
38 There is a range of patient experience surveys that
39 are undertaken across the district, and we receive feedback
40 through the safety and quality committee on our performance
41 in those surveys and issues that are raised.
42
43 MR GLOVER: The things that you are describing are dealt
44 with in paragraphs 17 to 22 of your outline; is that right?
45
46 MS PEARCE: Yes.
47

1 MR GLOVER: In paragraph 17 you say that there are several
2 mechanisms.
3
4 MS PEARCE: Yes.
5
6 MR GLOVER: In addition to the ones that are listed in
7 paragraphs 18 to 21 or 22, I'm sorry, are there any others
8 that you haven't referred to in the outline?
9
10 MS PEARCE: I think they are the main formal ones.
11
12 MR GLOVER: If we start - Mr Files, I will come to you in
13 a moment, don't worry, I haven't forgotten - if we start
14 with the patient story to which you have referred, you said
15 in an answer a moment ago that that's an anonymous story
16 and often the board will receive a positive and perhaps a
17 not so positive experience; is that right?
18
19 MS PEARCE: I would say it's positive and areas for
20 improvement or concern within the one story, so most
21 patients will give both types of feedback.
22
23 MR GLOVER: How many of those stories or journeys, as it
24 has been described in other places, will the board receive?
25
26 MS PEARCE: So we receive one at each meeting, and the
27 safety and quality committee also receives one at each
28 meeting.
29
30 MR GLOVER: How many meetings of the board are held each
31 year?
32
33 MS PEARCE: Eleven.
34
35 MR GLOVER: Eleven?
36
37 MS PEARCE: Yes.
38
39 MR GLOVER: And how many of the safety committee?
40
41 MS PEARCE: Eleven.
42
43 MR GLOVER: Then you have mentioned in your evidence the
44 health councils. What is the composition of the membership
45 of those councils?
46
47 MS PEARCE: It's members of the community that have

1 volunteered to sit on the health council.
2
3 MR GLOVER: Are you aware of how they are selected?
4
5 MS PEARCE: We are currently - the chief executive is
6 currently reviewing the policies around that. There was
7 a new policy came out from the ministry, and so we're
8 looking at implementing that policy and ensuring it's in
9 line. I think, generally, if somebody wants to be a member
10 of a health council, we don't set a highly restrictive
11 process. If somebody wants to come along and give up
12 a couple of hours of their time each month to give us
13 feedback, we're happy to have them participate.
14
15 MR GLOVER: In paragraph 20, you tell us that there is
16 a recently implemented system of touring the facilities
17 within the LHD. Do you see that?
18
19 MS PEARCE: Yes.
20
21 MR GLOVER: In the last sentence, you say:
22
23 *The new arrangement should provide more*
24 *time to meet with community members and*
25 *staff ...*
26
27 MS PEARCE: Yes.
28
29 MR GLOVER: How will those new arrangements provide
30 members of the board with more time to directly engage with
31 community members?
32
33 MS PEARCE: So what we were doing previously was going
34 out, say, to Wilcannia, we would go out for the day, hold
35 our board meeting during the day, have lunch with the
36 health council, have a quick tour with the chat, and then
37 drive back. So it really was a little bit limited. It was
38 also a little bit overwhelming. For some of our small
39 communities, you might have two or three people that show
40 up, and they are suddenly surrounded by eight board
41 members, a chief executive, a board secretary, and a few
42 other people. It's not really conducive to having an open
43 discussion.
44
45 THE COMMISSIONER: A bit like 10 lawyers turning up at
46 various sites. Yes, I understand what you are saying.
47

1 MS PEARCE: We didn't get a spotlight out but - yes. So
2 I think - we're hoping, and this happened, I did a trip
3 when I first became acting chair, we did a trip with just
4 myself and a couple of members of the executive team, and
5 I found that much more valuable in that people would really
6 sit down and just have a normal conversation and tell you
7 what's worrying them, what ideas they've got, and often
8 come up with incredibly simple things that would just make
9 life easier. That's - you know, we want the "Here is the
10 major thing that's missing in our area that we'd really
11 like to have", but we also want to hear about the niggles
12 and the things that just make things difficult, so getting
13 that diversity of feedback I think that will give us more
14 time.
15
16 MR GLOVER: In that answer you referred to engagement with
17 members of the health council. What about the community
18 more generally?
19
20 MS PEARCE: So I'm hoping that this will actually allow us
21 to meet with some of the other community groups while we're
22 out there as well.
23
24 MR GLOVER: How will it do that?
25
26 MS PEARCE: Because we'll organise to meet with them at
27 the same time. Because we're not holding a board meeting,
28 we can say we'll go and meet with Maari Ma if we're at
29 Wilcannia.
30
31 MR GLOVER: Mr Files, in paragraphs 17 to 19 of your
32 outline, you address the issue of community engagement. In
33 paragraph 17, you express the view that the board has
34 a close relationship with the community and an ear to the
35 ground.
36
37 MR FILES: Yes.
38
39 MR GLOVER: Could you just expand on what leads you to
40 that view?
41
42 MR FILES: Yes. So - well, as you have already canvassed,
43 the four of us are locals, one being the ex mayor,
44 a business person in Broken Hill, another being connected
45 on the regional board and also CWA. They are our
46 non-Indigenous board members. And, of course, there are
47 two Indigenous board members - myself as a traditional

1 custodian and another who is a neighbouring tribal group
2 that has been born in Broken Hill and whose family has
3 moved here years ago.
4
5 When I say "an ear to the ground", I think that our
6 board have a very robust conversation with community issues
7 that come up, because the four local board members are very
8 interested in our health service benefiting the whole
9 community. Each of us have different passions or
10 priorities, and so we feel very safe in talking about that
11 at the board meeting.
12
13 Each of us are connected to different pockets within
14 the community and within the region. My colleague, who is
15 Aboriginal, who is from a neighbouring tribal group, is the
16 general manager of the Aboriginal housing company of this
17 region and he goes into people's homes and people are very
18 comfortable in providing feedback around the health system
19 with him.
20
21 MR GLOVER: Did you also happen to catch any of the
22 evidence that was given yesterday by Broken Hill City
23 Council?
24
25 MR FILES: No, I didn't, sorry.
26
27 MR GLOVER: One of the issues that was raised by the
28 witnesses from Broken Hill City Council was, as I raised
29 with Ms Pearce, at least a concern or perception within the
30 community that the board was not visible or accessible.
31 Would that come as a surprise to you?
32
33 MR FILES: Very much.
34
35 MR GLOVER: Now that you are aware of that, can you see
36 any things that might be done differently to overcome that
37 perception within the community?
38
39 MR FILES: I guess - well, for sure. I think that
40 conversations and relationships can be built, and I think
41 that's a two-way street also.
42
43 THE COMMISSIONER: Perhaps a different question might be,
44 you said, when Mr Glover put to you the council's view -
45 you were asked would it come as a surprise to you and you
46 said "Yes, very much" - you are surprised to hear that.
47 Tell me why you are surprised to hear that?

1
2 MR FILES: I guess because council are present at most
3 community events that we as board members may be in
4 attendance with, and there just may not be conversations
5 had, therefore my kind of thought that it's a two-way
6 street. In saying that, why it would surprise me is that
7 I think, from a local government perspective, there would
8 be as much effort, if not more, from us as a service
9 provider's perspective, to want to engage to build those
10 relationships also, and I think it's a little surprising,
11 given that our four board members are very visible in
12 Broken Hill and two of us are visible in the region, myself
13 belonging to the largest kinship system on the Darling
14 River, 20 years within the health system, providing
15 leadership around community activities and engagement,
16 including with the predecessors of local government who
17 have kind of been in for a couple of years, but certainly
18 board members have had relationships with previous
19 predecessors of local government as well.
20
21 MR GLOVER: In fairness to the council, I don't think
22 their concern was a lack of accessibility for the council
23 organisation but, rather, a concern that they had become
24 aware of within the community that the community members
25 didn't have access to the board. Would that also be
26 something that comes as a surprise to you?
27
28 MR FILES: Maybe not so much a surprise, in that we don't
29 kind of, I guess, promote the board with bells and
30 whistles, because - especially for the locals, we have
31 families and kind of community circles that each of us are
32 in, and I'll refer to the pockets that I mentioned before.
33 So in terms of community events like NAIDOC in the Park, a
34 thousand people attending that, we might get one or two
35 board members in attendance to that. For another colleague
36 on the board who might be at the Country Women's
37 Association, that is another pocket.
38
39 And so - and council, I guess, would be invited to
40 most activities within our community, if not having a lead
41 role within our communities and, therefore, engaging
42 service providers to participate and engage around
43 community engagement.
44
45 MR GLOVER: Could I direct you to paragraph 19 of your
46 outline, Mr Files, and can I ask you about the gates that
47 you describe there to engage with the First Nations

1 community?
2
3 MR FILES: Definitely, yes.
4
5 MR GLOVER: Could you just explain in practical terms
6 those gates that you set out there and how the board
7 engages with those organisations and representatives?
8
9 MR FILES: So in terms of - well, I guess the big one is
10 around native title and the board working closely with the
11 prescribed body corporate of native title, the
12 administrative arm, in implementing the Aboriginal land use
13 agreement that there is for our southern health facility in
14 Buronga, first in our region to happen, and so I commend -
15 and it was prior to my joining the board - and so I commend
16 our board for that engagement and that influence to enter
17 into that agreement with the native title group who had the
18 largest native title claim kind of determined in New South
19 Wales.
20
21 The other groups, we have for the past 20 years had
22 a structure in the region that we refer to - well, it came
23 on the back of ATSIC, which was the elected Indigenous body
24 for the region, but that is at a local level, our community
25 working parties, which is made up from any community
26 members wishing to engage with service providers. There is
27 an agreement with the Premier through accord agreements,
28 where it is mandated that service providers attend these
29 gatherings, which are monthly gatherings. Within different
30 communities, that's kind of not always regular, but Broken
31 Hill is pretty thorough on that front. So that's a forum
32 where you have a captured audience. In terms of --
33
34 MR GLOVER: Just pausing there, how does the board or the
35 board members engage with those groups, the community
36 working parties?
37
38 MR FILES: That's what I was just about to explain.
39
40 MR GLOVER: I'm sorry, you continue.
41
42 MR FILES: Often, it is our executive that are encouraged
43 to attend as service providers and their directorate lines,
44 but my colleague, who is the second Indigenous board member
45 on our LHD board, is the outgoing chairperson of that
46 Community Working Party. So, I mean, those other forums
47 are the local Aboriginal Land Councils, which we're members

1 of as First Nations people; there are our families that we
2 live in, that we have Elders within our families that tend
3 to hear the challenges from our extended families, and
4 because, as a First Nations person engaging within the
5 systems, we are often kind of informed of challenges that
6 we then share with our board colleagues at board meetings.
7 And, also, we're part of the community, four of us, so
8 whether we hear it from our circle of friends or whether we
9 hear it from our families, we have a safe place in our
10 board to discuss real life issues.
11
12 MR GLOVER: Can I turn to the issue of service planning
13 and Ms Pearce, I will start with you. In paragraph 8 of
14 your outline, you tell us that the board establishes the
15 strategic direction and ensures appropriate clinical
16 financial and corporate governance, et cetera. Do you see
17 that?
18
19 MS PEARCE: Yes.
20
21 MR GLOVER: What role, if any, does the board have in
22 service planning within the district?
23
24 MS PEARCE: I think that really comes from the strategic
25 direction we set, and as part of that strategic direction,
26 identifying gaps in service provision. It's one of the
27 areas I'm keen to work with the PHN in doing some quite
28 detailed mapping of the gaps across our communities, and
29 then bringing that in to our strategic planning to
30 identify, where there are gaps, what services we could
31 provide, who we could partner with.
32
33 And I would very clearly say the board are not
34 involved in determining the actual processes of service
35 delivery. So once you get down to the operational planning
36 for a service, that would definitely sit with the clinical
37 teams that have expertise in that area.
38
39 MR GLOVER: How - at the outset of that answer, you
40 mentioned part of the setting of the strategic direction is
41 identifying gaps in service provision.
42
43 MS PEARCE: Yes.
44
45 MR GLOVER: You said that you are quite keen to work with
46 the PHN in doing some mapping.
47

1 MS PEARCE: Yes.
2
3 MR GLOVER: What work, so far in your time on the board,
4 has been done to identify gaps in the service provision?
5
6 MS PEARCE: I think it has been a little less structured,
7 in that we haven't worked with the PHN to do that. One of
8 the major gaps in service provision that was identified by
9 board members and by the Wilcannia community is dialysis at
10 Wilcannia, and we're definitely looking at what we can do
11 to rectify that gap, and that has taken quite a bit of
12 work.
13
14 I think as well that we've had a fairly significant
15 capital development program over the last - over the period
16 I've been on the board,, so we've got nine facilities, and
17 I think firstly a small facility up at Tibooburra was
18 upgraded, but we've rebuilt Buronga, we've rebuilt - we're
19 in the process of rebuilding Wentworth Hospital, and we're
20 doing the ED and mental health services at Broken Hill.
21 And so a lot of that service - working on what services we
22 provide and how they are provided has been done in
23 conjunction with planning for those new facilities.
24
25 MR GLOVER: Has any of the planning on the services that
26 are to be provided and where they are to be provided at
27 a strategic level involved an assessment of the health
28 needs of the communities in which those services are to be
29 deployed?
30
31 MS PEARCE: That would certainly be a component of - we
32 would do that.
33
34 THE COMMISSIONER: Could I just go back to what you said
35 about Wilcannia and dialysis?
36
37 MS PEARCE: Yes.
38
39 THE COMMISSIONER: And which you described as a gap in
40 service provision.
41
42 MS PEARCE: Mmm-hmm.
43
44 THE COMMISSIONER: You say "we're looking at" - I assume
45 that is the board is looking at - "what we can do to
46 rectify the gap, and that has taken quite a bit of work".
47 At a practical level, so I understand it, what is required

1 to fill that gap of dialysis at Wilcannia?
2
3 MS PEARCE: So our renal medicine is overseen through
4 Royal Adelaide Hospital, so it is having engagement with
5 them on the viability of running a service at Wilcannia.
6 It is a remote community. It is two hours from Broken
7 Hill. It's also - this might seem like a detour so
8 I apologise, but there are gaps quite often in our data,
9 because people will move away when services aren't
10 available to be delivered. So if we look at how many
11 people currently living in the community are on dialysis,
12 the numbers are really small, but anecdotally, through
13 discussions with the community at Wilcannia, through the
14 knowledge our board members have and, of course, through
15 our staff, we know of a number of people that have left the
16 area to be able to receive dialysis, and we also know of
17 a number of people that have elected not to commence
18 dialysis.
19
20 THE COMMISSIONER: Just to give you some background, it is
21 one of the things we were told when we went out to
22 Wilcannia, "We need a chair for our community."
23
24 MS PEARCE: Yes. There is also - dialysis is quite
25 a complex service to deliver in terms of the infrastructure
26 needs - so the water and a whole heap of other things that
27 I am not an expert in.
28
29 THE COMMISSIONER: Sure.
30
31 MS PEARCE: So looking at that. So we've had - we've
32 worked with groups that operate remote dialysis services in
33 the Northern Territory, for instance, who have been
34 advising the executive; Sydney LHD have provided some
35 expertise on how we could go about that service. But
36 I think if you asked what, as a board, we are passionate
37 about, this is exactly the type of thing that we are very
38 focused on, where our community that live remotely have
39 really serious health conditions and how can we better meet
40 the needs of those communities in the place where they
41 live. It's - achieving an outcome for dialysis at
42 Wilcannia will be a really significant thing for our
43 organisation, I believe, if we can achieve that.
44
45 THE COMMISSIONER: The chairs that are going to go in at -
46 right, okay. Can I ask another question about a service
47 gap, while we're on this topic, and I will ask Mr Files,

1 but please feel free to add anything you would like to,
2 Ms Pearce.
3
4 One of the things we were told more than once on our
5 site visit was there is a bit of a gap with particularly
6 mental health and perhaps just guidance services for young
7 Aboriginal men. This was something we were told, well,
8 both at Wilcannia and Menindee, but the main conversation
9 was at Wilcannia, that there are services, as there need to
10 be, for women; there is a shelter, assistance escaping from
11 violence, that that sort of thing is all necessary, but
12 there is not the same provision of a kind of
13 guidance/mental health service for young Aboriginal men to
14 go somewhere if they are not willing or don't want to
15 approach a direct health service, to go somewhere where
16 there is a counsellor, a safe space to talk to
17 a counsellor, to talk to Elders. Is that sort of gap
18 something that's across your radar, that you are aware of?
19
20 MR FILES: Definitely, yes. That's a real issue. And, if
21 I can - I would like to speak more broadly than my role as
22 a board member also.
23
24 THE COMMISSIONER: Yes, please go ahead.
25
26 MR FILES: Because I've worked in the health system in the
27 Far West for two decades and when I moved to Broken Hill -
28 I commenced in my home town, Menindee, which is
29 100 kilometres east of Broken Hill, and then came to Broken
30 Hill and provided medical services weekly from the ACCHO
31 sector, which was funded by the LHD to set up a more
32 engaging model of care around social and emotional
33 wellbeing. So that was back in 2005. And, to my
34 knowledge, that agreement still stands with the LHD and the
35 ACCHO sector.
36
37 In terms of the LHD, they provide a counselling
38 service to the outreach communities - with Wilcannia
39 weekly - and, of course, like many mainstream models, not
40 engaged very well with by First Nations communities for
41 a number of different reasons. But, speaking more broadly,
42 there have been attempts in the health system, especially
43 the ACCHO sector, to engage better. There's been kind of
44 engagement around healing programs, which are designed
45 specifically via feedback from our communities, in our
46 region, Wilcannia, Menindee and Broken Hill. In fact, it
47 was a partnership between the ACCHO and the University of

1 New South Wales.
2
3 Within that approach, with the healing program
4 approach, it's a - and I will use the words "hit and miss"
5 also - depending on community members' readiness, if you
6 like, and that's been a dialogue that has been happening in
7 our region and --
8
9 THE COMMISSIONER: On the topic I've raised with you that
10 we're discussing, if - funding is always an issue, but if
11 it wasn't an issue, what would you like to see done and
12 what do you think would work, or might work?
13
14 MR FILES: I think it's a stepped-out kind of approach.
15 Certainly a healing program would work for many of our
16 community that require cultural sensitivity and, for some
17 people, a psychologist will work, and for others, it's more
18 around the social determinants issues we've got in our
19 communities.
20
21 THE COMMISSIONER: You see, I got the impression, which
22 might be imperfect but it is the impression I got, that
23 with the troubles in particular that the young men were
24 facing, that I was being told about, that there is a mix of
25 issues - that it's relationship problems with their
26 partners; it's drugs; it's alcohol; there are employment
27 issues, and then there is the range of colonisation-type
28 issues, all mixed together perhaps. Is that probably - is
29 that a reasonable summary and is what you are talking about
30 as a possible solution something that could address that in
31 a holistic way?
32
33 MR FILES: I think so. I think it's very much requiring
34 a holistic approach. It certainly needs more than
35 a specific area like mental health services to address,
36 which is why I've said social determinants. But in saying
37 that also, the community - I mean, these are issues that
38 community have spoken of for decades, and often the data
39 doesn't equate to that demand of that feedback from
40 community.
41
42 THE COMMISSIONER: Is that the sort of data problem that
43 Ms Pearce was kind of talking about?
44
45 MR FILES: Partly is the data, it's not being captured.
46 And, as a First Nations person, I share this information
47 that often we don't share with the system those challenges,

1 so it's not being captured. A lot of us don't share data
2 at all. Like, we're not on the electoral roll, we're not
3 in the census, and mostly, people have reverted to that
4 clan group support mechanisms, which with, as you have
5 mentioned, the substances such as drugs and alcohol and
6 that becoming highly prevalent, comes with that a lot of
7 high distress on those family support mechanisms and, of
8 course, the families who have had enough will be the ones
9 that will be the first to say "This is enough", like,
10 "Surely there is something in this medical model that can
11 address these issues".
12
13 In saying that, if we think of the traditional mental
14 health services that we're providing, it's because we have
15 ample research to say that it benefits the wider
16 population. We're yet to actually kind of capture what is
17 benefiting the First Nations population, and so I suspect
18 that there is - there is, I guess, from me, from a First
19 Nations perspective, I trust my families when they say "We
20 need this", because just because it's not in the evidence
21 base of the system, the voices still need to be heard.
22
23 So what you are hearing is a real issue, and that's -
24 I mean, I come from a very large extended family, number
25 16th descendant of 200 descendants of my grandmother, and
26 so I see it within my own clan group also.
27
28 MR GLOVER: Mr Files, can I just build on that last answer
29 where you have highlighted the challenge in perhaps the
30 assessment of needs within the community and that
31 data-driven aspect. Is there anything that you consider
32 could be done differently or enhanced mechanisms to better
33 capture those needs within First Nations communities that
34 would then assist the board in the setting of the strategic
35 direction?
36
37 MR FILES: I mean, it's multifaceted. If I can give an
38 example from the board to try and describe something that
39 is influencing influencers within the system. So at our
40 board, I provide a welcome each meeting, like I did today,
41 and shared the reasoning for it so that people can have
42 a better understanding that a First Nations perspective has
43 value systems attached to it, and so now we've gotten to
44 a point where my colleagues will do an acknowledgment, and
45 we're rotating each month, and that provides an opportunity
46 for my colleagues to really reflect from a First Nations
47 perspective and start to own the challenges that are faced

1 by First Nations.
2
3 Prior to me witnessing this on this board, it was
4 a constant sharing and advocating for that First Nations
5 perspective, where influencers often did not hear or
6 understand the message that's trying to be communicated.
7 So what I'm suggesting is that it really involves
8 engagement from different influencers, whether they are on
9 a board, in a governing structure, or whether they are at
10 an executive level, and through our committee, the
11 Aboriginal health and workforce committee, I've also
12 witnessed a growth - my words and my perspective - in more
13 engagement from our different executive members that are
14 now having - feeling safer and having more conversations
15 about what their directorates can do for Aboriginal health.
16
17 So I guess, to sum that, often it's intangible until
18 you start to engage and start to see the tangibility of
19 people actually having buy-in to those challenges, and it's
20 no different to any minority group, whether it's
21 a disability group, whether it's a mental health group or
22 it's a First Nations group. Unless you have buy-in from
23 the influencers, often people abdicate responsibility or
24 full understanding in their roles where they can influence
25 until that voice is starting to be heard and they are being
26 included in that.
27
28 MR GLOVER: Is this the issue that you raise in
29 paragraph 10 of your outline? In particular, about halfway
30 down, you say:
31
32 *I'm aware that many of my colleagues with*
33 *decision-making roles have often left First*
34 *Nations business up to those holding First*
35 *Nations identified positions.*
36
37 MR FILES: Most definitely, and that's two decades in the
38 health system in our region, that often, the collective
39 that have influence can often abdicate any engagement
40 towards. And the rhetoric is used, I might add, from
41 colleagues that "Yes, we will do what we can, we will do
42 what we can". Unless they actually have an understanding
43 and be more engaged around those challenging issues, and
44 it's very difficult to get that buy-in or any understanding
45 of any motivation or encouragement to move in.
46
47 So, as I have said, moving from an intangible, where

1 people - and the feedback from my colleagues on the board,
2 one in particular, "I've heard the welcome being said
3 often, but it's just become part of the furniture. It's
4 just something that just now happens", as opposed to having
5 the opportunity to do an acknowledgment, "Oh, okay, this
6 is ... ", so they have had self-reflection, become
7 self-aware and are providing more engagement around, in
8 this case, Aboriginal health.
9
10 MR GLOVER: And that comes from an increased understanding
11 of the community and the issues facing that community?
12
13 MR FILES: That's correct, and the dialogue and having the
14 safe space within our board to actually speak freely.
15
16 MR GLOVER: In addition to members of the community like
17 yourself, who can assist in engagement and knowledge
18 building, is there benefit in more regular and formalised
19 relationships with those providers of health services
20 within First Nations communities, say, for example,
21 Maari Ma?
22
23 MR FILES: Yes. So it's engagement. It's relationship
24 building. It's feeling safe to do so. And I've been on
25 the board two years, and a good 12 months had passed before
26 my colleagues even felt ready to do an acknowledgment from
27 a point where, once upon a time, they didn't. So these
28 are - it's longer standing relationships that are required
29 for that engagement.
30
31 Certainly, from an Indigenous perspective within our
32 communities, we have community members that will vouch for
33 different service provision and say "That's actually
34 a really good doctor, go and see them", or "That's a really
35 good nurse", and so that information can be shared, but
36 unless someone actually takes their role seriously and
37 engages to get that perspective - that's where we'll see
38 the outcomes.
39
40 MR GLOVER: Can I take you, Mr Files, to paragraph 14 of
41 the outline. This is the paragraph that you corrected this
42 morning.
43
44 MR FILES: Yes, amended, yes.
45
46 MR GLOVER: I think the correction was that the board
47 intends to meet regularly with Aboriginal community

1 controlled health organisations. Is the one you are
2 referring to Maari Ma, or is it someone else?
3
4 MR FILES: So we have two ACCHOs in the region, one down
5 south and Maari Ma Health. That's our intent. The LHD
6 wants to engage.
7
8 MR GLOVER: Has there, to your understanding, been any
9 barriers to that engagement being established before now?
10
11 MR FILES: There's been a decade of - a longstanding
12 stand-off, if you like.
13
14 MR GLOVER: Do you have any understanding of what led to
15 the stand-off as you have described it?
16
17 MR FILES: I think it is a challenge. It is a challenge
18 because, as a First Nation perspective, and Maari Ma Health
19 very much are advocates, if not activists, for the
20 wellbeing of our First Nations community, and of course,
21 the LHD really is there for the whole community and I've
22 witnessed - I witnessed the two work really well together
23 and then I've witnessed the two break down in their
24 relationship.
25
26 I think we're at a point where both would like to see
27 the best outcomes for the whole community. Certainly
28 Maari Ma Health is - they provide services to the whole
29 community in our remote communities, and have an extensive
30 list of the wider population on their Broken Hill
31 Aboriginal Medical Service also.
32
33 MR GLOVER: Ms Pearce, if I can take you to paragraph 23
34 of your outline.
35
36 MS PEARCE: Yes.
37
38 MR GLOVER: There you tell us that the LHD and the board
39 maintain relationships with a range of other providers,
40 including the RFDS, Maari Ma, et cetera. Do you see that?
41
42 MS PEARCE: Yes.
43
44 MR GLOVER: Then, about just prior to halfway down that
45 paragraph, you say:
46
47 *The focus of the Board is ensuring services*

1 *are provided by the most appropriate*
2 *organisation and duplication of services is*
3 *limited.*
4
5 Do you see that?
6
7 MS PEARCE: Yes.
8
9 MR GLOVER: How does the board achieve that aim in its
10 work?
11
12 MS PEARCE: I think one of the challenges we have, which
13 you have probably heard many times during your visit, is
14 the shortage of staff that we have. So I think, from
15 a board perspective, it is really important, and in the
16 meetings I've had with our partners - so be it Mildura; we
17 have met with Maari Ma, it was great, in an informal
18 setting; we've had the first board meeting, boards getting
19 together, which was really good, and they raised it as
20 well - we want to look at what the services are that need
21 to be provided and then work out, well, who out of the
22 variety of organisations is best placed to do that.
23
24 I think it's done as part of that service planning
25 that we were talking about before. If we identify a gap or
26 an opportunity to provide enhanced services, it doesn't
27 have to be that the LHD provides every service. So an
28 example might be Mission Australia, who are providing the
29 Safe Haven cafe. They've got the requisite skills,
30 experience, knowledge, and they are doing a really great
31 job of providing that service in our LHD.
32
33 So it's about making sure that we're communicating to
34 the chief executive and the executive that when they are
35 setting up these arrangements, we want to work with our
36 partners, and particularly with our First Nations
37 communities, it is very understandable why some of those
38 communities want to receive care from Aboriginal-controlled
39 organisations.
40
41 MR GLOVER: Are you aware of any work being done by the
42 LHD towards this goal - that is, the coordination of
43 services delivered by the LHD and other service providers
44 within the region?
45
46 MS PEARCE: Sorry, I just missed the end of that question.
47

1 MR GLOVER: Yes. In that answer, you referred to the
2 delivery of the aim of ensuring services that are provided
3 by the most appropriate organisation and duplication of
4 services being minimised is one that is taken up in the
5 service planning process.
6
7 MS PEARCE: Yes.
8
9 MR GLOVER: Are you aware of any work that is being done
10 within the LHD towards that coordination of services with
11 other service providers?
12
13 MS PEARCE: I'm aware of one that was completed reasonably
14 recently where we felt that the current arrangements we had
15 in place for dental services weren't appropriately
16 delivering to our community and a considerable amount of
17 effort was put in to looking at those services. We
18 renegotiated our arrangements with the RFDS and they are
19 providing dental services across a number of our
20 communities and we've also entered into an arrangement
21 where we can access dental clinicians and hygienists and
22 various other trainee dentists - sorry, student dentists
23 through Sydney LHD, who also run the dental hospital in
24 Sydney.
25
26 So that's an example of looking at a very challenging
27 area to recruit staff out into the Far West. If we'd tried
28 to go and recruit dentists, it would have been quite
29 challenging. RFDS were able to provide those services and
30 they provide them not just to our facilities but also,
31 I understand, to Maari Ma.
32
33 MR GLOVER: That's an example of a particular service gap
34 that has been identified. What about at a broader level?
35 Are you aware of any work that has been done to analyse
36 across the district the services that are needed, the
37 services that are being provided by each of the other
38 providers within the region, as a baseline to then attempt
39 to coordinate the services in the way that you have
40 described in your outline?
41
42 MS PEARCE: So I think that's part of the work we're
43 looking at doing with the PHN, and we've set up a joint
44 board subcommittee with both, attended by both chief
45 executives. We've only had an initial meeting, but that
46 service plan was clearly to be a top priority, for our
47 organisations to work together. The PHN are well placed,

1 with some of the skills and knowledge, in doing that sort
2 of work.
3
4 MR GLOVER: Mr Files, in the answers just given by
5 Ms Pearce, the example of dental services was raised. Are
6 you aware of particular barriers or challenges to First
7 Nations people accessing dental services within the
8 district?
9
10 MR FILES: Yes. Multiple, actually. I guess in terms of
11 service provision, like I've already outlined, a lot of
12 service provision is - and engagement of those services -
13 are determined by who is providing services and so
14 sometimes that could be a service provider, or it could be
15 a personality employed by the service provider, and so
16 I guess the challenge for our remote communities is that
17 often they will travel, if they don't - if they miss an
18 appointment. I guess it goes back to what I shared
19 previously. There are social challenges, daily distressors
20 that often, as First Nations, we're not prioritising health
21 issues because there are more pressing, immediate issues
22 that can come in under the umbrella of poverty or other
23 daily distresses.
24
25 MR GLOVER: What about the manner in which the services
26 are structured and delivered? Is that also potentially
27 a barrier to access for First Nations people?
28
29 MR FILES: It can be because of - sometimes the schedule
30 of those services can often be reliant upon individuals
31 providing that service.
32
33 MR GLOVER: Can I raise with you one example that has come
34 to the attention of the Inquiry and it involves the need to
35 call a 1800 number to --
36
37 MR FILES: That's correct, from Dubbo.
38
39 MR GLOVER: You are aware of the number. One of the
40 issues that has been raised with the Inquiry is that that
41 mechanism of accessing and arranging dental services is one
42 that is not - doesn't resonate in First Nations
43 communities, such that --
44
45 MR FILES: Prefer to have a face-to-face.
46
47 MR GLOVER: Is that something you are aware of?

1
2 MR FILES: Yes.
3
4 MR GLOVER: How might that be overcome, in your view?
5
6 MR FILES: It's - well, providing the opportunity for
7 community to access more easily is - most definitely.
8 Sometimes that may not mix with some of those reasons that
9 Sally's given, that recruiting or having that kind of
10 expertise more easily available can be a challenge. And
11 also, I mean, it's, once again, relationships as well. If
12 people - that's an emergency number that you mentioned and
13 so that requires kind of making a phone call to another
14 community outside the region that then kind of get you to
15 make your own appointment with a mainstream service, and
16 that mainstream dental service would often not be familiar
17 to First Nations, of where they go or where they know
18 people, and so certainly it's important that people feel -
19 from a First Nations perspective, feel more familiar with
20 the environment that they are visiting.
21
22 MR GLOVER: Mr Files, can I take you to paragraph 11 of
23 your outline. There you tell us, as part of the work of
24 the Aboriginal health and workforce committee, one of its
25 main functions is to determine where value can be added
26 within the Aboriginal workforce. Do you see that?
27
28 MR FILES: Yes.
29
30 MR GLOVER: And how members of the workforce can be best
31 distributed to support relationship with the community. Do
32 you see that?
33
34 MR FILES: Yes.
35
36 MR GLOVER: How, in practice, does the committee, and
37 through the committee, the LHD, go about achieving that
38 aim?
39
40 MR FILES: If I go back to what I've mentioned before,
41 it's shifting from an intangible kind of engagement with
42 our executive to a tangible engagement. So having the
43 executive feel more confident and comfortable and safe to
44 speak about some of these issues, to get them to a point of
45 engagement and solution focused around some of the barriers
46 that are faced by First Nations. I mean, last week we had
47 our committee meeting and we got to a point where

1 a position in our emergency department contract is finished
2 and our executive director had suggested at that committee
3 meeting for want of a practical or pragmatic approach, the
4 position is an unidentified position and has been filled by
5 a non-Indigenous person at the emergency department that
6 supports patient flow, that supports people that come in to
7 the emergency department and, once again, very encouraged
8 to hear the director of clinical services say "This is
9 a position that we can identify", to have a First Nations
10 person be that patient flow for better engagement or more
11 familiarity for First Nations communities, and of course,
12 the peoples and culture executive, who was present "Oh, I'm
13 on to that. I will do that as well".
14
15 MR GLOVER: Does part of that work involve, or will it
16 involve, coordination with some of the First Nations
17 providers within communities to deploy the resources in
18 those communities in a strategic way?
19
20 MR FILES: I will get you to repeat the question.
21
22 MR GLOVER: Yes, it wasn't very clear. Does part of the
23 work of the committee - sorry, Mr Files, I just lost my
24 place - determining where value can be added within the
25 Aboriginal workforce and how members of that workforce can
26 be distributed to support the community --
27
28 MR FILES: Yes.
29
30 MR GLOVER: -- will that involve engagement with, for
31 example, Maari Ma, about the deployment of Aboriginal
32 health workforce across the community to align the
33 objectives of both the LHD and those service providers?
34
35 MR FILES: Most definitely. I mean, in my work life in
36 the health system, I've witnessed both the LHD be engaged
37 in a partnership with the ACCHO to provide the most
38 culturally safe accessible service by employing Aboriginal
39 health workers, and then we have site-specifics where
40 Maari Ma, through their leverage of kind of attracting
41 Commonwealth funds, also are able to engage the LHD to
42 provide or to employ Aboriginal health workers.
43
44 MR GLOVER: And that feeds into the work Ms Pearce was
45 referring to earlier about working with other agencies and
46 providers to ensure --
47

1 MR FILES: Yes. The LHD - well, actually, all health
2 providers in the region have attempted to do it and, of
3 course, can improve with all of that also, on all fronts,
4 all health providers.
5
6 MR GLOVER: Ms Pearce, can I turn to you and direct you to
7 paragraph 56 and following of the outline where you address
8 a number of challenges of current funding models. Do you
9 have that?
10
11 MS PEARCE: Yes.
12
13 MR GLOVER: If we start at paragraph 56, you tell us that
14 the current funding model doesn't provide funding beyond
15 the current financial year and you express the view that
16 a three-year or a three-year rolling service agreement
17 would provide greater certainty. Do you see that?
18
19 MS PEARCE: Yes.
20
21 MR GLOVER: Apart from providing certainty to staff and
22 certainty for recruitment, are there other benefits to
23 a three-year funding cycle that you see?
24
25 MS PEARCE: I think it would also allow for better
26 planning and to take a slightly longer view on a number of
27 projects. So when you operate within a 12-month service
28 agreement, a 12-month budget focus, there is sort of an
29 assumption that everything magically finishes in June and
30 starts again in July. That's not really the way things
31 work. So just being able to take a longer perspective,
32 have longer-term planning that is actually aligned to
33 funding I think is just much more conducive to better
34 strategic and operational delivery.
35
36 MR GLOVER: Would that type of arrangement also provide
37 the board with perhaps greater freedom to support the
38 implementation of innovation or new models of care
39 delivery?
40
41 MS PEARCE: Absolutely; that's correct, yes. So we really
42 don't know until the service agreement is issued in June,
43 normally - occasionally later - what our savings target
44 will be, or if we'll get any growth funding, and I say that
45 with a little bit of a smile because Far West doesn't
46 traditionally get growth funding, we're not a growing
47 community. So we're not really sure of will we have any

1 capacity to actually go out and make change and try new
2 things and do new services.
3
4 So most of the things you will hear talked about by
5 the district today in terms of the innovations we are
6 doing, a lot of them are done from within our existing
7 funding envelope, and often from making - moving this bit
8 of money and seeing if we can get that changed to allow us
9 to use it for this purpose. It's not just that our funding
10 is one year, it's also that sections of it are very tightly
11 controlled for specific purposes. So having some
12 flexibility to take a longer time horizon and be more
13 innovative in how we approach making our services more
14 efficient and more responsive to the community, I think it
15 is an intangible benefit but would be a definite one.
16
17 MR GLOVER: Mr Files, I saw you nodding along. Is there
18 anything that you would wish to add to that answer?
19
20 MR FILES: Of course any longer-term funding agreements
21 would suit kind of the - well, it would keep programs and
22 projects alive longer for further engagement with
23 community, but also, it would attract - it would be more
24 attractive to people wanting to apply for the roles as
25 well.
26
27 MR GLOVER: When you refer to attractiveness of people
28 wanting to apply for roles, is the issue you are referring
29 to one where roles may be established for the
30 implementation of an initiative, but with only short-term
31 funding there is no guarantee of ongoing employment?
32
33 MR FILES: That's correct.
34
35 MR GLOVER: Ms Pearce, if I can take you to paragraph 57.
36
37 MS PEARCE: Yes.
38
39 MR GLOVER: There you tell us that the ministry allocates
40 revenue budgets on a historical basis. In the sentence,
41 you say:
42
43 *An equitable model reflecting each LHD's*
44 *revenue capacity would be preferable.*
45
46 Can you just explain to the Commissioner what you are
47 referring to there?

1
2 MS PEARCE: That's correct. So different LHDs have very
3 different ability to raise revenue. One of the main
4 sources in revenue across health is patient fee revenue,
5 which is dependent on people having private health
6 insurance, so in communities like ours, those rates are
7 significantly lower than in some other LHDs.
8
9 There is also commercial revenue opportunities, so
10 I almost dread to say the word publicly, but we don't
11 charge for car parking, for instance, at our facilities out
12 here, so I think we currently have a deficit of about,
13 I think it's a bit over $2 million a year in our revenue
14 budget that we're given by the ministry. Our director of
15 finance will be speaking today and can speak more
16 specifically on this, but we do have - we did invite the
17 ministry out to come and identify areas where we were
18 missing opportunities for revenue, and I think they came up
19 with about $50,000.
20
21 MR GLOVER: So do I take it from that answer, in your
22 view, the current allocation of the revenue budget doesn't
23 take into account, at least sufficiently, the practical
24 realities of life in this district?
25
26 MS PEARCE: That's correct. That's absolutely correct.
27
28 MR GLOVER: Can I ask you next about paragraph 61, please.
29 There you raise the issue of remoteness categorisation.
30
31 MS PEARCE: Yes.
32
33 MR GLOVER: Is there any work that you are aware of being
34 done to try and address this particular issue?
35
36 MS PEARCE: I think it's an issue that unifies everyone
37 that operates out of Broken Hill. I think we're all aware
38 of it. It's something that I've become more aware of since
39 stepping into the role of chair, just how pervasive this
40 issue is in impacting so many areas of government funding.
41 So I think we are about to start working in that space and
42 I would very much like to be advocating with a range of
43 other health providers, and I think the council may have
44 mentioned that as well.
45
46 THE COMMISSIONER: I don't know the answer to this: how
47 do you get it changed? Is it just an administrative

1 decision-maker?
2
3 MS PEARCE: Yes. So what I did discover is that we are
4 granted an exemption - and I will just go back, I think
5 it's for the doctors of areas of workforce shortage, for
6 the medical practitioners. There is actually an exemption
7 granted to Broken Hill that says it's included in that and
8 it's considered remote for that purpose. So this is -
9 I mean, the Australian Statistical Geography Standard is
10 managed by the ABS and then there is another model based on
11 that called Modified Monash, which the Department of Health
12 and Aged Care in the Commonwealth look at. So I think we
13 will be going through, via the ministry, and seeking to
14 have a conversation with the Department of Aged Care.
15
16 THE COMMISSIONER: Has the ministry told you they think
17 Broken Hill should be categorised as something other than
18 3, and are they doing anything about it?
19
20 MS PEARCE: Not to my knowledge, but I'm not certain that
21 we have strongly advocated with the ministry either.
22
23 THE COMMISSIONER: What's your own opinion? Is your
24 opinion that Broken Hill's remote?
25
26 MS PEARCE: Absolutely.
27
28 THE COMMISSIONER: It is the outback.
29
30 MS PEARCE: We're 500 kilometres from the nearest tertiary
31 hospital. There is absolutely no way that this is the
32 same - and I give the examples in my statement. We are not
33 Bowral or Blackheath in the Blue Mountains. We are more
34 remote than Byron Bay, which is considered more remote
35 under Modified Monash Model than here, and, you know,
36 I have particularly raised it for Broken Hill. It equally
37 applies for the Two Rivers area, so Buronga, Dareton and
38 Wentworth.
39
40 MR GLOVER: Finally, Ms Pearce, can I ask you briefly
41 about a couple of observations you make regarding the ABF
42 model?
43
44 MS PEARCE: Yes.
45
46 MR GLOVER: In paragraph 59, you observe that the ABF
47 model is based on the quantum of services, and then you

1 say:
2
3 *It does not specifically address the level*
4 *of need within each community and the*
5 *services required to meet that need.*
6
7 Do you see that?
8
9 MS PEARCE: Yes.
10
11 MR GLOVER: Why do you say that?
12
13 MS PEARCE: So activity-based funding is an output model
14 and it is entirely based on the services delivered. So
15 we - I don't know of a mechanism for health funding that
16 adequately is able to identify the needs of a community,
17 their level - I mean, Justin has spoken beautifully about
18 the social determinants of health. We know that the health
19 outcomes for our community is well below that of other
20 parts of New South Wales. That's just the reality that we
21 operate in. We know that we have specific challenges out
22 here. I don't know that there is a funding model that is
23 able to capture that and say "Oh, here is the portion that
24 you deserve to be funded", but I think there should be some
25 mechanism statewide where that - we can start looking at
26 that and start funding based on bringing all our
27 communities up to a minimum standard.
28
29 I can give a specific example where I have gone
30 looking for something in a previous role and been unable to
31 find it, and that is our specialist outpatient services.
32 I did approach the ministry and say, "What is the base
33 level? How do we determine what outpatient services an LHD
34 should have?" - you know, as a sort of base level, or
35 what's excessive, or how we should frame looking at that,
36 and I was told that that hadn't actually been done, that
37 work hadn't been done.
38
39 So there is significant variation, and it's really
40 historic. So a number of our metro - even if you looked at
41 metropolitan hospitals, they would have a very different
42 mix of outpatient clinics. And then, of course, for us,
43 it's often been around our ability to attract and retain
44 clinical - clinicians to provide those services.
45
46 MR GLOVER: Whether or not there is a particular model
47 that currently exists that addresses it is perhaps one way

1 to meet the issue that you are raising to first identify
2 the need within the community?
3
4 MS PEARCE: Yes.
5
6 MR GLOVER: Then identify the resources required to meet
7 that need; correct?
8
9 MS PEARCE: Yes.
10
11 MR GLOVER: And then allocate a budget envelope directed
12 to the delivery of those resources to meet the need in a
13 place-based way?
14
15 MS PEARCE: Absolutely.
16
17 MR GLOVER: Mr Files, do you wish to add --
18
19 MR FILES: Yes, no, I agree with what you've just summed
20 it up as.
21
22 MS PEARCE: I think what we have seen over the last - over
23 my period on the board through to now is we've done a huge
24 amount of work in improving quality and safety of the
25 services we provide and the safety of our staff in
26 providing those services, and in that I'm particularly
27 looking at a lot of the work done with Sydney LHD, and that
28 has now positioned us to be looking at that place-based
29 planning, at the service gaps, and really advocating for
30 our communities with the ministry, with partner
31 organisations, to come up with innovative ways to lift the
32 health outcomes for our communities.
33
34 MR GLOVER: This is work that is going forward?
35
36 MS PEARCE: Yes.
37
38 MR GLOVER: Thank you. I have no further questions for
39 these witnesses.
40
41 THE COMMISSIONER: Can I just ask Ms Pearce if you could
42 go back to paragraph 25 of your statement. You did touch
43 on this briefly in your evidence, but just so I understand
44 it, the joint committee that has been established with the
45 primary health network, where it says - which it meets
46 quarterly, that that's the plan going forward, that there
47 will be quarterly meetings --

1
2 MS PEARCE: Yes.
3
4 THE COMMISSIONER: And you say a work plan is currently
5 under development, but I'm not sure I've got a full
6 understanding of what it is that - what work is going to be
7 done and what's hoped to be looked at and achieved through
8 this joint committee.
9
10 MS PEARCE: I wouldn't say that we have absolute clarity
11 after one meeting, either, but I think an initial --
12
13 THE COMMISSIONER: Let me - sorry to interrupt, but let's
14 go back to the beginning. What caused the establishment of
15 the joint committee?
16
17 MS PEARCE: So I think we had a clear need that it's for
18 the benefit of the communities we serve that the LHD and
19 the organisation representing primary health work
20 collaboratively to identify the gaps in services across our
21 community and also work collaboratively to support the
22 provision of primary care in our district.
23
24 THE COMMISSIONER: And was the establishment of this
25 committee or the idea to establish it - did that happen
26 shortly before February this year?
27
28 MS PEARCE: Yes. We had an initial meeting with the CE
29 and chairs and - in that discussion.
30
31 THE COMMISSIONER: Tell me if I'm wrong, but was
32 a reason - was one the key reasons for establishing this
33 committee the difficulties with access to primary care for
34 the community?
35
36 MS PEARCE: Yes, but I would say that access to primary
37 care has been a longstanding issue for this community.
38 It's not something they are experiencing for the first
39 time.
40
41 THE COMMISSIONER: So what were the other drivers for the
42 establishment of this committee?
43
44 MS PEARCE: I think we often talk about primary care and
45 it's seen as GPs, and that is often the focus in the media.
46 But I think it's the gaps in all of the primary care
47 providers, so both GPs, allied health and specialist

1 medical services. It's also - the primary care providers
2 are somewhat nebulous, so while we know many of the
3 services provided, we don't have that well documented, we
4 don't have it done in a way where we can look across our
5 communities and see where there are gaps or opportunities,
6 and I think having that detailed planning done at
7 a community level, and each of our communities are very
8 different, is absolutely critical, because otherwise, we
9 are making plans in the dark.
10
11 THE COMMISSIONER: And that's - you hope that's a core
12 part of this joint committee.
13
14 MS PEARCE: Absolutely.
15
16 THE COMMISSIONER: Okay. Can I also just ask you, just
17 for a clarification, on 34 of your statement?
18
19 MS PEARCE: Yes.
20
21 THE COMMISSIONER: Where you say in the second sentence:
22
23 *The RFDS is Commonwealth funded to provide*
24 *GP clinics across most of the LHD ...*
25
26 By that, do you mean that they can access the MBS, or are
27 you saying they've got a specific funding for GP clinics
28 from the Commonwealth?
29
30 MS PEARCE: I understood they had an agreement with the
31 Commonwealth as well, but I'm happy to take that out,
32 because I can't say with absolute certainty what the
33 arrangement is --
34
35 THE COMMISSIONER: I'm only asking what you meant by it,
36 that was your understanding.
37
38 MS PEARCE: Yes, my understanding is that they do have an
39 agreement with the Commonwealth as they have with the state
40 government for retrieval and emergency services.
41
42 THE COMMISSIONER: All right. Anything coming out of
43 that?
44
45 MR GLOVER: Just one matter briefly. Ms Pearce, the
46 Commissioner directed your attention to paragraph 25 and
47 the establishment of the joint committee with the Western

1 New South Wales PHN in February of this year.
2
3 MS PEARCE: Yes.
4
5 MR GLOVER: In some of your answers earlier you have
6 referred to the desire of the board to establish
7 relationships with other providers, in part for the
8 purposes of more strategic planning and identification of
9 gaps in service provision; correct?
10
11 MS PEARCE: Yes.
12
13 MR GLOVER: Is there any reason why that work has not been
14 undertaken until now?
15
16 MS PEARCE: So I joined the board in September 2019 and
17 the world shifted during the COVID period, I think for
18 a number of years. We've come out of COVID and we've been
19 very much focusing on some improvements across the services
20 we're currently providing and making those - ensuring they
21 are working at the level they should be. And, in that,
22 I am particularly referring again to the work we've done
23 with Sydney LHD, and I think that has been reflected
24 recently in our accreditation process, which we passed with
25 no recommendations, which was an outstanding result, which
26 reflects the investment we've made into the safety and
27 quality of our existing services.
28
29 The focus, over the past six months, is now moving
30 more towards that engagement. I also think that our
31 current executive has stabilised, so for the first time
32 in - certainly since I've been on the board but
33 I understand for much longer, we have a stable executive
34 team, and that just dramatically increases your ability to
35 engage with community, to build the trusting relationships
36 with partners that Justin was talking about, and to develop
37 new models of care, look at new services that we may
38 provide.
39
40 MR GLOVER: I appreciate that there has been focus on
41 other work, but even with that focus, is there anything
42 that would have prevented the engagement with other
43 providers and the PHN for the purposes of establishing gaps
44 in service from being undertaken at the same time?
45
46 MS PEARCE: Well, I think we have identified - I mean,
47 I've spoken today about Wilcannia and dialysis - we have

1 been working with our partners and, in doing that, we just
2 haven't done it in the same structured way.
3
4 MR GLOVER: What was it about the COVID period that
5 provided a barrier to engaging with the PHN and Maari Ma on
6 these issues?
7
8 MS PEARCE: So I think it diverted focus into the
9 immediate needs of the pandemic and consumed considerable
10 amounts of executive time. There were also barriers,
11 physical barriers, with communities being shut down and
12 with a very strong sense of not wanting to put particularly
13 our remote communities at risk. We did have an outbreak in
14 Wilcannia as well during COVID that was concerning, but --
15
16 MR GLOVER: COVID told us that things can be done online;
17 correct?
18
19 MS PEARCE: Yes.
20
21 MR GLOVER: I have nothing further, Commissioner.
22
23 THE COMMISSIONER: All right. Thank you. Do you have any
24 questions, Mr Cheney?
25
26 MR CHENEY: No, Commissioner, nothing, thank you.
27
28 THE COMMISSIONER: Thank you both very much for your time.
29 We're very grateful. You are excused.
30
31 **<THE WITNESSES WITHDREW**
32
33 MR GLOVER: Is that a convenient time, Commissioner?
34
35 THE COMMISSIONER: It is. So we'll adjourn until 11.30.
36
37 **SHORT ADJOURNMENT**
38
39 THE COMMISSIONER: Yes, Mr Fraser?
40
41 MR FRASER: Commissioner, the next witness is Dr Sarah
42 Wenham, on who I call, who is located in the witness box.
43
44
45
46
47

1 **<SARAH WENHAM, sworn:** **[11.33am]**
2
3 **<EXAMINATION BY MR FRASER:**
4
5 MR FRASER: Q. Dr Wenham, could you please give your
6 full name?
7 A. Sarah Elizabeth Wenham.
8
9 Q. Dr Wenham, you are currently the executive director of
10 medical services for the Far West Local Health District; is
11 that correct?
12 A. I am, yes.
13
14 Q. Dr Wenham, you have prepared an outline of evidence in
15 anticipation of coming here today. Do you have a copy with
16 you?
17 A. I do, yes.
18
19 Q. Have you read through that prior to giving evidence
20 today?
21 A. I have, yes.
22
23 Q. For the record, that's [MOH.9999.1256.0001]. Having
24 read through that, and prepared it, are you satisfied that
25 it's true and correct?
26 A. I am, yes.
27
28 MR FRASER: That will form part of the bulk tender in due
29 course, Commissioner.
30
31 THE COMMISSIONER: Yes.
32
33 MR FRASER: Q. Just firstly, you were appointed to your
34 role as executive director of medical services in March of
35 last year; is that correct?
36 A. Correct, to the substantive position, yes.
37
38 Q. And you had acted in that role for six months prior?
39 A. Correct, yes.
40
41 Q. By way of clinical background, you are a palliative
42 care senior staff specialist; is that right?
43 A. Yes.
44
45 Q. And we might deal with that aspect first. How long
46 have you lived and worked in Broken Hill?
47 A. So just coming up to 12 years in August of this year.

1 We moved and I have worked for the Far West LHD
2 since November 2012.
3
4 Q. When you came here to work for the LHD in 2012, that
5 was as a specialist palliative care physician?
6 A. Correct, yes.
7
8 Q. Prior to taking on the role as executive director,
9 medical services, did you hold a full-time appointment as
10 a - position as a senior staff specialist?
11 A. Yes, I did. So when I first moved in 2012 I worked
12 part time and then in 2016 became full time and remained
13 full time as the senior staff specialist in palliative care
14 until taking on this position.
15
16 Q. I think what you say in your outline at paragraph 12
17 is in the palliative care team, when you joined it, you
18 were the first permanent doctor in that team?
19 A. Correct, yes. So they had had some support from
20 Adelaide previously, on an ad hoc basis, but I was the
21 first permanent member of the team from a medical
22 perspective, yes.
23
24 Q. And throughout your time, were there other permanent
25 members of the team, as doctors, that is?
26 A. So no, I've been the only permanent member of the team
27 at a staff specialist level. We have had junior doctors
28 that joined the team on a rotational basis from Concord and
29 we have had a number of GP advanced skills trainee
30 registrar positions that came in for six to 12 months at
31 a time for a training program.
32
33 Q. I think what you say in your statement is since your
34 appointment as executive director, medical services, you
35 have maintained a fractional appointment in the clinical
36 role as the senior staff specialist in palliative care; is
37 that right?
38 A. Correct, yes. So I still do a little bit of work on
39 the inpatient unit in Broken Hill and I contribute to the
40 on-call roster for the whole of the district.
41
42 Q. And that's a 0.1?
43 A. Yes, in theory, yes.
44
45 Q. FTE in theory?
46 A. Yes. But the reality is we do have a full-time locum
47 that has taken over from my substantive clinical position,

1 so I suppose, depending on their - on the acuity of the
2 patients that are being seen at the time, sometimes it's
3 more appropriate for them to see the inpatients rather than
4 me to provide that continuity of care, and particularly
5 obviously if things are busy in the executive director
6 role. So it would be a maximum of 0.1, but sometimes it is
7 a little bit less, sometimes it's a little bit more. We
8 have had a gap in the clinical roster so I've taken on that
9 gap for a few days because we had - we couldn't get another
10 doctor in because of a locum sickness. So it's variable
11 depending on what the needs of the service are at the time.
12
13 Q. And you work - so is it fair to say you work a little
14 bit flexibly --
15 A. Absolutely.
16
17 Q. -- as you can, to assist in that regard, because you
18 are based here in Broken Hill?
19 A. Absolutely, yes. So I live and work here.
20
21 Q. And, of course, your executive director medical
22 services role is based at the hospital in any event?
23 A. Yes, so it is a district position, so it covers the
24 whole Far West Local Health District, but my office is
25 based at Broken Hill Health Service.
26
27 Q. If we just briefly stick with your background, may
28 I ask, as you have said in your statement, and as your
29 accent portrays, you are from the United Kingdom; is that
30 correct?
31 A. That is correct, yes.
32
33 Q. And you trained there?
34 A. Yes.
35
36 Q. You say that when you moved here - you moved here
37 12 years ago. What brought you to Broken Hill, just in a
38 general level?
39 A. So in a general level, my husband is a general
40 practitioner and he obtained a position with the Royal
41 Flying Doctor Service, based here in Broken Hill. So we
42 moved here together as a family.
43
44 Q. Is he still with the Royal Flying Doctor Service?
45 A. He worked for the Royal Flying Doctor Service for just
46 over four years. He now works - and during that position
47 he - it was a conjoint position with the university

1 Department of Rural Health, as the director of the clinical
2 medical stream. He's still in that role 0.5 and provides
3 private general practice here in Broken Hill on the other
4 0.5.
5
6 Q. Just going back to the palliative care service, it is
7 a service that covers the entire district, although it is
8 based here in Broken Hill?
9 A. So we have a number of different bases, so there is
10 the Broken Hill service and then there is a service that is
11 based out of Buronga PrimaryOne health service, which
12 covers the lower western sector, so that's Wentworth,
13 Dareton, Buronga and Balranald, and so we have two nursing
14 teams, one based here in Broken Hill and one based there,
15 but the medical service covers both of those teams.
16
17 Q. But in terms of where the medical service staff are
18 based, is that here in Broken Hill?
19 A. That's here in Broken Hill, yes, but we do travel out
20 to the district when that is required.
21
22 Q. So services to other parts of the district are
23 provided on an outreach basis by the medical staff?
24 A. Correct. But the nursing staff are based in the lower
25 western sector.
26
27 Q. And you have said in paragraph 13 that that service
28 currently has an accredited resident medical officer, or
29 RMO, on rotation from Concord Hospital, in partnership with
30 the prevocational training network?
31 A. Yes.
32
33 Q. Is that an arrangement that has been the case for some
34 time?
35 A. So I couldn't tell you the exact date, but it's
36 probably been about four years that we - at the time that
37 we got that accredited position. Prior to that, there was
38 no junior staff, medical staff, with the palliative care
39 team.
40
41 Q. We'll be returning to training of staff in a moment,
42 in your wider position. If we can move, therefore, to your
43 current role that occupies the bulk of your time, executive
44 director of medical services, at a broad level, that makes
45 you responsible for managing the medical workforce in terms
46 of ensuring there's - I think you have said in your
47 outline - medical support to all facilities across the

1 district?
2 A. Correct, yes.
3
4 Q. And parts of those - part of that includes
5 responsibility for recruitment?
6 A. Yes.
7
8 Q. In undertaking recruitment, are you assisted by
9 a medical workforce unit?
10 A. Yes. We have - our medical workforce unit consists of
11 three members of staff. We have a manager of medical
12 workforce and two workforce clerks and we also have one
13 additional member of our medical education team, a JMO
14 manager, who supports the JMO recruitment and looks after
15 the JMO - so junior medical officer - education, training
16 and wellbeing programs. So we have a total of four staff
17 within the medical services department.
18
19 Q. Do you also have any assistance from the people and
20 culture directorate?
21 A. So we do work closely with them, but medical
22 recruitment, medical credentialling is very unique in its
23 processes and so yes, we do work closely with them and the
24 medical workforce manager does have a background in HR and
25 previously used to work in the people and culture
26 department, so she has very specialist expertise, so we
27 work with them when we need to, but the majority of the
28 recruitment credentialling, et cetera, is done internally
29 within the medical services department.
30
31 Q. And what you have - the other parts of your
32 responsibility, medical workforce strategy?
33 A. Yes.
34
35 Q. Can I ask what you mean by medical workforce strategy?
36 A. Yes. So I think longer term, we are looking at how we
37 can look at the services that we need in the Far West Local
38 Health District and then look to recruit medical staff to
39 support those services, and that is obviously looking at
40 the bigger picture of medical workforce in the provision of
41 clinical services separate to the operational recruitment
42 and credentialling processes.
43
44 Q. Just to tease that out, does that involve an
45 assessment of what medical workforce is required to deliver
46 the services that are intended to be delivered --
47 A. Yes.

1
2 Q. -- with then, as you have termed, "the bigger
3 picture", perhaps looking at the realities of what medical
4 workforce you can attract to those positions that you would
5 like to fill?
6 A. Absolutely, and also looking at how do we do that, and
7 that links in with one of the other points, how do we look
8 at strategic ways of building pipelines, training pathways,
9 to bring medical staff into the area earlier on, and
10 support their training. So it's how do we engage in those
11 processes to build the medical workforce here locally as
12 well as to be having local doctors working here but, also,
13 how do we look at specialists that will be flying in and
14 flying out and how do we also engage with all of our
15 partner organisations to be providing virtual and
16 partnership medical programs.
17
18 So I think in the past there's been a hope that we
19 would be able to attract and recruit doctors to come and
20 live and work in Broken Hill. The reality is that I think
21 we've got to be much more strategic and look at lots of
22 different ways of recruiting and retaining doctors, so
23 that's part of what that medical workforce strategy is, is
24 looking at all of those different ways that we can do that,
25 rather than just having one way of recruiting and retaining
26 medical staff.
27
28 Q. And is it right that in terms of - to deal with
29 specialists - different specialties may require a different
30 approach?
31 A. Absolutely, yes.
32
33 Q. Partly, in some cases, because of the number of
34 sub-specialties that might be involved in providing
35 a service?
36 A. Absolutely, yes.
37
38 Q. And what services can be provided remotely via virtual
39 services and what are not so amenable to that?
40 A. Absolutely, and one of the big things that we look at
41 when we're looking at what services we can provide and what
42 medical staff we need to do that is the role delineation of
43 our hospital and so, therefore, we - there is the
44 NSW Health clinical role delineation framework, and each of
45 our services is based on that.
46
47 So, for example, the level of certain surgical

1 services that we are able to provide are obviously
2 dependent on our operating theatre capacity, our
3 anaesthetic capacity, but they are also supported by our
4 pathology, our radiology, our nursing role delineations as
5 well. And so whilst we may be able to attract a highly
6 specialised surgeon to come to Broken Hill and they may
7 have the skills and the credentials to perform a certain
8 operation, such as a liver transplant, for example, it may
9 not be appropriate and is not appropriate for such
10 a high-level specialist service to be provided in Broken
11 Hill, because we don't have the intensive care and the post
12 operative care that can safely provide that service here.
13 So it's not just about the skills of the doctor but it's
14 also about the role delineation and the capacity of the
15 facilities that we have in each of our locations.
16
17 Q. In terms of planning for services - is that done on an
18 annual basis in terms of - but kept under review, is that
19 how it operates?
20 A. I think first and foremost we look at the services
21 that we are providing and make sure that we are providing
22 evidence-based best practice services that are in keeping
23 with the needs of our community, and that we are keeping on
24 top of our waiting list, et cetera. So I think that's the
25 first way that we look at what our current services are.
26
27 But then we - I work closely with our director of
28 clinical operations to look at the other services that we
29 feel we need to develop, so, for example, our dermatology
30 service, our outpatient dermatology service. We know that
31 we have a long waiting list and we are doing what we can to
32 attract and work with our partners to attract more
33 dermatologists to come and work in Broken Hill so that we
34 can meet the needs of our patients with regards to
35 dermatology. So that's done on - our outpatient wait lists
36 are reviewed on a monthly basis, through our outpatient
37 steering committee. So some of the things are done on an
38 annual basis at a bigger level, but actually at a service
39 level and a patient level, we're often looking at that data
40 at least monthly and sometimes even more frequently to
41 ensure that we're bringing the staff in that we need to to
42 meet the needs of our patients.
43
44 Q. Can we come now, in terms of medical coverage for the
45 various facilities, you have set out in some detail in your
46 outline that coverage, and we might just pick up a few
47 aspects of that. It starts at paragraph 14. I think in

1 terms of BHHS - that's Broken Hill Hospital Health Service;
2 is that right?
3 A. Correct, Broken Hill Health Service, yes.
4
5 Q. If we go to paragraph 15, you deal with the emergency
6 department?
7 A. Yes.
8
9 Q. I just want to ask you about that. So that is covered
10 by rostered senior and junior medical officers each shift?
11 A. So we have one senior and one junior medical officer
12 per shift, and we have three shifts per day, so
13 a morning/afternoon shift, an afternoon/evening shift, and
14 then a night shift.
15
16 Q. And there is also GP VMOs and registrar - GP
17 registrars who provide service through the ED; is that
18 correct?
19 A. Correct. They are counted as senior doctors, so they
20 cover the senior - those shifts I have just described, the
21 senior doctors on those shifts.
22
23 Q. In terms of telehealth, there is also, you have
24 indicated, a contract between the district with a service
25 known as "My Emergency Doctor", to provide telehealth
26 medical consultations for triage categories 4 and 5?
27 A. Yes.
28
29 Q. We've heard evidence triage levels 4 and 5 are the
30 lower acuity presentations; is that correct?
31 A. Yes. So triage category 1 is when somebody presents
32 with a life-threatening condition and triage category 5 is
33 when they present with a minor condition, which often be
34 expected to be treated within general practice.
35
36 Q. Can I just ask you, why is it that you utilise the My
37 Emergency Doctor service?
38 A. So it was approximately November 2022, shortly after
39 I took up the position of the acting director of medical
40 services at the time, that through reviewing our ED data,
41 our presentations and also clinical incidents and
42 complaints, that it was becoming apparent that patients
43 were waiting - the lower acuity patients were waiting
44 a significant amount of time to be seen within the
45 emergency department.
46
47 So we reviewed that data and we found out that many of

1 these patients were presenting with GP-type of
2 presentations. One example is we had one patient that
3 waited 13 hours to be seen for a prescription, and that was
4 due to the acuity of the patients in the department at the
5 time. And we realised that due to the lack of availability
6 of general practice appointments within Broken Hill at that
7 time, that many patients were presenting to the emergency
8 department for things that they would otherwise go and see
9 their GP for but they could not get an appointment.
10
11 And we really did not want our community to be waiting
12 13 hours for a prescription, and so we felt we needed to do
13 something differently to meet that need of our community.
14 So that's why, then, in consultation with many different
15 partners across our LHD and including community members
16 within that consultation, we engaged with My Emergency
17 Doctor to provide an alternative to that wait for our
18 patients. So they are offered - patients with a triage
19 category 4 and 5 are offered the ability to see the My
20 Emergency Doctor virtual doctor. They can choose to wait
21 longer and see one of our local doctors in the department
22 should they choose to do so, but if they wish to see the
23 virtual doctor and have a shorter wait, they are given the
24 opportunity to do that.
25
26 Q. I will just ask, are you familiar with the service
27 provided in Western Local Health District known as the
28 Virtual Rural Generalist Service?
29 A. Yes, I am.
30
31 Q. Can I just ask, is that a service that - has there
32 been any consideration to utilising that service to deal
33 with these acuity patients?
34 A. I believe that there was previously, prior to me
35 taking up the position of this role, but I couldn't talk
36 more to that, because it happened prior to my time.
37
38 Q. That was prior to your taking the role. Thank you.
39 The other thing I wanted to ask of you in respect of the
40 emergency department, at paragraph 17 you refer to the ED
41 and the inpatient teams being supported by junior medical
42 officers who are employed by the district through the JMO
43 rural preferential recruitment pathway.
44 A. Yes.
45
46 Q. Or rotate to Broken Hill from metropolitan New South
47 Wales network hospitals?

1 A. Yes.
2
3 Q. Is that - can you just explain the rural preferential
4 recruitment pathway?
5 A. Yes, of course. So we recruit junior medical
6 officers, so prevocational trainees in their first and
7 second year, so in their first year they are called interns
8 and in their second year they are called resident medical
9 officers or RMOs, and as a training hospital, we support
10 education and training of prevocational trainees through
11 a number of different departments. That includes the
12 emergency department.
13
14 So we have an intern and an RMO that work in addition
15 to those six positions I previously described within our ED
16 department, and then they also work within our medical
17 teams, surgical teams, psychiatry, palliative care,
18 paediatrics, and as of February next year, obstetrics and
19 gynaecology as well.
20
21 Q. I think you say at paragraph 44 that you have - the
22 hospital has capacity to take up to four interns under this
23 program per year?
24 A. Correct.
25
26 Q. But you say:
27
28 *Unfortunately, this has not been as*
29 *successful as we hoped.*
30
31 A. Correct.
32
33 Q. What do you mean by "not as successful as we hoped"?
34 A. So the rural preferential program is a way that
35 rurally - medical students with a rural interest can apply
36 to a rural location and have their applications considered
37 earlier than the general cohort of medical students
38 applying to become interns across New South Wales. So it's
39 a way of trying to promote and encourage medical students
40 to consider rural placements.
41
42 Our experience here in Broken Hill - so we have the
43 ability to attract four interns into that, which then
44 rotate through into becoming four RMOs in their second
45 year. The challenge that we have out here in Broken Hill
46 is we're what we call a three-term hospital. So all junior
47 doctors have to complete five terms in their first and

1 second year, but our rural preferential doctors can only do
2 three out of their five terms here and HETI, the Health
3 Education and Training Institute, who accredit Broken Hill
4 Hospital to be a prevocational training hospital, in that
5 accreditation, they are - junior doctors are able to do
6 emergency medicine and surgery here in their first year,
7 but there is an expectation that they go to Concord to do
8 two - Concord or Canterbury, our network hospitals, to do
9 two of their other terms so that they get a broader
10 experience.
11
12 Now, that limits us sometimes in the recruitment
13 because - for two reasons. Medical students who are
14 interested in being rural doctors want to do the majority
15 of their training in rural sites, so they may not want to
16 come to Broken Hill if they have then got to move away
17 from - if they are moving to Broken Hill to do two years of
18 training and then are expected to spend two of those terms
19 in Sydney, they may not want to do that, move away from
20 family. They may preference having their training rurally.
21
22 But the other limiting factor that we have is that
23 there are - there is a program called the New South Wales
24 cadet program, rural cadet program, where medical students
25 receive sponsorship in their - during their medical student
26 training years, and as part of that, they have to do the
27 majority of their first two years' training in named rural
28 hospitals. And because Broken Hill is only a three-term
29 hospital, not a five-term hospital, we're not attractive to
30 the rural cadets that are wanting to do their rural
31 training.
32
33 The impact of that has meant that in the last few
34 years we've been attractive to overseas medical students
35 who have wanted a gateway into working in Australia,
36 because they come to Broken Hill and they do want to go to
37 Sydney, but even this year, we've not been able to attract
38 international medical students into our four home intern
39 positions.
40
41 Those positions aren't vacant, though. We are very
42 well supported by the network, so Canterbury and Concord
43 hospitals, and they were able to recruit an additional four
44 interns into their program who then rotate out to us. So
45 those positions have been filled by interns on rotation,
46 but not our own rural preferential program interns.
47

1 Q. I see. So, in effect, you're not - it hasn't resulted
2 in you being short in numbers of junior medical officers?
3 A. No.
4
5 Q. But it has meant that those that might have a rural
6 preference, for various reasons may not be choosing Broken
7 Hill --
8 A. Correct.
9
10 Q. -- as opposed to one of the other rural locations?
11 A. Yes.
12
13 Q. And just so I understand, in terms of the three-term
14 assessment, what is it that makes it a three-term hospital
15 as opposed to a five-term hospital?
16 A. Yes, so originally when we first had our
17 accreditation, we had a limited number of placements
18 available, so it was predominantly emergency medicine,
19 medicine, and surgical terms. Subsequently, we now have
20 paediatrics, psychiatry and palliative care also accredited
21 and, as I've already mentioned, we're hoping to have
22 obstetrics and gynaecology from next year as well.
23
24 The other aspect is the after-hours supervision. So
25 it is important that junior doctors do after-hours work as
26 part of their training, but they obviously need to be
27 appropriately supervised, and when we originally got our
28 accreditation, we had limited after-hours supervision, but
29 we do now feel in a position where we have a greater
30 opportunity of different terms and specialties to offer,
31 but also greater supervision, particularly in the evenings
32 and weekends because of our change in the way we staff our
33 emergency department in the evenings and weekends. And so
34 because of that, we are in negotiation with HETI to see
35 whether we can become a term five hospital so we can be
36 more attractive via the cadet program and for the rural
37 preferential program.
38
39 Q. Is that just a process of asking HETI to reassess you?
40 A. We did have our assessment last year, there are some -
41 yes, it is a process of HETI reassessing us, but obviously
42 we have to provide them with the evidence to ensure that we
43 can appropriately train for five terms.
44
45 Q. Do you have any conception of how long that process
46 may take?
47 A. No.

1
2 Q. We might just, having gone there, stay with some of
3 the other aspects of training, particularly what you have
4 termed the pipeline of future medical staff?
5 A. Yes.
6
7 Q. The other program you have touched on there is at
8 paragraph 43, the university Department of Rural Health of
9 Broken Hill?
10 A. Yes.
11
12 Q. And its extended clinical placement program, which -
13 where medical students come from a number of universities
14 including Sydney, Wollongong and Adelaide?
15 A. Yes.
16
17 Q. In their final year of training; is that right?
18 A. Yes. That's correct.
19
20 Q. You have said that it is particularly - it is
21 difficult for Adelaide students?
22 A. (Witness nods).
23
24 Q. You have said that that is due to their low placement
25 as interstate students in the matching scheme. Can you
26 just explain what you mean by that?
27 A. Yes, of course. So when medical students apply to
28 New South Wales to do their internship and their
29 prevocational training within New South Wales, there is
30 a priority system, so priority 1 student will be a student,
31 an Australian or New Zealand citizen who graduates from
32 a New South Wales university. Priority 2 will be an
33 Australian or New Zealand citizen who graduates from an
34 interstate university but completed their year 12 education
35 in New South Wales. And, then, priority 3 is a New Zealand
36 or Australian citizen who completes their medical student
37 training interstate and also completes year 12 interstate.
38
39 Obviously, geographically, Adelaide is our nearest
40 metropolitan city. We do have a lot of medical students
41 that come and do their final year here in Broken Hill, but
42 obviously, because they are South Australian graduates,
43 many of them will have completed their year 12 schooling in
44 Adelaide. They would be a priority 3.
45
46 And so what that means is that when the first round of
47 offers are sent out to the medical students, they will not

1 be included in those offers. They may not be included in
2 the second round. They may only be given an offer in the
3 third round. So it takes a lot of patience and a lot of
4 confidence for a medical student to wait until the third
5 round when they are being offered placements in their own
6 state in round 1. And so what that has meant is we have
7 known that there have been a number of medical students
8 from The University of Adelaide that would have loved to
9 have done their internship here in Broken Hill, but what
10 they have ended up doing is accepting offers in round 1 or
11 round 2 from South Australian hospitals because of the fear
12 of not being offered a round 3 placement with us and then
13 not wanting - and then not being able to go to any of their
14 preferences.
15
16 Q. In other words, yes, they've accepted earlier offers
17 and dropped out of the scheme by the time they would get to
18 a Broken Hill offer?
19 A. Exactly.
20
21 Q. Who administers that scheme?
22 A. So that's administered through HETI.
23
24 Q. You also outline at paragraph 47 that the district has
25 accreditation for a GP advanced skills - I think that may
26 be intended to say "trainee"; is that correct?
27 A. Yes, it is meant to, yes, sorry.
28
29 Q. Not at all. In palliative care?
30 A. Yes.
31
32 Q. So in your original - in your department?
33 A. Yes.
34
35 Q. Or your clinical department. And working on other
36 accreditations.
37 A. (Witness nods).
38
39 Q. You say at the end of that paragraph you have been
40 unable to recruit successfully in the past four years. Is
41 that to, particularly, the palliative care AST position?
42 A. Yes.
43
44 Q. And in terms of why that is, are you able to shed any
45 light on that?
46 A. So the AST recruitment occurs centrally via HETI, so
47 there are two pathways that that can be done. It can

1 either be done through the rural generalist training
2 program, which is when pre-fellowed general practitioner
3 registrars can come and do an advanced skill term; or, if
4 HETI are unsuccessful in recruitment, they will support
5 local recruitment of fellowed GPs through the GP procedural
6 training program, and HETI fund those positions, if there
7 are people in them.
8
9 I think part of the challenge again with recruiting to
10 these positions is they are six- or 12-month positions, so
11 it means that somebody relatively late in their training
12 would have to uproot and move to Broken Hill for these
13 training positions, and the areas where they have been most
14 successful is when they are embedded into existing GP
15 training pathways within a community or within the local
16 training area, and so they can be taken up by local GP
17 trainees within that area.
18
19 We do have somebody interested from interstate from
20 next year, and so when we do have that interest, we will
21 work with the interested GP trainee and HETI to do what we
22 can to support them to take up that training position with
23 us. Frequently, these positions are often done by word of
24 mouth and working within the GP training network so people
25 know what's available. But I think it's a bit like the
26 situation with our prevocational intern training and also
27 this position, that there are actually more positions
28 available than there are junior doctors that need the
29 positions and so, therefore, what we tend to find is Broken
30 Hill seems to be at the bottom of people's list and, if
31 there are vacant positions, it would tend to be out here in
32 the Far West.
33
34 Q. You have said at paragraph 48 that you believe there
35 is a college cap on GP training supervisors and registrar
36 positions --
37 A. I believe so.
38
39 Q. -- in Broken Hill. Can you explain that? Is that -
40 this is just related to GP trainees?
41 A. So I believe this is related to GP training.
42
43 Q. So the RACGP?
44 A. Correct, yes.
45
46 Q. And what's your understanding of the cap?
47 A. So my understanding of the cap is it is based on

1 demand, and so when they are - so that there is a limited
2 number of registrar positions available in Broken Hill,
3 which means that if they are not filled, there isn't deemed
4 to be a need to accredit further training practices or
5 create additional registrar training positions in the area
6 and, similarly, the college, I believe, do not endorse
7 additional GP supervisors if there is not the need.
8
9 Obviously, as I said in my statement, this can be
10 quite challenging, because it then does not give trainees
11 the opportunity to consider and make a choice about the
12 placements they want to go to, if there are limited
13 placements, but it is also challenging in that many GPs
14 wish to be part of training and education as part of their
15 portfolio, and so if they know that they are not going to
16 be approved as a training supervisor here in Broken Hill,
17 they may look to go to an area or a practice where they
18 know that they can be a supervisor or a trainee, so it is
19 a bit of a catch 22 situation.
20
21 Q. Are you aware of any numbers in relation to GPs that
22 may not be - that have chosen to go elsewhere?
23 A. I couldn't give you specific numbers. I did meet with
24 the Royal College of General Practitioners a couple of
25 weeks ago and raised this with them.
26
27 Q. And what was the response?
28 A. The response was they hadn't - the response that I had
29 was that they hadn't seen our perspective in terms of
30 giving trainees and GPs options in the past, and so that
31 they would then take that back to their seniors within the
32 college and discuss that further, particularly in rural
33 areas and areas where GP workforce is challenging.
34
35 Q. Was there any indication that they would come back to
36 you?
37 A. There wasn't, no, but I will follow that up because we
38 are in constant conversation with the college around
39 developing our own training programs. So it won't be
40 a conversation - it will be a conversation that I will
41 follow up.
42
43 Q. At paragraph 49 you have dealt with some training -
44 attempts to increase the medical training capacity, and you
45 have already touched on the rural generalist GP training
46 program, which I think is, as you have said your statement,
47 under a single employer model?

1 A. So there are two parts. Some of it can be under the
2 single employer model, but it can also happen independently
3 and trainees can still find their own pathway through, if
4 they choose to do so.
5
6 Q. But in relation to this program you have
7 highlighted --
8 A. Yes.
9
10 Q. -- a challenge for this, more particularly Broken
11 Hill --
12 A. Yes.
13
14 Q. -- and I'm not sure if you heard the end of the
15 previous witnesses, but it relates to the classification
16 under the Modified Monash Model.
17 A. Yes.
18
19 Q. And Broken Hill is classified as MMM3?
20 A. Correct.
21
22 Q. And that effectively means that for a number of - this
23 program and a number of, I think you say, other programs,
24 you are therefore competing against a number of other areas
25 which may not, in reality, be like Broken Hill?
26 A. Yes.
27
28 Q. Is that a fair summary?
29 A. Yes.
30
31 Q. I think what you say in paragraph 49 is under - is it
32 the rural generalist GP training program that in the last
33 round, no candidates were interested in Broken Hill?
34 A. Correct.
35
36 Q. You had a number apply, and you were the lowest
37 preference; is that effectively right?
38 A. So the LHDs across New South Wales that are involved
39 in the single employer model have been split into two
40 cohorts, so within our cohort, which is with Murrumbidgee,
41 Southern and Western New South Wales LHDs, so out of the
42 four LHDs, we had eight candidates, and all of those
43 candidates preferenced the other LHDs.
44
45 Q. You have also raised the limitation, going back to
46 supervision in the last paragraph - the limitation by the
47 availability of supervisors in specialist areas?

1 A. Yes.
2
3 Q. Just firstly, to put it simply, you can't train
4 specialists locally without supervisors.
5 A. Correct.
6
7 Q. And yet, of course, if you are not able to train
8 junior people coming up through the specialties, it makes
9 it more challenging to attract or to achieve having senior
10 specialists; is that right?
11 A. Yes.
12
13 Q. You have said some colleges, some specialist colleges,
14 require two onsite fellowed supervisors to supervise
15 a single training position?
16 A. Yes, so I can give you an example, whereby we've been
17 able to accredit the palliative care advanced skills
18 training position for general practice, because we could
19 have one onsite specialist palliative care physician and
20 the second onsite supervisor could be a fellow of the Royal
21 College of Physicians, but they were able to be a general
22 physician. So we were able to use two supervisors onsite,
23 a palliative care physician and a general physician, and
24 then they also supported us with an offsite GP supervisor.
25
26 Now, if we wanted to look at advanced skills training,
27 so specialist - sorry, advanced training for a doctor
28 wishing to train to become a specialist palliative care
29 physician, you have to have two specialist palliative care
30 physicians on site.
31
32 Q. And you do not, is that --
33 A. We do now because I'm in this role, but normally, with
34 all of our specialties other than anaesthetics and general
35 medicine, we only have one specialist on site at one time.
36 Now, some of the colleges are considering alternative
37 supervision methods, such as remote supervision, possibly,
38 as the second supervisor, but that's - we're - our
39 accreditation is dependent on the colleges. Not only does
40 that cause challenges for registrars in specialty training,
41 but it also causes challenges if we're recruiting overseas
42 doctors who are overseas trained specialists who then want
43 to move to Broken Hill and get specialist registration here
44 in Australia - we're often limited in terms of which
45 doctors we can then recruit, depending on what the
46 supervision requirements are for that particular specialty
47 and the level of supervision that those overseas trained

1 specialists need and whether some of that can be done
2 remotely or by telehealth.
3
4 Q. In terms of those colleges that are piloting or
5 considering remote supervision for secondary supervisors --
6 A. So the Royal College of Physicians?
7
8 Q. Yes.
9 A. I believe the Australian College of Emergency Medicine
10 and also the Royal College of General Practitioners. There
11 may be others, but those are the ones that we're looking at
12 at the moment.
13
14 Q. Circling back, then, to attracting existing medical
15 workforce, qualified medical workforce, to the district,
16 there presumably is an ongoing challenge in that regard, as
17 you have set out in your statement?
18 A. There is an ongoing challenge and I think we need to
19 think about what we are trying - the senior doctors that
20 we're trying to recruit. There has previously been, as
21 I think I mentioned, an aim to try and have doctors moving
22 to Broken Hill, particularly at a senior level, but we -
23 since being in this position, we're now trying to work with
24 doctors to provide a continuity of care, but that may not
25 be a case of moving to Broken Hill to provide that, and it
26 may be more around supporting a fly-in fly-out model where
27 care can be provided in the way that our community needs it
28 to be, but also attract senior medical staff for the longer
29 term, where they can maintain their clinical skills, being
30 attached to a tertiary or more specialist level facility,
31 but also continue to provide clinical care in a remote
32 environment as well.
33
34 Q. You have set out a number of the challenges that
35 I think probably apply at various points to attracting
36 people - doctors - to come and live and work here, but some
37 of which also apply to attempts to get doctors on other
38 arrangements such as fly-in fly-out?
39 A. Yes.
40
41 Q. One practical issue you deal with briefly is you have
42 indicated there has been a reduction in the regularity and
43 reliability of flights to Broken Hill?
44 A. Yes.
45
46 Q. Is it the case - and that's since COVID; is that
47 right?

1 A. Yes, that's right.
2
3 Q. And, in effect, there were more flights to Broken Hill
4 prior to COVID; is that right?
5 A. There were a lot more flights to Broken Hill prior to
6 COVID, and then the same schedule just has not recommenced
7 since COVID.
8
9 Q. And what you indicate in paragraph 34 is that a number
10 of specialists have not renewed their contracts and citing
11 the unreliability of flights as a factor?
12 A. Yes.
13
14 Q. Can I just ask, what kind of numbers - these are VMOs;
15 is that right?
16 A. These are VMOs, so in the last 12 months since I've
17 been in this position, six VMOs have not renewed their
18 contracts.
19
20 Q. All of whom have cited that as one of the issues?
21 A. As one of the issues. There were other issues as
22 well, but that was being one of the issues, yes.
23
24 Q. And you have also cited cancellation, reliability of
25 flights. Is that a regular occurrence?
26 A. Yes, it is not as much as it was, but certainly
27 towards the end of last year I would have said we actually
28 calculated about 20 per cent of our operating theatres and
29 clinics were either delayed or cancelled because of late
30 flights or cancelled flights. It's probably about
31 10 per cent of our theatres and clinics now for our
32 visiting VMOs. But we still have frequent cancellations
33 for our regular doctors that fly in, particularly our
34 emergency doctors, and that often, unfortunately, happens
35 at a weekend.
36
37 Q. Presumably this doesn't just affect medical staff but
38 also any agency nurses that are attending or due to fly out
39 as well, et cetera?
40 A. Yes, yes. I think that the bigger impact for medical
41 services is we run on a very - we're very vulnerable, our
42 rosters, and we really fly the doctors in and out as we
43 need them and we have very little capacity to bring in
44 extra staff to cover rosters if a flight is late or
45 a flight is cancelled. Whereas a little bit more - because
46 there are more nurses in town, there is the ability to
47 cover those rosters a little bit easier than there is

1 sometimes the medical rosters.
2
3 Q. In terms of tools that are available to you in the
4 district to attract people, to attract doctors, just
5 dealing with those that you seek to attract on an ongoing
6 basis, you have noted at paragraph 35 that the award in
7 relation to JMOs, the Public Hospital Medical Officers
8 (State) Award, does contain some incentives for rural and
9 regional --
10 A. Yes.
11
12 Q. -- location hospitals?
13 A. Yes. So that incentive is that if you have a junior
14 doctor that's working and is employed by a metropolitan
15 local health district, when they are rotated to a regional
16 or rural LHD, then they have a pay increment for the time
17 they are away, and they also have a return flight home
18 after every seven weeks.
19
20 Q. Those incentives apply across all those hospitals
21 listed in the schedule to the award?
22 A. Yes.
23
24 Q. Broken Hill is one of them?
25 A. Yes.
26
27 Q. And - I don't think it is in evidence at the moment
28 but it is something we will obtain - are you familiar with
29 some of the other hospitals on there?
30 A. Yes.
31
32 Q. Does that include Albury?
33 A. I believe so.
34
35 Q. Byron Bay?
36 A. I believe so.
37
38 Q. So there is no differentiation between the grouping?
39 A. No.
40
41 Q. I will ask you in relation to the senior ongoing staff
42 specialists, that award, the staff specialists award, you
43 are familiar with that to an extent?
44 A. I am, yes.
45
46 Q. Of course, you work under it --
47 A. I do, yes.

1
2 Q. -- in terms of your 0.1 --
3 A. In terms of my whole position, I'm employed under the
4 staff specialist award.
5
6 Q. In any event, what does it contain by way, if
7 anything, of incentives for those taking positions in rural
8 or regional hospitals, to your knowledge?
9 A. There are no incentives for rural or remote locations,
10 and in addition, I believe that there is actually
11 a disincentive with regards to the TESL entitlements, so
12 TESL being travel, education and study leave.
13
14 Q. I think it is training --
15 A. Sorry, training, thank you.
16
17 Q. Training, education and study leave is what you have
18 set out in your statement?
19 A. That's correct, I'm sorry, I apologise.
20
21 Q. Can you just explain how you consider there to be
22 a disincentive in that regard?
23 A. Yes, indeed. So there is an allocated number of TESL
24 days and an allocated TESL budget for each staff specialist
25 that works under the award. If I travel to a day
26 conference in Sydney, I will probably have to take two, if
27 not three, days of that as TESL leave and I will have to
28 use my TESL budget to fly to Sydney, probably have two
29 nights of accommodation in Sydney, and then fly back again.
30
31 If you have a consultant that lives in Sydney, they
32 will take one day of study leave and probably be able to
33 get the train and won't have to pay for any overnight
34 accommodation. So there is the obvious difference between
35 two staff specialists, say one from Sydney and one from
36 Broken Hill, attending the same day conference.
37
38 Q. In effect, you can do a lot more with the entitlement
39 if you are in a metropolitan area than you can do with the
40 same entitlement here in Broken Hill?
41 A. Correct.
42
43 Q. The other matter you touch on is the determination
44 that relates to visiting medical officers or VMOs?
45 A. Yes.
46
47 Q. Before I go there, I should have asked, you have said

1 in your statement, in the outline, that there are only
2 employed two staff specialists currently?
3 A. Yes.
4
5 Q. In the local health district?
6 A. Yes.
7
8 Q. Does that include you?
9 A. Yes.
10
11 Q. So one other?
12 A. One other.
13
14 Q. And presumably - well, I will ask you. If you could
15 attract them, presumably you would employ a number of
16 others?
17 A. If doctors wished to work for us as staff specialists,
18 we absolutely would employ them as staff specialists, yes.
19
20 Q. Are there any particular disciplines or specialties
21 which that would particularly apply to?
22 A. So the other staff specialist is a physician.
23
24 Q. Working in the emergency department?
25 A. No, working as a general physician.
26
27 Q. General physician. In terms of the visiting medical
28 officer determination, that applies to all the other
29 medical staff, effectively?
30 A. Yes.
31
32 Q. Senior medical staff providing services?
33 A. Yes.
34
35 Q. And, to your knowledge, does it include provision for
36 any rural incentives?
37 A. So there are rural incentives if you live within
38 50 kilometres of the hospital that you are providing the
39 service to, but we do not have any VMOs that live within
40 50 kilometres, and as I'm sure you can be aware, the
41 50 kilometres radius, if you are living, say, on the
42 south-east coast or the southern coast of Sydney, in terms
43 of where you can live and still work in a rural hospital,
44 is very different than where you can live within
45 50 kilometres of Broken Hill.
46
47 Q. The other part of the filling the medical roster is

1 presumably then temporary staff, locums?
2 A. Yes.
3
4 Q. What is often termed premium labour?
5 A. Yes.
6
7 Q. What proportion of your roster do you have to fill
8 with premium labour? Obviously it varies, but --
9 A. It does vary.
10
11 Q. -- generally?
12 A. Some of our rosters are filled 100 per cent by premium
13 labour, some of them down to 25 per cent, but on average
14 across our medical services it's running between 75 and
15 80 per cent of premium labour.
16
17 Q. And is that a proportion - I appreciate you have only
18 been in the position about 18 months or a little longer -
19 is that a proportion that has, during that time, grown or
20 remained steady or declined?
21 A. It has remained steady, but I'm pleased to report that
22 as of next month, we have two senior VMO positions that
23 will be taken up by regular doctors, so we are very much
24 working on decreasing that percentage as a priority for us.
25
26 Q. What you have said at paragraph 40 is that as
27 a district you have explored opportunities for new and
28 innovative medical workforce recruitment, retention and
29 training. What are you doing in that regard?
30 A. So of the two doctors I have just mentioned, one is
31 a doctor who has recently been working in Sydney who we are
32 sponsoring their longer-term visa in order for them to come
33 and work as a VMO with us. The other VMO we have recruited
34 from overseas in New Zealand and we are looking at how we
35 can enhance our international recruitment pathways, because
36 all of our senior positions are constantly advertised, so
37 we don't go to premium labour - we only go to premium
38 labour because we have no other options, and obviously it's
39 important that we have our rosters covered. We can't not
40 have an anaesthetist in Broken Hill, for example.
41
42 So - but we have adverts constantly out for VMOs and
43 staff specialists to give people the opportunity to apply
44 for whatever their preference would be. We're open to
45 people moving to Broken Hill; we're open to people flying
46 in and flying out and, as I have said, we're actively
47 looking at the international recruitment to support senior

1 doctors and specialists moving into Australia and
2 potentially using Broken Hill as a stepping stone to do
3 that.
4
5 Q. You have also cited exploring academic appointments
6 and research opportunities?
7 A. Absolutely. So working with university Department of
8 Rural Health to offer academic - honorary academic
9 appointments with the University of Sydney, looking at the
10 other things that we can offer here over and above
11 financial incentives in order to be a place that is
12 attractive and gives often specialists earlier on in their
13 career opportunities that they may not get if they worked
14 in bigger metropolitan areas.
15
16 Q. Just lastly, in those respects, those opportunities
17 and partnerships that you are exploring in that regard,
18 have they come to fruition yet in any --
19 A. Well, we've got two new doctors starting next month,
20 so that's a start. But we still have a long way to go.
21
22 Q. That's not through academic appointments?
23 A. No, not yet. That's through some of the international
24 and sponsorship opportunities, yes.
25
26 MR FRASER: Commissioner, those are the questions I had
27 for this witness.
28
29 THE COMMISSIONER: Thank you.
30
31 Q. Can I just ask you about paragraph 19 of your
32 statement, just so I understand it. Where you are talking
33 about the agreement between the ambulance service and the
34 RFDS --
35 A. Yes.
36
37 Q. -- about aeromedical transfers, the next sentence
38 says:
39
40 *This agreement with RFDS also includes the*
41 *provision of primary health medical*
42 *clinics.*
43
44 You are including, as an example, Menindee or Wilcannia.
45 Is that the agreement with the ambulance service?
46 A. Yes. So the ambulance service and the RFDS have an
47 agreement to provide aeromedical transfers and within that

1 there is a schedule, where the RFDS - and I quote from the
2 schedule - provide primary health medical clinics to those
3 remote facilities in the Far West Local Health District.
4
5 THE COMMISSIONER: This isn't for you, but there are also
6 agreements between the HAC and RFDS. I don't think they
7 are in the evidence. We probably should tender - I don't
8 think they are proposed to be tendered, but I think we
9 probably should tender the agreements, because there are
10 agreements between the HAC and the RFDS that I've recently
11 been sent that also, amongst what the witness is talking
12 about in 19, also include provision of medical clinics as
13 well.
14
15 MR FRASER: Yes, Commissioner. We'll attend to that.
16
17 THE COMMISSIONER: We can probably tender it as a bundle
18 of all these agreements, I think.
19
20 MR FRASER: We will ensure that we have the full suite,
21 including the one that this witness is referring to in
22 paragraph 19.
23
24 THE COMMISSIONER: Yes, very good, thank you. Mr Cheney,
25 is there anything?
26
27 MR CHENEY: No questions.
28
29 THE COMMISSIONER: Thank you very much for your time,
30 doctor. We're very grateful. You are excused.
31
32 **<THE WITNESS WITHDREW**
33
34 MR FRASER: I'm told we need a very short break before the
35 next witness, Dr Agar, who is giving evidence remotely.
36 Dr Agar is available until 1.15 when he has to leave for
37 a flight.
38
39 THE COMMISSIONER: He is online, did you say?
40
41 MR FRASER: He will be. That's what needs to be set up.
42
43 THE COMMISSIONER: I will just adjourn until he is online.
44
45 MR FRASER: Thank you, Commissioner.
46
47 **SHORT ADJOURNMENT**

1
2 MR FRASER: Commissioner, I think we are ready to
3 commence, when you are.
4
5 THE COMMISSIONER: Please go ahead, then.
6
7 MR FRASER: Commissioner, the next witness is Associate
8 Professor Ashish Agar. There is, before Dr Agar is sworn,
9 an appearance on behalf of Dr Agar also via the
10 audio-visual link.
11
12 MS HOLCOMBE: Yes, Commissioner, my name is Holcombe -
13 H-O-L-C-O-M-B-E - and I appear for Dr Agar.
14
15 THE COMMISSIONER: All right. Well, to the extent that it
16 is necessary, I will grant you leave to appear for Dr Agar.
17 Dr Agar, welcome.
18
19 **<ASHISH AGAR, affirmed: [12.41pm]**
20
21 **<EXAMINATION BY MR FRASER**:
22
23 MR FRASER: Q. Dr Agar, could you give your full name,
24 please?
25 A. Ashish Agar.
26
27 Q. Dr Agar, you are an associate professor based at
28 a number of hospitals, but by training an ophthalmologist
29 with a sub-specialty in glaucoma; is that correct?
30 A. That's correct.
31
32 Q. We will go into some detail, but you hold visiting
33 medical officer appointments at the South Eastern Sydney
34 Local Health District; is that right?
35 A. Yes.
36
37 Q. And also at the Far West Local Health District?
38 A. Yes.
39
40 Q. And you also hold a fee-for-service VMO agreement,
41 which I believe is with the Western New South Wales Local
42 Health District; is that right?
43 A. Correct.
44
45 Q. You prepared an outline of evidence in preparation for
46 this morning; is that correct?
47 A. Yes.

1
2 Q. And you have a copy there with you?
3 A. I do.
4
5 Q. And for the record, that's [SCI.0009.0104.0001].
6 Doctor, you have had an opportunity to read through that?
7 A. I have.
8
9 Q. And is it correct and accurate, to the best of your
10 knowledge; is that right?
11 A. Yes, that's correct.
12
13 Q. Thank you. Doctor, you have also, through your legal
14 representatives, provided copies of your three
15 appointments, the relevant contracts with the three
16 districts that I referred to. Is that right? You have
17 provided those to those assisting the Inquiry?
18 A. Yes, I did.
19
20 MR FRASER: Commissioner, those are currently contained in
21 a separate folder. It is proposed to tender those
22 separately. There is sought a non-publication order in
23 respect of those, as they contain Dr Agar's personal
24 information.
25
26 THE COMMISSIONER: All right.
27
28 MR FRASER: I understand there is no opposition to that.
29
30 THE COMMISSIONER: Pursuant to section 8 of the Special
31 Commissions of Inquiry Act, I'll make a non-publication
32 order in relation to the documents I will simply describe
33 as CE.07 through to CE.09.
34
35 MR FRASER: Thank you.
36
37 Q. Those matters out the way, doctor, if I can ask you
38 first, in relation to your appointment at the South Eastern
39 Sydney Local Health District, that's primarily at the
40 Prince of Wales Hospital, Randwick; is that correct?
41 A. Correct, Prince of Wales and also covers Sydney Eye
42 Hospital.
43
44 Q. And as you have said in your outline, that's
45 a sessional appointment for 80 budgeted hours per annum?
46 A. Correct.
47

1 Q. And albeit your agreements run for - are renewed from
2 time to time, you've held an appointment of that nature
3 since 2008; is that right?
4 A. That's correct.
5
6 Q. To come to your appointment here in Broken Hill, under
7 that appointment, you are effectively - well, you are the
8 director of the ophthalmology service here in Broken Hill?
9 A. Yes, I am.
10
11 Q. And currently have a five-year sessional contract,
12 which we understand provides for one theatre day and two
13 clinic days per visit; is that right?
14 A. Yes.
15
16 Q. Or, as agreed, depending on clinical need, I think is
17 what you have said in the statement?
18 A. (Witness nods).
19
20 Q. Can I ask you, how often do you come to Broken Hill?
21 A. Between four to six times a year.
22
23 Q. And that depends on clinical need, effectively?
24 A. Clinical need, but also there is the roster of about
25 10 VMOs who provide the service and so it depends on the
26 availability of them and if I need to fill in a vacancy.
27 Generally, between the 10 of us, we all do around four to
28 six.
29
30 Q. As you have said in your statement, those 10 VMOs who
31 together provide - make up the medical workforce for the
32 service --
33 A. Yes.
34
35 Q. -- they are VMOs with expertise in different
36 ophthalmology sub-specialties; is that right?
37 A. Correct. The majority are. There are some what we
38 would call comprehensive ophthalmologists, so there is
39 a couple of those, but the majority are sub-specialists who
40 provide that high level of care for a particular aspect of
41 ophthalmology.
42
43 Q. You have cited corneal specialists, retinal
44 specialists and ocular inflammation specialists in addition
45 to your own specialty of glaucoma?
46 A. That's correct, and there's also retinal specialists
47 and paediatric or children's eye specialists, and what is

1 called ocular plastic, which is to do with the eyelids and
2 orbits.
3
4 Q. Thank you. You have told the Inquiry that you have
5 held an appointment here in Broken Hill since 2010. Can
6 you just give the Inquiry an overview of your knowledge of
7 how this service came to be operational, as it clearly
8 depends on contributions from a number of ophthalmological
9 specialists?
10 A. Yes, correct. So it's probably worth going back to
11 the genesis of the service. This started in the early
12 2000s. It was following on from what had been a service
13 provided by some VMOs only from South Australia and from
14 Victoria historically. This service came into existence on
15 the basis of a training position being created for Broken
16 Hill. I was one of the first registrars who formed that
17 service, and what that meant is that we were based in
18 Broken Hill for the majority of the time and we have an
19 arrangement whereby VMOs would come from various centres to
20 act as our supervisors and also to provide the training and
21 education.
22
23 So I started that, as I said, in the early 2000s.
24 Subsequent to that, one of the good things about the
25 service, which is unique in Australia - there is no
26 equivalent high-level sub-specialist surgical service in
27 any regional centre where there is not a permanent
28 specialist based - so one of the things that we found as
29 trainees and as registrars is that the experience was
30 amazing. As I'm sure the Commission will be discovering,
31 Broken Hill's a unique place, it's got an amazing character
32 to it and the people are, you know, genuinely engaging, and
33 many of us find, once we've done that training there as
34 part of our Prince of Wales network, that we want to go
35 back. And so most of my current specialists are people
36 that actually trained there, worked there as registrars and
37 had enough of a positive experience to want to go back and
38 provide the service long term.
39
40 Q. Can I ask you, seeing as you were involved at that
41 early stage, how was it that Broken Hill came to be
42 identified?
43 A. So the initial consultants who had been working there
44 were very highly regarded and esteemed members of the
45 profession and they had significant roles within the
46 college and within the teaching fraternity, and they
47 basically made a proposal to create a training position in

1 Broken Hill. So it was on the basis of eminent people
2 working there for a long time, seeing a need and wanting to
3 create something sustainable and long term.
4
5 Q. So it was identified that there was an ongoing
6 clinical need for such a service here in Broken Hill?
7 A. Yes. I guess the other thing that is relevant is that
8 where I trained and where I work at the Prince of Wales, we
9 have a long history of outreach services, so that
10 Professor Fred Hollows, who was the previous head there,
11 started the outback work in the '70s, which is now quite
12 legendary across Australia and internationally, and our
13 program is unique in that all of us who are taught there
14 spend six months on an RFDS rotation, six months out at
15 Broken Hill or times like that, and that means that it's
16 part of our training and part of our core work ethic, and
17 so many of us find that one of the best parts of our jobs.
18
19 Q. Can I ask you about how the training program currently
20 operates?
21 A. Yes.
22
23 Q. You have said there is obviously - you have said that
24 the registrar is here three weeks on and one week off; is
25 that right?
26 A. That's correct.
27
28 Q. And you have also said in paragraph 14 that yourself
29 and your colleague VMOs provide the supervision and
30 training, and obviously when you are here in Broken Hill
31 you provide that on a face-to-face basis?
32 A. Yes.
33
34 Q. But that when not in Broken Hill, you are able to
35 provide that support via remote means, be it telephone or
36 videoconferencing?
37 A. That's correct. The other aspect is that the
38 registrars out there are relatively senior, so they have
39 a high level of competency and independence, and that's
40 a prerequisite for being somewhere like that, which allows
41 us to have that confidence in that remote supervision for
42 those couple of days that we're not there.
43
44 Q. Can I ask, how long has it been possible to provide
45 that supervision and training via those remote means?
46 A. Well, it's obviously been magnified by the pandemic,
47 but even prior to the pandemic, we had actually set up, for

1 the time, what was quite sophisticated integrated cameras
2 and video systems into our equipment. One of the beauties
3 of ophthalmology is that you can see what the problem is,
4 and so a lot of these things are transmissible via secure
5 electronic means. Plus just the ability to contact our
6 team directly on the phone and finding we did have
7 a linkage, even before technology caught up with us, with
8 our main base at Prince of Wales, which meant that whatever
9 the trainee was seeing on the equipment in Broken Hill was
10 exactly the same view that we got at Prince of Wales, so we
11 were able to provide almost direct supervision on exactly
12 what they were seeing.
13
14 Q. This ability to do for the training - well, some of
15 the training and supervision to be provided remotely, is
16 that different to the position when you yourself were
17 undergoing training out here?
18 A. Yes, good question. I mean, this was in the days when
19 we just had basic technology. So we were probably more
20 reliant on phones, but the basics of a CCTV system and an
21 imaging system, that was there. Clunky, slow, but it did
22 work and it did allow that supervision to be undertaken.
23
24 Q. You make the point in relation to this particular
25 service that you provide here that, in your opinion, it
26 would not work - would not be able to be operated on
27 a staff specialist model?
28 A. Correct.
29
30 Q. Presumably that's due to the number or the range of
31 sub-specialties that need to be involved to provide the
32 service in the way that you do?
33 A. Yes, correct. That is an essential feature of it.
34 Plus also the flexibility of the VMO arrangements, because
35 the availability of surgeons and supervisors can vary, and
36 the flexibility of the VMO arrangement allows that - the
37 variation to be taken into account on an ongoing basis, and
38 it is the model that also applies to all of our outreach
39 services. So, for example, all of the VMOs in the Broken
40 Hill service, which is part of what of what is called the
41 Outback Eye Service from Prince of Wales, are also VMOs.
42 Most of the staff across Broken Hill specialties will also
43 be VMOs. So, from my understanding, it's basically the
44 default model for most regional centres.
45
46 Q. Can I ask you now briefly about the Bourke outreach
47 program that you are becoming involved in, I think it is

1 more recently. When did you --
2 A. Yes, sure.
3
4 Q. When did you become involved in that program?
5 A. So this was actually - pre-dates the Broken Hill
6 program. This was a direct successor to Fred Hollows' work
7 in Bourke and places like that. Professor Minas Coroneo is
8 the current head of the department, but basically has
9 overseen the expansion of the program from two or three
10 visits to Bourke a year to what is now 110 clinics across
11 western New South Wales, and about eight or 10 operating
12 lists covering pretty much everything between Dubbo and
13 Broken Hill and up to the border.
14
15 So this is a service that is based at the Prince of
16 Wales, but involves Royal Flying Doctor Service visits out
17 to these regional places - Bourke, Lightning Ridge, Cobar,
18 Brewarrina, Walgett, and Bourke being the hub, that's where
19 we do our micro surgery and do our procedures. So this
20 service has actually evolved quite dramatically, but it
21 actually pre-dates what we've been doing at Broken Hill and
22 actually was one of the learning experiences that allowed
23 us to then begin Broken Hill on the basis of our
24 experiences in Bourke. So it's actually much bigger and
25 a longer-lasting service.
26
27 Q. How long have you been involved with that service?
28 A. Once again, from when I was a trainee, so, gosh,
29 longer than I want to remember, but once again, the early
30 2000s.
31
32 Q. Thank you. And in terms of the number of
33 ophthalmologists involved in that service, firstly, it
34 involves numbers with different sub-specialties again in a
35 similar way; is that right?
36 A. That's correct.
37
38 Q. Your appointment as a VMO to that particular service
39 is under what's known as a fee-for-service agreement; is
40 that right?
41 A. That's correct.
42
43 Q. As opposed to what is known as a sessional agreement,
44 which is your appointment here in Broken Hill?
45 A. Yes.
46
47 Q. In terms of that, is there a reason for that

1 differentiation that you understand?
2 A. I think it's more to do with the frequency and the
3 regularity of the service. So, in Bourke, for example,
4 each of the surgeons - again, it is around eight to 10
5 involved - each of us will be going out for maybe two or
6 three visits a year. There is no department there, per se,
7 it's a purely fly-in fly-out service, there is no permanent
8 staff or permanent presence there. So essentially -
9 I understand that that was one of the historical reasons
10 for the basis. I can find out what more reasons there are,
11 but essentially it's been an involvement over time for the
12 particular model that was developed there, as opposed to
13 a hospital-based system with permanent staff.
14
15 Q. In terms of when you travel, are required to travel
16 out to that service, is that on a clinical - effectively on
17 a clinical needs basis as to the timing and regularity?
18 A. Correct. So the schedule is prepared in advance
19 because we need to tie in to the RFDS schedule as well, and
20 essentially we have monthly clinics out in Bourke, we have
21 operating lists every one to two months, and we have
22 a lower frequency of clinics to the other sites mentioned.
23 The clinical need is always there, so it's a matter of
24 really how much we can manage to accommodate that clinical
25 need, but essentially, it's trying to provide as much of
26 a regular service as is possible to each of these sites.
27
28 Q. And how is that coordinated? Presumably with
29 different sub-specialties involved there is a need to group
30 patients requiring the attention of a particular
31 sub-specialist. Who coordinates that?
32 A. An amazing lady who is worth 10 of her pay grades, her
33 name is Sister Joanna Barton, she is the manager of our
34 Outback Eye Service. So Jo and an orthoptist who works
35 with her, these two people manage to run half the state.
36 So it's basically some incredibly hardworking nurses and
37 ancillary staff that help us to do that, but essentially,
38 they create the schedule, manage the schedule, liaise with
39 all of the specialists, organising the transport,
40 organising procedures. It's a huge job, but they have been
41 absolute stalwarts at this - very much overworked and
42 underpaid and we've been trying for years to get additional
43 funding, managed to get some through the Hollows
44 Foundation, but essentially it's a big job and, you know,
45 it manages on the skeleton team that we have, but in answer
46 to your question, it is some very, very hardworking people.
47

1 Q. Can I just ask you this, so the Royal Flying Doctor
2 Service have a role in --
3 A. Transport.
4
5 Q. -- in transport in this clinic. Is that --
6 A. Correct.
7
8 Q. In terms of that, is that administered under
9 a particular agreement, do you know?
10 A. Yes. There is an agreement, which is a service level
11 agreement, which also includes the Greater Western Local
12 Health District, between that and the Prince of Wales
13 Outback Eye Service, so essentially, the clinics are
14 arranged by our team at the Outback Eye Service, surgical
15 lists are arranged by our team in consultation with Greater
16 West, to provide nursing support, and the transport
17 arrangements are in consultation with the RFDS to basically
18 get us to and from.
19
20 Q. And just in terms of where you provide the physical -
21 well, the premises you provide the physical service out
22 of --
23 A. Yes, these are generally based in the hospitals, in
24 the local hospitals.
25
26 Q. In those locations that you cited earlier on?
27 A. Correct.
28
29 Q. Thank you. Can I just ask you now about, at a general
30 level, your arrangements and remuneration. Just in terms
31 of your fee-for-service contract, that is in accordance
32 with - is that under the - I think it is under the rural --
33 A. Rural doctors --
34
35 Q. Settlement package?
36 A. Arrangements.
37
38 Q. Is that right?
39 A. Yes.
40
41 Q. Thank you. Which is a specialist arrangement on
42 a fee-for-service basis. But if I ask you about your
43 arrangement out here, where you are providing the VMO
44 services on a sessional basis, that's under - your
45 remuneration is under the VMO sessional contracts
46 determination, is that right - public hospitals VMO
47 sessional contracts determination?

1 A. Correct.
2
3 Q. And is that the same determination that applies to
4 your remuneration for your position, VMO position, in
5 Sydney?
6 A. As far as I'm aware, it is similar.
7
8 Q. And in terms of financial incentives to undertake the
9 work out here, is there any financial incentive?
10 A. No. I think, as a rule, our team are very cognisant
11 of the fact that taking time out and coming to do an
12 outreach service will actually cost them in terms of time
13 out of their practice or time out of their normal
14 workplace. So the bottom line is none of us do it for the
15 money. There are much more efficient and productive ways
16 to make a buck. We do this out of commitment and service.
17 Financially, there is simply no incentive to be doing this
18 over what could be done in Sydney, or wherever we're based.
19
20 MR FRASER: Those are the questions I had for this
21 witness, Commissioner.
22
23 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
24 questions?
25
26 MR CHENEY: No, Commissioner.
27
28 THE COMMISSIONER: Thank you very much for your time,
29 doctor. We're very grateful.
30
31 THE WITNESS: Thank you for the opportunity.
32
33 THE COMMISSIONER: You are excused.
34
35 **<THE WITNESS WITHDREW**
36
37 THE COMMISSIONER: All right. Is that a convenient time
38 for lunch?
39
40 MR FRASER: That's a convenient time for lunch.
41
42 THE COMMISSIONER: We will adjourn until 2 o'clock.
43
44 **LUNCHEON ADJOURNMENT**
45
46 THE COMMISSIONER: Yes, Mr Glover, we can resume.
47

1 MR GLOVER: Thank you, Commissioner. The next witness is
2 Ms Apsara Kahawita.
3
4 **<SENANAYAKE MUDIYANSELAGE APSARA**
5 **KAHAWITA, affirmed: [2.01pm]**
6
7 **<EXAMINATION BY MR GLOVER:**
8
9 MR GLOVER: Q. Ms Kahawita, could you tell us your full
10 name for the record, please.
11 A. Senanayake Mudiyanselage Apsara Kahawita.
12
13 Q. You are currently the director of finance and
14 corporate services for the Far West Local Health District?
15 A. Yes, I am.
16
17 Q. And you have been in that role for about 18 months; is
18 that right?
19 A. Yes.
20
21 Q. Prior to that, over the last about 17 years, you have
22 held various finance roles within the umbrella of NSW
23 Health; is that correct?
24 A. Correct.
25
26 Q. In anticipation of giving your evidence today, an
27 outline of your evidence has been prepared?
28 A. Yes.
29
30 Q. For the benefit of the transcript, it's
31 [MOH.9999.1253.0001]. Do you have a copy of that with you
32 there?
33 A. I do.
34
35 Q. Have you had a chance to read it before giving your
36 evidence today?
37 A. Yes, I did.
38
39 Q. Are you satisfied that its contents are true and
40 correct?
41 A. It is.
42
43 Q. I will ask you some questions by reference to that
44 document, so feel free to use the one on the screen or the
45 hard copy you have with you. Can I start by taking you to
46 paragraph 7, please. In paragraph 7 you tell us that the
47 district is funded by a combination of block funding, ABF

1 and the small rural hospital funding model; do you see
2 that?
3 A. Yes.
4
5 Q. Is the Broken Hill Hospital the only facility that's
6 funded by ABF?
7 A. Correct.
8
9 Q. In paragraph 8, you refer to the categorisation of the
10 Broken Hill Hospital as an outer regional facility. Do you
11 see that?
12 A. Yes.
13
14 Q. We've heard some evidence this morning about the
15 effect of the categorisation. Do you have a sense of the
16 impact to the LHD's budget if that facility was categorised
17 as a remote facility?
18 A. Definitely. There is an impact to the LHD. We are
19 living a lot - far away from Sydney and we are part of
20 New South Wales, even though we are closer to South
21 Australia. There's only 30,000 people. We have to bring
22 skills outside the Far West region. Therefore, the normal
23 mathematical calculations would not work for Far West, is
24 my broader statement.
25
26 Q. And if the categorisation were different, such that
27 the region was considered remote, would that have an impact
28 on the funding models?
29 A. A hundred per cent.
30
31 Q. And the distribution of funds to the LHD?
32 A. Sorry, yes, it will impact the LHD positively.
33
34 Q. In what way?
35 A. The outer regional has had adjustments for
36 Aboriginality, for postcodes, there is block funding
37 portion for under the small rural health funding component,
38 and Broken Hill Hospital is not receiving that.
39
40 When there is a deficit, we always try to give the
41 benefit to the smaller facilities in the district at a cost
42 of Broken Hill, being the largest for the district.
43
44 Q. Is the categorisation and the potential change to that
45 categorisation something that is being picked up by the
46 LHD - that is, is the LHD, to your understanding, taking
47 any steps to raise the issue of categorisation firstly with

1 the ministry?
2 A. Yes. Together with the MM model, Modified Monash
3 Model, we have spoken a number of times with various
4 parties of the ministry, including rural incentive schemes,
5 through those discussions, and the service agreement
6 process. The ABM compendium is the source for budget
7 distribution across the state, and I understand that,
8 according to the compendium, it is the methodology now, but
9 there are forums for us to raise those concerns, which we
10 have.
11
12 Q. And those concerns having been raised, has there been
13 any response to them from the ministry, as you understand
14 it?
15 A. This is my 18 month in Far West, so I have been in
16 full financial year only once. I have started raising and
17 there are discussions in progress, but I am not aware of
18 any past proceedings in this space.
19
20 THE COMMISSIONER: Q. Who were the various parties of
21 the ministry that there have been discussions with?
22 A. System purchasing and performance branch in the
23 ministry, where we negotiate the service agreements.
24
25 Q. And what is their response to the suggestion that
26 Broken Hill, for example, is more remote than it has been
27 categorised as?
28 A. That's a good question, Commissioner. There are a few
29 things happening as we start discussing these topics with
30 the ministry. There is a case study - sorry, there is
31 a case study in progress to understand the variable and
32 fixed components of our hospital system, of our - of Far
33 West, and I have put my hand up voluntarily for that.
34 Secondly, there were a number of - two multi-purpose
35 facilities missing in the whole formula for a long period
36 of time in Far West. Through the last financial year
37 I have found that and there are discussions in place to
38 correct that, to identify the facilities which will attract
39 another - more funding to the district.
40
41 This discussion is still very - at its beginning of
42 the stage. Therefore, further discussions need to happen
43 with the system purchasing branch to bring Broken Hill into
44 that level.
45
46 Q. Help me. What is the complexity about this? I don't
47 understand how it is not fairly obvious that this is not

1 Byron Bay or Katoomba.
2 A. Commissioner, the complexity is we - for everything
3 that I say today, the mathematical approach of looking at
4 a guidance and going by the guidance is the problem. So it
5 is - to answer your question, it is not difficult, but it
6 is a variation to the standard practice.
7
8 Q. I see. Have you or anyone else actually done - you
9 referred to the mathematics. Has anyone done the
10 mathematics, if this was - if Broken Hill was put into
11 a category perhaps more consistent with its location as to
12 what difference it would make to the funding?
13 A. I don't - I'm not aware of that, but I am very hopeful
14 that the new case study that is going to be built, based on
15 Broken Hill, Far West and there are other districts
16 participating, will give us that opportunity to explore why
17 we should be different, and this is the only district that
18 is fully rural. It is not - it should not be categorised
19 as regional.
20
21 Q. Did you say you had put up your hand to be involved in
22 that, to lead that case study?
23 A. To participate in that case study.
24
25 Q. What does that mean? What does "participate in the
26 case study" mean?
27 A. The case study is led by the ministry Activity Based
28 Management team, and the University of Sydney team. It's
29 complex costing. Even though I'm an accountant, costing is
30 not my specialty. So we will be telling the story for
31 someone to capture that and cost that and analyse it.
32
33 Q. Do you know what the time frame is for this case
34 study?
35 A. The outline is given to us, Commissioner, but it's not
36 now in my head to tell you the timeline.
37
38 Q. Is this something that would take months or years, or
39 is it something that ought to take a week?
40 A. Months.
41
42 Q. Why? I mean, if people focused on it and got to work
43 on it, why would it take months?
44 A. I would assume that there are at least three LHDs
45 participating, therefore, there will be a time of
46 listening, collecting data, then translating into numbers,
47 then coming back to us. It is a collective effort and the

1 other two districts are adjoining - adjoining districts,
2 therefore there will be similarities, but with my 17 years
3 of experience in health, Far West is - cannot be compared
4 with other districts is my - what I'm feeling.
5
6 THE COMMISSIONER: Thank you.
7
8 MR GLOVER: Q. Although in answer to one of the
9 Commissioner's questions you said that the mathematics
10 hasn't been done to work out what the difference would be
11 if the classification were changed, I think in an earlier
12 answer you said that your sense is that it would improve
13 the district's budget at a general level; is that right?
14 A. That's correct.
15
16 Q. Can I take you to paragraph 9, please. In paragraph 9
17 you refer to some challenges with the ABF model. Do we
18 take it that these challenges arise in the context of
19 Broken Hill Hospital?
20 A. I have focused on Broken Hill Hospital, because other
21 multi-purpose facilities are costed in a different way, but
22 Broken Hill is not. Therefore, when writing this paper,
23 I focused on Broken Hill.
24
25 Q. Yes. Just so I understand, the concern in
26 subparagraph (a), in paragraph 9, where you refer to the
27 size of the population and the need to bring staff in, is
28 the reason why the ABF model is challenging in that context
29 that it doesn't accurately capture those increased costs?
30 Is that what you are referring to?
31 A. That's correct.
32
33 THE COMMISSIONER: Q. Does that mean that the cost to
34 provide services, health services, in Broken Hill Hospital
35 because of the - as an example, the travel and
36 accommodation costs you talk about, it doesn't reflect the
37 state efficient price?
38 A. The state efficient price, the LHD price and then
39 national efficient price is there. We are above all of
40 them.
41
42 Q. And significantly so, I think.
43 A. Significantly above.
44
45 MR GLOVER: Q. And is it in that context that in the
46 last sentence you raise the - or you express the view that
47 it would be assistance if there were provisions under the

1 ABF model to cover these additional costs?
2 A. Yes.
3
4 Q. What do you have in mind when you say it would assist
5 if there were provisions in the ABF model to cover the
6 additional costs?
7 A. I will take the - can I give an example, please?
8
9 Q. Please do.
10 A. Thank you. Maternity ward. Our annual report reports
11 less than 200 beds per annum. We need the highly skilled
12 staff 24/7, every day, to be in the hospital, whether there
13 is a birth or not. So when Broken Hill Hospital is funded
14 per activity base and with adjustments, our total cost is
15 well ahead of the budget figure. And I have given, in
16 9(c), further examples of paediatrics, renal, that we are
17 noticing similar patterns for a long time.
18
19 Q. Does that suggest to you that funding Broken Hill
20 Hospital as an ABF facility is not appropriate?
21 A. Yes, because the fixed cost is very high.
22
23 Q. Is that an issue, to your knowledge, that has been
24 raised with the ministry by the LHD?
25 A. Yes.
26
27 Q. And are you aware of what response has been given to
28 that concern?
29 A. We have been heard for the last one year during my
30 time. It has been minuted with various meetings. I'm not
31 yet - I'm not sure about the outcome yet until I see the
32 service agreement for financial year '25. But for current
33 year, there is no additional budget being provided.
34
35 Q. So the current year being the current financial year?
36 A. Yes.
37
38 Q. And is it the case that you are yet to see what is
39 proposed for the forthcoming financial year?
40 A. Correct, I agree with that.
41
42 Q. Can I take you to paragraph 10, please. In there, you
43 refer to the small rural hospitals funding model. Do you
44 see that?
45 A. Yes.
46
47 Q. Can you just describe to the Commissioner briefly, in

1 practical terms, how that model operates within your
2 district?
3 A. The expenses are captured in the ledger. It is
4 converted into a district network return, DNR. Then the
5 district network return is the source for next year's
6 funding. When we have multi-purpose facilities under the
7 rural scheme, each facility will get additional nearly
8 $900,000 as fixed costs, and in that statement we - there
9 are six facilities that received fixed costs of 900,000
10 each, but two were missing. And we have discussed that
11 with the ministry.
12
13 Q. I will come back to the two that are missing, but if
14 we can just take that step, break that up just a little
15 bit, briefly. So the first thing that is done is expenses
16 are captured for each of the facilities; is that right?
17 A. Correct.
18
19 Q. And when you refer to "expenses", that's the cost of
20 delivering care within those facilities over a year period;
21 is that right?
22 A. Yes.
23
24 Q. And then you say that's converted into a district
25 network return?
26 A. Yes.
27
28 Q. How is that done?
29 A. That's done - we have a cost accountant. There is
30 cost accountants everywhere across the state, or teams. As
31 a small LHD, we have one person. They will do the - they
32 will use the formulas to bring the overheads on top of the
33 direct costs that we see on a day-to-day basis. The
34 overhead cost in Broken Hill or Far West is very high
35 compared to other districts.
36
37 Q. Is it very high for the reasons that you have
38 described earlier around workforce?
39 A. And there are more, as described by my other
40 colleagues in the Commission today.
41
42 Q. And after the district network return is calculated,
43 how is that figure then used as the source for the funding
44 for the next year?
45 A. There is a gap in my knowledge --
46
47 Q. That's okay. If you --

1 A. -- of how it's converted into the budget process, but
2 I know that that is the source of truth for next year
3 funding.
4
5 Q. And then over and above the amount that's calculated
6 using that process, is it the case that the fixed cost
7 adjustment of, in the case set out in paragraph 10,
8 $0.878 million, is applied to each facility as well; is
9 that right?
10 A. Yes.
11
12 Q. Then, in paragraph 10 - and in the answer you gave
13 earlier, you referred to the fact that two facilities did
14 not receive the adjustment?
15 A. Yes.
16
17 Q. Is that right?
18 A. That's correct.
19
20 Q. Have you been able to identify why that has been the
21 case?
22 A. The numbers, the mathematics, as I say, has been done
23 in 2018. There was no revisits in 2018 until I started
24 this job and I - there was a large turnover of director of
25 finance position during that time, until I started.
26 Probably I will be the longstanding person for a long time.
27 So I am not sure, but I wonder if people had the ability to
28 pay attention to these fine details of the service
29 agreement and challenge and come with a plan.
30
31 Q. The two facilities that you refer to in paragraph 10,
32 were they facilities that were opened in the intervening
33 period between 2018, I think you said, and --
34 A. There is one, Buronga One health service was opened
35 newly, Dareton is closing down, so that's - Dareton going
36 out, Buronga One is coming in. As I understand, from
37 1 July 2024, for the next financial year, Buronga One has
38 been identified as a separate facility.
39
40 White Cliffs is combined with another one, because
41 it's too small, is what I hear, but now we have raised our
42 hand and asked for help.
43
44 Q. Can I take you to paragraph 11. There you refer us to
45 the comprehensive expenditure review savings allocation,
46 and you expressed a view that it has a disproportionate
47 effect on the district.

1 A. Yes.
2
3 Q. Then, if you keep your finger on paragraph 11 and then
4 turn over at the same time to paragraph 23, there you give
5 us some particular examples of KPIs that are challenging
6 around fleet management and travel costs, do you see that?
7 A. Yes.
8
9 Q. Are the issues that you refer to in paragraph 11 those
10 that you also set out in more detail in paragraph 23?
11 A. Yes.
12
13 Q. Are there any other aspects of the comprehensive
14 expenditure review savings allocation, in addition to those
15 matters that you have set out in paragraph 23, that have
16 a disproportionate effect on the district?
17 A. Yes. The comprehensive expenditure review allocation
18 has different parts in it - travel, advertising,
19 consultancy, and other - and procurement savings. We
20 struggle with the travel cuts, the travel savings target,
21 because every person comes through the door
22 hereafter mostly will be coming outside Far West region,
23 and especially medical services now being we only have two
24 staff specialists, the travel is part of our normal
25 business as usual. Reducing travel year on year is -
26 cannot be observed hereafter. I think that's the fact.
27
28 THE COMMISSIONER: Q. Can I just ask, the travel
29 reduction from the comprehensive expenditure review savings
30 allocation, does that reduction of roughly one-third apply
31 equally to this health district as it would to, say, the
32 Sydney Local Health District?
33 A. Commissioner, I'm not sure what has happened to the
34 other districts, but when I look at my - our budget, it was
35 a one-third reduction from last year total expenses.
36
37 Q. So there was a one-third reduction in this LHD's
38 budget from that?
39 A. Correct.
40
41 Q. Do you know if anyone here suggested that perhaps that
42 shouldn't apply to a health district like this, where there
43 is so much travel involved and so much distance between
44 remote areas?
45 A. We have discussed this in all the formal forums that
46 we could. When I say "we", the ELT, the executive
47 leadership group, and the chief executive.

1
2 Q. And what response was given?
3 A. There is a recognition. This will be corrected next
4 year, but there was no correction for this financial year.
5
6 Q. Why not? If you don't know, you just say you don't
7 know.
8 A. I don't know.
9
10 MR GLOVER: Q. The other issue you raise as a particular
11 example is reduction in fleet vehicles?
12 A. Correct.
13
14 Q. And like the issue of travel costs, is that also
15 a matter that has been raised with the ministry to your
16 knowledge?
17 A. Yes.
18
19 Q. And has the outcome been the same, that is, it's been
20 acknowledged but there's been no particular adjustment made
21 at the moment?
22 A. Same outcome, but this one, we have given a brief to
23 the ministry explaining why the fleet reduction cannot be
24 achieved. The reason for the brief is there is a lack of
25 knowledge of using other travel modes in Broken Hill.
26 There is no taxi-like services, there is no Uber services,
27 very limited taxis, and there is no HealthShare presence
28 for patient transport. So there are three - there were
29 three patients from Wilcannia travelling to Broken Hill
30 three times a day, and we were using our cars.
31
32 Q. When was that brief given to the ministry, do you
33 know?
34 A. During this financial year. I'm sorry, I can't
35 remember the exact month.
36
37 Q. That's all right. Was it before or after the new
38 year, do you know, doing the best you can? If you don't
39 know, that's fine.
40 A. 2023. Late '23.
41
42 Q. And has there been a response to that brief, to your
43 knowledge?
44 A. Not a written response.
45
46 Q. Has there been another form of response that's not
47 written, to your knowledge?

1 A. Yes, there was a phone call, verbal response, that "We
2 acknowledge your challenges". The service agreement has
3 been signed off and further discussion will take place.
4
5 Q. Further discussions take place in the context of the
6 next service agreement?
7 A. Correct.
8
9 Q. But no adjustment to the budget for the current
10 financial year?
11 A. No adjustment.
12
13 Q. Can I ask you about paragraphs 12 and 13. There you
14 tell us that the district has limited revenue generating
15 opportunities and, in 13, suggest that revisiting the
16 current own-source revenue budget allocation is imperative.
17 Just in the context of these questions, I might show you
18 the services agreement, which is [MOH.9999.1261.0001].
19 I will just have that brought up on the screen to your
20 left. If we go to internal page 16, please, do you see
21 there, about a third of the way down the page, there is the
22 own source revenue line. Do you see that?
23 A. Yes.
24
25 Q. That's the category within the budget that you were
26 referring to in paragraphs 12 and 13, is it?
27 A. Yes.
28
29 Q. Why is it that you say in paragraph 13 that revisiting
30 the current own source revenue budget is imperative?
31 A. When I started this role I wanted to see why we are
32 underperforming in the revenue generation area - always
33 underperforming. So we went back all the way to financial
34 year 2018, pre-COVID conditions, to assess what's gone
35 wrong. There are one big reason. The fast track clinic
36 was in operation in Broken Hill, and that was closed during
37 the - during COVID pandemic. It was a clinical decision.
38 There is a large - we missed a large revenue generation
39 opportunity with the closure of the fast track clinic.
40 That's one reason.
41
42 Second reason is private health insurance, we are
43 living in a different demography here. With the changes to
44 the private health insurance schemes and the prices, there
45 is limited opportunities for us to use private health
46 insurance from the patients coming through the door. And
47 the Department of Veterans Affairs, the number of people

1 holding those cards are getting smaller and smaller, and
2 that is a statewide problem, not unique to Far West. All
3 those three reasons are giving a significant gap in the
4 budget - opportunity for us to achieve the revenue budget.
5
6 Q. And if we have a look at the budget line under the
7 heading "Own source revenue", if you are able to say, which
8 of the lines G to J, or if its a combination of them, say
9 so, but which of the lines in that budget are the ones that
10 are particularly impacted by the examples you have just
11 given?
12 A. G.
13
14 Q. So in the current financial year, there is an own
15 source revenue budget of a little under 15.5 million; is
16 that right?
17 A. Correct.
18
19 Q. Do you have a sense of how much own source revenue
20 against that line the district will be able to generate in
21 this financial year?
22 A. A little above 12 million.
23
24 Q. A little above 12 million?
25 A. Yes.
26
27 Q. Has this issue been raised with the ministry to your
28 knowledge?
29 A. I have raised.
30
31 Q. With which area within the ministry?
32 A. In the finance division.
33
34 Q. In what context has it been raised?
35 A. For someone to look at the revenue budget - building
36 the revenue budget and giving us the reasons why we have
37 a 15 million budget.
38
39 Q. And has there been a response to that engagement from
40 the ministry, to your knowledge?
41 A. Yes. There are a few inefficient areas within the
42 district of using private health insurance; we can improve
43 on our systems; we can invest on more people to look at
44 improving other private health insurance usage conversions;
45 and we have a revenue action plan that is in progress, so
46 this discussion is to be taken again in parallel with the
47 revenue action plan implementation.

1
2 Q. Even taking into account the potential for improvement
3 in efficiencies, do you have a sense of whether an own
4 source revenue budget in line G of about 15.5 million is
5 realistic for this district?
6 A. Definitely not.
7
8 Q. Just to be clear, it is not "definitely not" you don't
9 have a view; your view is it is definitely not realistic,
10 is that right?
11 A. Correct.
12
13 THE COMMISSIONER: I understood it that way, but you are
14 right, for the transcript. Yes.
15
16 MR GLOVER: I did too, but if one is reading it in six
17 months' time --
18
19 THE COMMISSIONER: Q. Can I just ask, before we move on,
20 it may be these questions are for someone else, but the
21 fast track clinic, what was that?
22 A. That's a clinical - that's a question for
23 a clinical --
24
25 Q. To the extent that you said you missed a revenue
26 opportunity by closing it, you told me that it was closed
27 due to a clinical decision. You are not saying anything
28 about that?
29 A. I'm not saying anything about that.
30
31 Q. You are just saying it was a source of lost revenue
32 because it was closed?
33 A. Correct.
34
35 MR GLOVER: Q. Can I take you briefly to the issue of
36 capital developments that you address in paragraphs 14 to
37 18 and I want to direct your attention to paragraph 17 just
38 to make sure that at least I have understood it correctly.
39 There you refer to one of the challenges in developing
40 business cases and financial impact statements for capital
41 improvements; do you see that?
42 A. Yes.
43
44 Q. Do I understand that the issue that you raise in this
45 paragraph is that an assessment of those business cases and
46 statements is more focused on those things that can be
47 measured, and they don't, in your view, adequately take

1 into account the intangible benefits of the projects that
2 the district is looking to implement; is that correct?
3 A. That's correct.
4
5 Q. Taking into account the issue you raise in
6 paragraph 17, is there something that could be done
7 differently to ensure that those intangible benefits of
8 projects are better recognised in the assessment process?
9 A. I think so. The - if the people who are doing these
10 economic appraisals have an understanding of how the
11 rural/regionals work, it is a better way of responding to
12 the - sorry, it's a better way of looking at the economic
13 appraisals. I will go back to my previous statement,
14 everything mathematically is not working here. It's the
15 misunderstanding of how the LHD or the district works and
16 the impact to the community. I can give an example, if
17 required.
18
19 Q. Please do.
20 A. Wentworth Hospital has 20 beds, $30 million capital
21 investment. We are replacing 20 beds with 19 beds. If
22 this is given to an accountant, they will say "You don't
23 need X amount of staff now you only have 19 beds", but
24 that's not the reality. We are replacing an 80-year-old
25 building with bigger spaces, with new Australian Standards,
26 with the more elbow space for doctors, for patients,
27 cleaning, culturally appropriate places to maintain and
28 that all comes with an additional cost, operational cost.
29 To convince that level is a little bit challenging. Can
30 I take the word out "a little bit", it is challenging. It
31 is because of the lack of understanding of replacing like
32 for like in the rural areas.
33
34 Q. And does that challenge feed in to the issue you raise
35 in paragraph 18 about what you describe as the top-down
36 approach for costing?
37 A. Yes.
38
39 Q. Can you just explain in general terms the particular
40 issue that you are raising in paragraph 18 and why it is
41 a concern to you?
42 A. I will take the same example, Wentworth Hospital,
43 $30 million. That $30 million has been calculated
44 centrally by following a formula. When you - when we start
45 looking at every part of the hospital rebuild, the
46 professional services to bring those skills to even design
47 the hospital, to do every little bit, it's very costly.

1 There are a lot of instances where we - the LHD - had to
2 decide - the executive group and the chief executive, had
3 to decide that we will be doing this section because it's
4 culturally appropriate for the community. It goes above
5 the $30 million. So we decide to chip in.
6
7 Similarly, there are people we need on the ground who
8 can support through the change process. Some parts of
9 those - some costs of those people have been absorbed by
10 the project, but not all. In those instances, we have to -
11 or we decide to spend from our operational budget through
12 our vacancies.
13
14 Q. And that obviously has an impact on the district's
15 ability to fund other measures?
16 A. Correct.
17
18 Q. Finally, Ms Kahawita, can I ask you about
19 paragraph 24.
20
21 THE COMMISSIONER: Q. Just before you move on, so
22 I understand what was just said, so the Wentworth Hospital
23 redevelopment, someone, what, in health infrastructure,
24 says it's $30 million to do it; is that how it --
25 A. Yes.
26
27 Q. But to actually build it and make it as useful as it
28 can be to this particular local health district, including,
29 for example, having culturally appropriate places, bearing
30 in mind the population of First Nations people in this
31 health district, it actually costs a lot more - or costs
32 more than 30 million, is that --
33 A. That's correct.
34
35 Q. And then it's up to the LHD to find how to fund that
36 some other way?
37 A. Yes. We have decided to do that way, Commissioner.
38 If it is a 700 million project or 1 billion, as other metro
39 LHDs, it's quite easy to put the little things in. But we
40 have no place to hide.
41
42 THE COMMISSIONER: Okay, I understand.
43
44 MR GLOVER: Q. Finally, I will take you to paragraph 24,
45 and there, as you have made clear throughout your evidence
46 this afternoon, the district faces a number of unique
47 challenges. In the last sentence there, you say that the

1 ministry teams sitting under the deputy secretary for rural
2 and regional health is a positive mechanism. Do you see
3 that?
4 A. Yes.
5
6 Q. Have you had engagement with that team?
7 A. I do.
8
9 Q. What are the benefits of the establishment of that
10 team?
11 A. There are bigger programs such as staff accommodation
12 that we, and the whole state, believes - we need to take
13 a different approach than fighting for the same houses in
14 Broken Hill by transport, ambulance, health, education and
15 so on. So when we have these great ideas, we have the
16 opportunity to engage with this division and express the
17 opportunities.
18
19 Similarly, they have developed the regional - sorry if
20 I go wrong with this name - regional health strategic plan
21 and the implementation of the strategic plan sits with us.
22 We take that seriously. Therefore, there is engagement,
23 there are people coming to visit us to understand various
24 parts. Probably finance, as a finance person, my
25 engagement will be really limited. Finance questions go to
26 the finance division.
27
28 Q. Would there be benefit in the rural and regional
29 health department being involved in some of those finance
30 issues to improve the awareness or understanding of some of
31 the unique challenges that you have discussed today?
32 A. It is beneficial, and they are. We have received
33 a number of opportunities to bring them into those
34 conversations, to probably elevate the pitch. Yes.
35
36 MR GLOVER: Thank you, Ms Kahawita, I have no further
37 questions.
38
39 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
40 questions?
41
42 MR CHENEY: No, Commissioner.
43
44 THE COMMISSIONER: Thank you very much for your time. We
45 are very grateful.
46
47 THE WITNESS: Thank you, Commissioner.

1
2 THE COMMISSIONER: You are excused.
3
4 **<THE WITNESS WITHDREW**
5
6 MR GLOVER: Mr Astill is the next witness.
7
8 **<BRADLEY DAVID ASTILL, affirmed: [2.40pm]**
9
10 **<EXAMINATION BY MR MUSTON:**
11
12 MR MUSTON: Q. Mr Astill, could you please state your
13 full name for the record?
14 A. Bradley David Astill.
15
16 Q. You are chief executive of the Far West LHD?
17 A. Yes.
18
19 Q. A role that you have held since 1 January 2023?
20 A. Yes. I started - well, this time around I started out
21 here on 22 July 2022. Initially, I was acting while the
22 district was recruiting to the chief executive role, and lo
23 and behold they recruited me, so officially appointed on
24 1 January 2023.
25
26 Q. In total, how long have you spent in and around the
27 Far West LHD in getting a sense of the way things work on
28 the ground?
29 A. So I had the opportunity to act as the chief executive
30 in 2019/2020, again while they were recruiting the chief
31 executive that time. So that was about a period of six
32 months. But I've had involvement with Broken Hill Hospital
33 and the services in Far West for probably upwards of
34 20 years in different roles that I've held through the
35 Ministry of Health.
36
37 Q. You have prepared a statement to assist with the
38 Inquiry's work, dated 8 May 2025 [sic]?
39 A. Yes.
40
41 Q. For the record, it's [MOH.9999.1258.0001]. Have you
42 had a chance to review that statement before giving your
43 evidence today?
44 A. Yes, I have.
45
46 Q. Are you satisfied that the contents are, to the best
47 of your knowledge, true and correct?

1 A. To the best of my knowledge, yes.
2
3 MR MUSTON: That will be tendered in due course,
4 Commissioner.
5
6 THE COMMISSIONER: Thank you.
7
8 MR MUSTON: Q. Could I just start by testing a couple of
9 baseline propositions. Perhaps if we could bring up a copy
10 of yesterday's transcript at page 3107. Do you see that
11 commencing at line 5 - do you see on the left-hand side
12 some numbers, they are the line numbers? At line 5,
13 Dr Nott gives an answer about the irrefutable evidence or
14 what he understands to be the irrefutable evidence
15 regarding the role of primary care. If you could read that
16 first paragraph down to about line 12.
17 A. Okay.
18
19 Q. Is that a proposition you agree with?
20 A. Absolutely, yes, no question.
21
22 Q. Consistent with your understanding?
23 A. Yes.
24
25 Q. Perhaps if you could go back, line 20 of the same
26 passage, down to about line 29, commencing "If you look at
27 the number of enablers"?
28 A. Yes.
29
30 Q. Again, that's a proposition you agree with?
31 A. Yes. Yeah.
32
33 Q. And while we're in that transcript, I might just take
34 you to one more - no, I will come back to it. In terms of
35 the way in which the population that is served by this LHD
36 are distributed and the remoteness of that relatively small
37 population, would you agree that in order to best deliver
38 health care to them, it's essential that there be a close
39 collaboration between the various entities, by which
40 I really mean the LHD, the PHN, Flying Doctor Service and
41 the Aboriginal community controlled health organisations?
42 A. Yeah. Remoteness is a really significant factor for
43 us to contend with, and we've all experienced that, and the
44 Commission had the opportunity to experience that to
45 a certain extent on our site visits on Tuesday. Provision
46 of services into those remote communities is a real
47 challenge and you have heard evidence from all sorts of

1 people over the last two days about that. We seek to work
2 really closely with our partner organisations, whether it
3 is RFDS or the ACCHO sector or the PHN, and I guess, for
4 us, it's about who the most appropriate provider is for
5 a particular type of service, and it's not necessarily that
6 we need to provide everything, and that in fact there are
7 other providers in the region that are better equipped to
8 provide certain types of services, and from our perspective
9 we would like to support them to do that however best we
10 can.
11
12 Some of the constraints on us being able to do that
13 are around funding mechanisms and, you know, you will have
14 heard across the whole state about issues between the
15 Commonwealth and state funding models, and so we only have
16 control over a certain portion of that - ie, the budget
17 that you've just heard Apsara talking about, but equally,
18 if one organisation is better at providing something, then
19 from my perspective, I think we should be helping them to
20 do that rather than competing. And the worst situation
21 that could occur for all of us is that there is either
22 duplication or we are tripping over each other or stamping
23 on each other's toes in the provision of service to the
24 community because that doesn't service the community as
25 well.
26
27 Q. We've heard it described variously during our time
28 here in Far West as a patchwork of services which is being
29 pulled together or stitched together in a way that best
30 enables them to meet the health needs of the communities
31 that they serve. You mentioned the funding arrangements.
32 Just as a starting proposition - and we might come back to
33 funding in a little bit more detail - is there a need for
34 funding to be allocated to or deployed towards that
35 stitching process, the collaboration exercise that enables
36 those various organisations to come together in a way that
37 makes sure that the patchwork is put together as best as it
38 can be?
39 A. I think one of the biggest issues for these
40 communities in our region is that they are not enabled to
41 have access to their share of Medicare dollars. You have
42 heard from Dr Wenham today about the arrangement we have
43 with My Emergency Doctor, and that's a pure replacement for
44 GP-based services, and we're funding that out of our
45 operating budget.
46
47 Q. If I can ask you to pause there, we will come to that

1 in a bit more detail as well, you say it is a replacement
2 for GP services, but the My Emergency Doctor service is not
3 really stable and continuous primary care of the type you
4 get from a GP.
5 A. No, absolutely not, no.
6
7 Q. And it doesn't - whilst it patches up urgent need for
8 primary care type services, it doesn't provide the benefits
9 that Dr Nott was alluding to in that initial
10 paragraph I asked you to consider; is that right?
11 A. Yes. And going back to Dr Nott's evidence yesterday,
12 he talked about the fact that there are dollars to deliver
13 services, but there is no real dollars for us to sit down
14 and properly plan those services.
15
16 Q. That's getting right to the heart of the question
17 I was asking you. In order to sit down and plan how that
18 patchwork of services is to be brought together, there is
19 a few steps, we'll identify the steps first. Each of the
20 key deliverers of service, so, say, yourselves, the RFDS
21 and the community-controlled health organisations need to
22 get together and work out what your services are, what you
23 have each got to offer?
24 A. (Witness nods).
25
26 Q. That's point 1. Point 2, the PHN probably needs to be
27 brought in to that process with a view to identifying,
28 first of all, what health needs analysis or data that
29 organisation has that can be drawn upon in combination with
30 the data that each of the other bodies has available, to
31 work out what, at least on paper, the health needs are.
32 A. (Witness nods).
33
34 Q. Based on that, some, let's call it a draft, assessment
35 can be made between you of exactly how services might be
36 delivered across the various communities to meet the needs
37 that have been identified on paper.
38 A. (Witness nods).
39
40 Q. I note that you are nodding. You have to say "yes"
41 out loud so it goes on the transcript.
42 A. Oh, sorry, yes, apologies.
43
44 Q. There is probably a further step that I might have
45 missed there which is insofar as the PHN is concerned,
46 whilst they are not really a provider of services, they
47 might be a funding source and there may be some funding

1 that can be tapped into, so they bring that to the table as
2 well. So those processes, as a starting proposition to get
3 us to a draft of the way we might deal with some of these
4 issues, take time. Is there room within your
5 organisation's budget to devote that time to that task?
6 A. I think there has to be. I think it's - it goes
7 without saying.
8
9 Q. There might be two - it might be a slightly different
10 question. The first question is, is there actually room
11 within your budget to do it? Maybe I should have asked in
12 the other order. I know the answer to the first one.
13 Should there be room in your budget to do that?
14 A. Yes, there should.
15
16 Q. Is there room in your budget to do that?
17 A. I think we could find a way to contribute to that.
18
19 Q. Finding a way to contribute to that, does that involve
20 taking money away from other services that are potentially
21 meeting urgent need within the community?
22 A. No, not necessarily. We have - so picking up the
23 subject of needs data, we have access to a range of
24 demographic, population and arguably needs data, which we
25 can access through the health information unit in Western
26 New South Wales, and that unit is funded through a shared
27 service agreement with Western New South Wales. That type
28 of unit wouldn't be able to be - it wouldn't be feasible to
29 have two separate units, one for us and one for Western,
30 and it is much better to pool those resources for that type
31 of function. And so we would have access to some of that
32 information to start with, as a natural part of our current
33 situation.
34
35 My understanding is that the PHN has a deliverable as
36 part of their funding agreement with the Commonwealth to
37 also do a needs assessment of their patch. So there is an
38 opportunity there as well for them to participate in that
39 needs analysis.
40
41 I think this region is really uniquely positioned in
42 that, probably largely due to our remoteness, there is not
43 a lot of sort of border issues with other LHDs. We sort of
44 end up having to make our own way in many respects, and it
45 does lend itself to this region being quite an interesting
46 sort of test bed or Petri dish, or whatever you want to
47 call it, where we could test some of these theories with

1 the agreement of all the different funding agencies. But
2 I think that opportunity should be there, and it would be
3 a unique opportunity to trial that, and the learnings from
4 that could well contribute to other rural areas.
5
6 Q. So that opportunity is an opportunity, to use
7 Dr Nott's term from yesterday, to pool the funds available
8 and to decide in a collective and collaborative way how
9 best to deploy those funds to meet the health needs of
10 individual communities?
11 A. Yes.
12
13 Q. I think I've taken you through the process to the step
14 that I, at least in my language, had described as a draft
15 of how you might go about meeting some of these issues.
16 The next step, we're told by Dr Nott, is one needs to go
17 into the communities and actually ground-check or
18 ground-truth some of the data that you have collected.
19 Would you agree that that's a necessary step in terms of
20 good service planning?
21 A. Yes. And we've got a process for doing that already,
22 and we meet annually with the Aboriginal community working
23 parties particularly, and come up with a community action
24 plan with each of those towns, really. Across our patch,
25 you know, you have seen the map and you have seen where the
26 towns lie, and many of those towns have very different and
27 unique needs. It's not as if you could do a cut-and-paste
28 to Ivanhoe and that would apply equally to White Cliffs and
29 vice versa. So it does require that local discussion, and
30 we certainly do that with the local Aboriginal working
31 parties.
32
33 And then you would have heard earlier today, we also
34 have local health advisory councils associated with every
35 one of our facilities. I think we're in a bit of a unique
36 situation compared to other rural areas where those health
37 advisory committees have been in place for a long time.
38 They are voluntary and we do rely on them to provide advice
39 to us. We see them as a conduit into the community as
40 a way of gauging the community's needs. But, again, in
41 different towns, we engage with a whole range of different
42 groups.
43
44 So, for instance, in Wilcannia, there is probably
45 about four different community groups, and it's a bit of
46 a Venn diagram. So some of them overlap but some of them
47 don't, and they represent different aspects of the

1 community. You heard earlier, I can't remember who spoke
2 to it, but the work that we're doing around dialysis in
3 Wilcannia, we've actively engaged with all of those groups
4 to gauge what they feel they need and check that what we're
5 planning to deliver is on track with what they need. And
6 we do that on a regular basis and we're due to go up there
7 again in a week or so's time to have a further chat about
8 our current progress on that project.
9
10 Q. Dealing with the LHACs, do you get the sense - and
11 there may be variation amongst them - that they are truly
12 representative of the communities served by the facilities?
13 A. I would say they are somewhat representative. They
14 are voluntary, so people volunteer to participate and, you
15 know, we all know about the time commitment that volunteers
16 make. I think in many of the towns, they are probably
17 fairly representative. Most of them we have
18 representatives from the local Aboriginal community on
19 those LHACs, but again, they are voluntary, so it does
20 depend on people putting their hand up. And so, in that
21 context, you can't be sure, and I guess for Wilcannia, for
22 instance, we've taken that step of going even further, to
23 meet with local Aboriginal Land Councils, the local
24 Aboriginal working party, the LHAC and so on, so that we
25 can make sure that we're really speaking to as much of the
26 community as we can.
27
28 Q. Dr Nott gave some evidence yesterday to the effect
29 that what that nice deep and rich pool of data tells you
30 about the health needs of a community is incredibly useful
31 and important, but the next step is you actually need to
32 get down on to the ground --
33 A. Mmm.
34
35 Q. -- and say "This is what the data is telling us, what
36 do you think", and his observation is sometimes they will
37 say "That says we need Y but actually what we really need
38 here is X".
39 A. Mmm.
40
41 Q. Is that --
42 A. Look, yes, I think that's a fair comment. I think the
43 data will only tell you so much and it's, by and large,
44 often comparative data, so it's comparing our district to
45 the rest of the state and, you know, those comparisons can
46 apply but not necessarily and, equally, I think when you
47 have those conversations with the local communities, other

1 issues do arise that perhaps the data doesn't necessarily
2 point to.
3
4 Q. Particularly in communities with low health literacy
5 and significant health challenges, in many cases associated
6 with poor access to, or at least poor taking up of health
7 services, the data is always going to be a little bit
8 unreliable, isn't it - that is, the data on paper?
9 A. Absolutely, and you heard Mr Files from the board this
10 morning talking about the fact that members of the
11 Aboriginal community don't necessarily always participate
12 in events that would contribute to that data pool. In many
13 respects in health we only measure what we see, so we
14 measure the people that are coming through the door. We do
15 rely on other sources of data, though, like the Australian
16 Institute of Health and Welfare and other data sources like
17 that, but also census data, and you heard Justin speak to
18 that this morning. So it's representative to a point,
19 I think.
20
21 Q. So to get that more reliable data, you actually need
22 to get down on to the ground and speak to the people?
23 A. Yes, absolutely.
24
25 Q. Not every single person, obviously.
26 A. Yes, absolutely.
27
28 Q. You mentioned that the First Nations working parties
29 that you have associated with the facilities, that you
30 have, did you say, an annual meeting with them?
31 A. We've - we meet with them on an annual basis to review
32 the work plan for that year, so we rely on the community
33 working parties, which is a function of the Murdi Paaki
34 Regional Assembly and so on. They are subsets of that
35 group. But it is particularly focused on the needs of the
36 Aboriginal community, and that's okay, because a stated aim
37 of ours is to try to redress that balance.
38
39 Q. In a town like Wilcannia, for example, where whilst
40 I think I saw in one of your documents your area-wide
41 percentage of population who identifies as First Nations is
42 around 13 per cent?
43 A. 13 per cent.
44
45 Q. In a town like Wilcannia, that's closer to 70 to
46 80 per cent?
47 A. Correct.

1
2 Q. So it is critically important in some of those
3 communities to get in and focus very closely on the First
4 Nations --
5 A. Correct and, equally, that's why we've been engaging
6 with those different elements in the community to make sure
7 we capture as much of that information as we can.
8
9 Q. So in terms of the annual meeting with the community
10 working groups, is that a one-day meeting or a multiple day
11 meeting?
12 A. I could - it is a very iterative thing because they
13 may well come up with an action plan which requires further
14 discussion and editing and so on before it is finally
15 signed off by the group. So it would be a series of
16 meetings, I would suggest.
17
18 Q. It may not be possible within your budget, and
19 certainly tell us - I'm not suggesting critically that it
20 is not happening - but are you satisfied that the
21 engagement that you are having, say, with the community
22 working groups is actually giving you a real ground truth
23 sense of what the health needs of each of the individual
24 communities within your LHD are as compared with what maybe
25 the data tells you?
26 A. I think when we - we measure - when we balance what
27 the community working parties are telling us and then match
28 that to what some of the data tells us, I think that gives
29 us a fairly clear picture. It can always be better. Now,
30 our communities are quite diverse. In many respects, some
31 of them are quite transient, and so what you get told this
32 year might be very different next year because it is
33 a different group of people that you are speaking to, and
34 that's entirely natural, but I think, you know, we try to
35 embrace all of those data sources as best we can to try and
36 help guide us in what services we ultimately deliver, but
37 we can always do better.
38
39 Q. But the dynamic nature of the population group only
40 reinforces, doesn't it, the need to check in very regularly
41 to make sure you've got a good ground truth assessment of
42 what the health needs are?
43 A. Yes, absolutely.
44
45 Q. And also to make sure that whatever strategy you might
46 have formulated for delivering on those health needs, it's
47 constantly well suited - still remains well suited --

1 A. Yes.
2
3 Q. -- to the delivery of those needs in the particular
4 population at that particular point in time?
5 A. Yes, and if I could talk about the Wilcannia dialysis
6 service as an example, we received very strong messages,
7 particularly from the Aboriginal community but not only the
8 Aboriginal community, that it was a priority for that town
9 to have better access to dialysis, and if we were to go
10 down a pure health services planning pathway, you wouldn't
11 establish a dialysis service for a handful of patients.
12 But, equally, to have those handful of patients expected to
13 travel to Broken Hill two hours each way, which we all
14 experienced earlier this week, three times a week, for the
15 rest of their lives, is clearly untenable and unacceptable,
16 and on the basis of that, we started to investigate what
17 was - what we could do.
18
19 The first thing that we did was that we implemented
20 the transport service so that the patients weren't required
21 to essentially make their own way to Broken Hill, or have
22 their family bring them to Broken Hill, because that was
23 putting quite a large burden on those families - time away
24 from work, time away from school for kids, so on and so
25 forth.
26
27 Q. Pausing there, having established the transport
28 service that you did, did it become apparent that the
29 number of people requiring renal services was larger than
30 whatever the data you had available to you might have
31 suggested?
32 A. I don't know that we've got unequivocal data yet
33 around that, and certainly what we're - I think in the back
34 of our minds, we're relying a little bit on anecdotal
35 advice and I guess --
36
37 Q. Where do the anecdotes come from?
38 A. Listening to the community.
39
40 Q. So primary health care in that community is, in a
41 largish part, delivered by Maari Ma?
42 A. It is a mixture of Maari Ma and RFDS, yes.
43
44 Q. Have you spoken to Maari Ma and RFDS about their sense
45 of the --
46 A. Yes. Yes. Maari Ma have a renal specialist who comes
47 out from Sydney LHD and he's been delivering specialty

1 services into that community for a long time. It's very
2 handy for us that we've got this developing relationship
3 with Sydney LHD because it's very easy to plug in to that,
4 but certainly the advice is that there is probably a level
5 of - I don't know what word you would use, but un -
6 invisible disease in the community, and the suggestion is
7 that there would be people in the community who are not
8 seeking activity treatment for their renal disease for fear
9 of signing up to that travel to Broken Hill on a regular
10 basis.
11
12 We've also heard of families who have moved away from
13 town, moved off country, so to Dubbo, for instance, in
14 order to have easier access to dialysis services, and we
15 fully expect that once we get the dialysis service
16 established in Wilcannia, that those families may well move
17 back on country to access that service. So much of our
18 planning around capacity for that service is with that in
19 the back of our minds at least.
20
21 The other thing I guess that we're factoring in in
22 developing that service is we're not going to have
23 a maintenance engineer just sitting around the corner
24 coming in to fix the machine if something goes wrong, so we
25 need to have a bit of redundancy within the service so that
26 we can afford one of the machines to be down and still be
27 able to deliver a service.
28
29 So we're taking a very measured approach to how we
30 implement the dialysis service in Wilcannia, because the
31 last thing we want to do is open it on Monday and close it
32 on Friday because something's gone wrong.
33
34 Q. I'll cut you off midstream. You were telling us that
35 the first thing you had introduced was the transport from
36 Wilcannia to Broken Hill. Next phase in the planning
37 process is what you were about to tell us about?
38 A. Well, that will be the establishment of the - the
39 opening of the dialysis service in town. We're well into
40 the planning of that. We've been able to secure funding
41 from both the Commonwealth and the state to help us to fund
42 that - capital funding. That doesn't cover the recurrent
43 costs, but equally, we're flag - it was interesting your
44 discussion with Apsara, we're flagging that through the
45 service agreement process for next year, flagging that we
46 expect that partway through next financial year that
47 service would go live and so we would need part year's

1 funding for the recurrent costs, the staffing costs and so
2 on, to operate that service.
3
4 Dialysis is not a cheap service to operate. Equipment
5 and consumables are quite expensive and then the staffing
6 expertise is something that we've got to build on.
7
8 Q. We'll come to it in a little bit more detail shortly,
9 but in your service development priority focus areas
10 document, prepared in March of 2024, which for the record
11 is [MOH.9999.1283.0001], at page 15, having discussed
12 priority 2, the development of purposeful partnerships, you
13 identify one of the potential benefits is opportunities for
14 shared service delivery, collocation of services,
15 et cetera.
16 A. Yes.
17
18 Q. Has there been any discussion, say, with Maari Ma in
19 Wilcannia about the possibility of locating some of the
20 renal services within their magnificent facility on the
21 bank of the river?
22 A. Yes, we have talked about the delivery of the dialysis
23 specifically with Maari Ma, or I certainly have with the
24 CE, and I guess with Maari Ma's focus being on primary
25 care, they are far more interested in that space. In terms
26 of delivering a breadth of renal services for that
27 community, though, there is the element of the first
28 diagnosis stage through to the stage where the patient
29 requires dialysis, and so we need a pathway for patients
30 going through that whole flow, and certainly we've started
31 to have discussions about that. It is very early.
32
33 But, certainly, their renal physician, who I mentioned
34 before is coming out from Sydney LHD, has been involved in
35 a lot of the discussions we've been having internally about
36 models of care. It's a technically complex model that we
37 have to put in place. Our renal services in Broken Hill
38 here have their clinical medical oversight from the Royal
39 Adelaide Hospital, and our plan is to operate the dialysis
40 unit at Wilcannia essentially as an outreach service from
41 Broken Hill.
42
43 So we need a way for those two groups of medical staff
44 to talk to each other and, I guess, hand patients between
45 themselves, so if the renal physician who is seeing the
46 patients in a primary care sense in the Maari Ma facility
47 believes Mrs Smith now needs dialysis, we need a pathway so

1 that those discussions can be held, if you like, to hand
2 over the care to the Royal Adelaide renal team, but also
3 interface with us.
4
5 So down the track - and, you know, we're still in
6 pretty early stages and we've really only secured the final
7 approval for capital funding very recently - but it does
8 allow us to now say "Right, we have a project, we're going
9 forward", although internally we've said that all along
10 anyway, because we have felt that it was so important. We
11 need to start implementing those discussions about how the
12 services will interface.
13
14 Q. We have heard in some of our discussions along the way
15 that traditional hospitals are not necessarily happy or
16 inviting places for a number of First Nations people. As
17 part of this project at Wilcannia, has there been any
18 engagement with the community about where members of the
19 community who might be needing, either now or in the
20 future, renal services would wish to go for those services?
21 A. We've certainly talked to them about the space that
22 we're planning to use, and you saw that on the site visit,
23 and the people we've spoken to are a representative of
24 their community and are quite comfortable with that. It's
25 a particular focus of ours to increase the percentage of
26 Aboriginal people in our workforce across the district.
27 Obviously, places like Wilcannia is a priority focus for us
28 in doing that.
29
30 We're currently training a number of Aboriginal health
31 workers and practitioners through TAFE here. We actually
32 have the largest portion of the cohort currently being
33 trained, which we're really pleased about. We've got no
34 shortage of roles that we can put them into. We've got
35 a number of Aboriginal health workers and practitioners
36 already at Wilcannia. We've reached out to people in the
37 community who we know have been trained who are perhaps not
38 working at the moment to look at whether they will
39 re-engage with us and work for us, and there's been some
40 interest in that space.
41
42 But we're very conscious of training our own workforce
43 locally. You heard Dr Wenham talking about medical staff,
44 but it's equally important for us with our nursing staff
45 and particularly with our Aboriginal health staff. So
46 we've had quite a focus on applying resources to training
47 additional Aboriginal people in a range of roles across the

1 board in the organisation.
2
3 Q. While we're on that topic, perhaps if we can go to
4 paragraph 104 of your statement. You tell us about a range
5 of strategies that have been introduced to train local
6 people, including some school-based apprenticeships and
7 training. In relation to the school-based training, can
8 I ask, how many schools are there - not necessarily to the
9 number - in the Far West LHD?
10 A. I wouldn't know the number off the top of my head, but
11 I think Mr Green mentioned yesterday we've recently
12 recruited a school-based apprenticeship and training
13 coordinator, and part of her role will be reaching out to
14 all the schools in the district, not just in Broken Hill
15 but all of the schools, to encourage students to take up
16 the SBA/T traineeships.
17
18 Q. I take it from that, at the moment the focus of that
19 SBA/T pathway has been Broken Hill?
20 A. But certainly, in recent times, since the appointment
21 of the coordinator, we've certainly looked at reaching out
22 to Wilcannia particularly, Menindee to a lesser extent and
23 then ultimately down south as well. But she is one person
24 and it's a big district. So the challenge is that, I guess
25 there's been somewhat of a history of the students not
26 staying on to year 11 and 12, and that's a requirement for
27 them to undertake the TAFE component of the training. So
28 that's the first step.
29
30 And the role of the coordinator will be not just to
31 get some names on a list but to actually work with them,
32 support them, provide even as simple as filling out
33 application forms, to encourage students to take up
34 opportunities with that program.
35
36 I guess we would like to be - we like the community to
37 see that careers in health are a viable thing for people in
38 the community. They don't have to move away to get
39 employment.
40
41 Q. We heard some evidence yesterday that that - to be
42 most effective, that process may even start in primary
43 school?
44 A. Yes. Yes.
45
46 Q. Keeping kids engaged and with a career path that might
47 keep them in school?

1 A. Absolutely. Absolutely.
2
3 Q. And then assisting them, once they get to that level
4 of their schooling, into the vocational training as part of
5 their schooling, no doubt in collaboration with the
6 schools?
7 A. Yes. Oh, and with TAFE, for that matter, because
8 the - if you like, the educational component is delivered
9 through TAFE, and I think we've probably had too narrow
10 a focus on that program in the past. We've tended to
11 either train people to do admin roles or early entry type
12 nursing paths, but there's far more that we can offer, and
13 particularly I think we're interested in looking at how
14 they can get into training programs, particularly for those
15 Aboriginal health focused roles, workers and practitioners.
16
17 Q. So, historically, to the extent that those efforts
18 have been made, they've been targeted in Broken Hill?
19 A. (Witness nods).
20
21 Q. You now have the one person who is covering a very
22 large footprint of schools?
23 A. Correct, yes.
24
25 Q. It is right that workforce challenges are some of the
26 most significant that you face within your LHD, at least in
27 terms of service delivery?
28 A. Correct.
29
30 Q. It's also right, is it not, that issues associated
31 with cultural safety and the delivery of safe and available
32 healthcare services to First Nations people critically
33 depends on increasing, to the best extent we can, First
34 Nations workforce within those services?
35 A. Absolutely.
36
37 Q. It's in those - for those reasons and no doubt others,
38 it should be a key priority of government to have as many
39 people trained through these programs, particularly First
40 Nations people trained through these programs, as is
41 possible?
42 A. Yes. I would say yes.
43
44 Q. You at the moment have, within your budget, an ability
45 to have set one person at that task?
46 A. Well, yes, but we've also employed an Aboriginal
47 employment officer, who will help people to take up

1 employment with us, so from the application process right
2 through to starting with us, through their orientation
3 component, but also as a resource as they settle into our
4 workforce. So that's another key role.
5
6 Q. Let's focus for the minute on the school-based
7 traineeships?
8 A. Sure.
9
10 Q. It would be preferable, wouldn't it, having regard to
11 the size of the LHD and the amount of effort that probably
12 needs to go into managing these relationships within each
13 school cohort and amongst each set of students, that there
14 be more than one person doing that job?
15 A. I guess ideally. We have had discussions with TAFE as
16 well to ensure that they are on board with our aspirations
17 as well, and certainly they are, and the local TAFE manager
18 here also is responsible for the TAFE service delivery in
19 Wilcannia, Menindee and Coomealla, so in that context - and
20 he's very keen to support us in that function.
21
22 Q. And the support from TAFE presumably involves
23 maximising the extent to which the delivery of that
24 training can be something which occurs within community or
25 within the workplace that these students are located as
26 opposed to a student from, say, Wilcannia having to go to
27 Dubbo to do a course?
28 A. Yes, and we've certainly had discussions with TAFE
29 about that, because just by the nature of the size of
30 Wilcannia or Menindee, they are not going to be able to
31 have a class cohort a similar size to Broken Hill, but TAFE
32 have signalled that they are prepared to run a program with
33 a smaller cohort, but to do it locally, so in Menindee or
34 Wilcannia.
35
36 Q. And in terms of the number of people who in the ideal
37 world would be involved in this task of engaging with
38 schools across the LHD on a regular basis, and in a way
39 which facilitates a workforce pipeline of the type that you
40 would want, it's - is the reason there is only one of them
41 because the head room that you have got available in your
42 budget at the moment would not extend to any more?
43 A. I think that's a fair comment but, you know, as the
44 program develops, if there is a need for more resource,
45 I think it is contingent on us to try to find the funds to
46 support that as well.
47

1 Q. Just while we're on that page, if you could have
2 a quick look at paragraph 105, you tell us that you are
3 engaging with some partner organisations across the
4 Victorian border to investigate opportunities for shared
5 positions across the health systems. Am I to take it that
6 that relates to particularly your border area employees
7 who, whilst you might not have a need for one full-time
8 FTE, occupational therapist, say, if there is someone on
9 the southern side of the border who's potentially got a 0.5
10 FTE OT role down there, you might be able to roll that up
11 across the two health services in order to get an employee
12 that might not otherwise be available?
13 A. We've had a lot of discussions with Mildura Hospital
14 particularly as probably the largest provider on the
15 Victorian side of the border, and equally when you travel
16 from Buronga or Gol Gol, it's literally 500 metres and you
17 are in Victoria, and you are in Mildura.
18
19 So many of our staff travel to Mildura routinely for
20 shopping and whatever else. It's a seamless region and,
21 you know, the artificial border that's been there for
22 various reasons really doesn't exist for those communities,
23 and so it makes absolute sense for us to share with Mildura
24 across that space.
25
26 We've been particularly talking with them about
27 student placements. There's been some pressure within the
28 education department in Victoria around student placements
29 in rural areas, and, you know, student placements come with
30 a certain overhead to supervise them and so on, and so
31 we've talked about potentially sharing student placements
32 across our campuses or our sites, and it makes a lot of
33 sense. Equally, just the same as having a partnership with
34 other providers locally here, it makes sense to develop
35 partnerships with Mildura Hospital particularly.
36
37 Q. On the topic of other providers, have you had
38 discussions with local providers of healthcare services of
39 a similar nature around the opportunities for shared
40 positions, so RFDS, Coomealla, Maari Ma?
41 A. We've certainly had very preliminary discussions, and
42 I guess this is where the funding issue rears its head, and
43 particularly having to account for funds, and so we've had
44 an arrangement with Coomealla for quite some time where one
45 of the GPs that works for them, who doesn't work full time
46 for them but works part time for them, also spends some
47 time providing medical cover for our patients at Wentworth,

1 and that's been a longstanding arrangement with Coomealla
2 Health, and it's worked quite well for both of us. And
3 it's also, I think professionally for that GP, given them a
4 variety of caseload that adds a certain level of interest
5 for them as well. So certainly we've had that shared
6 arrangement with Coomealla Health.
7
8 We've explored ways of sharing other properly
9 hard-to-staff services with Coomealla particularly, and
10 there is a shared arrangement that they have with
11 St Vincent's around drug and alcohol services, for
12 instance, and we've also explored other services that we
13 can share. I don't know that we've got quite there yet,
14 but we've had those discussions.
15
16 Locally with Maari Ma and RFDS, we've talked - well,
17 RFDS we've talked about doctors, but I don't think we've
18 quite got there yet, but I think we could construct some
19 really interesting placements for doctors where there is an
20 aspect of retrieval, there is an aspect of hospital work,
21 and potentially an aspect of general practice that we could
22 cobble together. But I think the funding issue still rears
23 its head across some of those boundaries.
24
25 Q. In what way?
26 A. Well, the - you know, we've got to account for our
27 funding to the ministry; RFDS have got to account for their
28 funding to their funder, whether it's the Commonwealth or
29 the state, and so there is that accounting thing which
30 I think sometimes gets in the way.
31
32 Q. I think maybe I'm oversimplifying it, but is it the
33 situation that whilst you might be able to employ someone
34 part time and then be able to account to the ministry about
35 a 0.5 appointment and there is the salary and there is the
36 person who is doing the job, to actually pay, for example,
37 Maari Ma or RFDS the exact same amount of money to share
38 the occupational therapist, or whatever it is --
39 A. Yes, for sure.
40
41 Q. -- is, for some administrative reason, harder?
42 A. I don't know that we've had the discussions at that
43 level yet, but certainly I think we should.
44
45 Q. May I take you back to paragraph 76 of your statement,
46 just coming back briefly to the topic of primary care. You
47 tell us in paragraph 76 that a decline in the access to

1 primary care is manifesting itself in an increase in
2 emergency department presentations. In paragraph 77 you
3 conclude with the statement you made earlier, that the
4 community of Broken Hill is not receiving an equitable
5 share of Medicare funding. Do you want to just elaborate
6 on what you mean by that?
7 A. I guess those general practice services are
8 traditionally funded through Medicare and with models such
9 as we've got in place around My Emergency Doctor, and
10 I suspect that some of these patients aren't even seeking
11 general practice, because they can't get appointments, or
12 it's very difficult.
13
14 We also hear anecdotally that the communities of our
15 region are very high users of the Healthdirect service,
16 which allows them to link for a telehealth consult with
17 a GP, and that's with no promotion or encouragement from
18 us, it's just something that they have discovered of their
19 own accord. But none of that is funded through Medicare,
20 and so, you know, many of community here are not really
21 getting their equitable share of the Medicare dollar, if
22 you like.
23
24 For us, we've instituted My Emergency Doctor, and it
25 was a pragmatic approach to try and ease the burden on our
26 ED staff to deal with the patient load that they should be
27 dealing with, the emergent type cases, but equally
28 conscious that many of those patients at the time when we
29 established that were waiting what could be argued was an
30 unreasonable period of time just to get a fairly
31 straightforward GP appointment for a medical certificate,
32 or a repeat script, or whatever.
33
34 I guess the only other comment to make is that primary
35 care is much more than just GPs and, in this region, there
36 is limited access to community-based allied health,
37 counselling services, psychologists, psychiatrists, drug
38 and alcohol practitioners and so on that would be probably
39 far more commonplace in some of our eastern colleagues'
40 LHDs, and so the community is not getting those services at
41 all, or in an extremely limited way.
42
43 Q. We heard some evidence yesterday from Mission
44 Australia. Did you hear that evidence given?
45 A. Yes, yes.
46
47 Q. Again, if you think I'm oversimplifying it, tell me,

1 but the strong sense one got from that evidence was that to
2 the extent some of the mental health - the array of mental
3 health services delivered via different grants and funding
4 sources through Mission Australia are being delivered
5 within your LHD, they are heavily concentrated within the
6 Broken Hill area.
7 A. Mmm, yes, that's a very fair comment.
8
9 Q. And would it be right that, in that sense, they are
10 not actually being delivered in areas which do have
11 significant need for a lot of those services?
12 A. We do have a range of outreach services to Menindee
13 and Wilcannia particularly, as probably two of the larger
14 towns outside Broken Hill and immediately close to Broken
15 Hill. So we do deliver outreach services there, either
16 ourselves, we have a contract with RFDS to deliver some
17 mental health services to those remote communities as well,
18 and I'm aware that Maari Ma provide some of those services
19 as well, and we do have a contract, a health and wellbeing
20 contract with Maari Ma for some of those services.
21
22 So going back to some earlier discussions we had, we
23 do have some sort of joint planning around some of that
24 stuff. We're not all trying to duplicate that, and, you
25 know, essentially in Wilcannia there are mental health
26 services available somewhere in town pretty much every day,
27 but by an array of providers, and that's probably where the
28 better model could be developed in having consistent
29 providers, rather than almost a different service every
30 day.
31
32 Q. It may be driven by awareness rather than
33 availability, but we were certainly told in Menindee that
34 one of the significant challenges with the mental health
35 services is, whilst you might have an outreach service that
36 comes on a particular day each week or each fortnight,
37 which is excellent. Unlike a lot of chronic illness, your
38 heart check or your blood sugar follow-up, a mental disease
39 is a little bit more dynamic.
40 A. That's right.
41
42 Q. It is one of those things where you need that care
43 when you need it and that could be any old time?
44 A. It might not be there for that day, correct.
45
46 Q. It might not be the day when it's there, and that, we
47 were told by the community, is something which presents as

1 a very significant problem to them. Is that an awareness
2 of the availability of service, do you think, or is it
3 a reflection of the fact that the service is just not there
4 to meet that need?
5 A. I think it is a bit of both. I think we could be
6 doing far more in making the community aware of services
7 that are available on a particular day and it's very early
8 days and we're nowhere near achieving it, but we're
9 planning to do that type of model for Wilcannia
10 particularly, so that, you know, the doctor is in, sort of
11 thing, sign can go up in town so that people know that the
12 service is in town that day and increase awareness and,
13 I guess, to a certain extent, the sort of health literacy
14 around some of those availability - the availability of
15 some of those services can be improved.
16
17 Q. Again, maybe it is a feature of this collaborative
18 service planning, but another thing we have been told about
19 over the past few days and also in Western New South Wales
20 is that gaps in physical - a physical presence of
21 particularly mental health support are often filled by
22 telehealth-type services, your 13YARN type projects, which,
23 on a piece of paper, as a service plan or map, look like
24 a fairly seamless line, but for the purposes of someone who
25 is receiving or needing those services, if a 13YARN is not
26 something that they are ever going to call or want to get,
27 it is as good as a gap?
28 A. No, and I think there is work we can be doing in that
29 space, you know, if there is a telehealth service
30 available, to facilitate access to that. Now, people
31 shouldn't have to rock up to the hospital just so that they
32 can sit in front of the computer that happens to be in the
33 hospital to have their telehealth consult, so I think
34 there's work that we can be doing in that space.
35
36 Q. But it is also right, isn't it, that if telehealth -
37 this is just by way of hypothetical example - in that
38 mental health space was something which the community was
39 telling you, through a deep engagement with the community,
40 is really not going to be taken up, then the costs
41 associated with delivering it could be redeployed in a
42 better way?
43 A. Yes, we need to listen to that.
44
45 Q. Can I just ask you quickly to track down to
46 paragraph 79. Do you see in the last sentence of that
47 paragraph you tell us about remote communities being served

1 through the Aboriginal Medical Service and RFDS, and you
2 make the closing observation that the care needs are far
3 from covered by the Commonwealth. Is that effectively for
4 the same reason as you have already given, or is there
5 another reason?
6 A. Yes, it is largely around that access to Medicare,
7 yes.
8
9 Q. In paragraph 80, you tell us about some work that was
10 done in response to extremely limited GP access in Dareton,
11 Wentworth and Buronga. The project was scoped, but
12 ultimately it didn't proceed. A few questions about that.
13 As part of that scoping of the project, were there
14 discussions about how those primary health care needs might
15 be met, either individually or as part of a broader
16 collaboration, that involved RFDS?
17 A. RFDS weren't included in those discussions around that
18 particular project. Our discussions were primarily with
19 CHAC, the Coomealla Health Aboriginal Corporation. The
20 driver for us embarking on that project was that the GP
21 that I mentioned earlier in Wentworth, who covers our
22 medical needs of our patients in the hospital, took up the
23 opportunity to go and do GP VMO training as an anaesthetist
24 and moved out of the area for the period of that training,
25 and so we were looking at being in a bit of a spot in terms
26 of medical coverage for Wentworth, but equally, GP coverage
27 for CHAC, and so we explored what we might be able to do in
28 that space to try and get a GP into that region, and they
29 would spend part of their time covering the patients in the
30 hospital, but the bulk of their time, in fact, providing GP
31 based services in the community with CHAC.
32
33 As you can see from some of the illustrations there,
34 the costs associated with that were quite high. We were
35 working with an agency, but not the typical locum agencies
36 that we often work with to fill gaps in the hospitals.
37 This is a locum agency who tries, wherever possible, to get
38 a roster of potentially three or four GPs, who would work
39 a week about, so that there is some consistency. So Dr X
40 would be there this week, and then he would be back in
41 three weeks' time, and Dr Y would be there the following
42 week and back in three weeks' time, so that the community
43 got some consistency of the doctors that they would be
44 seeing, they would know that Dr X is in town every three
45 weeks. If they had an urgent need, they could still go and
46 see Dr Y, but it did give some consistency of care.
47

1 It's quite a useful model. I heard you talking with
2 Apsara about the fast track model here at Broken Hill and
3 that was the model that we had in place here for a while,
4 or they had in place here for a while, but the costs of
5 bringing those people to town were crippling and, I guess,
6 for us, we were probably only going to have about
7 20 per cent of the time of that doctor covering the
8 hospital, yet we were investing the vast bulk of the money
9 in making it happen and, on that basis, we decided not to
10 continue with that planning.
11
12 In happenstance, another GP came into the Wentworth
13 region and so was able to fill that gap. So, in fact, the
14 problem sort of solved itself.
15
16 Q. For now.
17 A. For now, yes. For now, yes.
18
19 Q. Is it the fact that a GP who goes away and does some
20 no doubt excellent advanced skills training - which
21 provides a better service through the hospital - which
22 creates an enormous service gap of that type, demonstrates
23 the fragility of a service like that?
24 A. Oh, certainly.
25
26 Q. You concluded there by observing that the costing that
27 was done didn't include funding sources from Medicare,
28 because - and you also observed a 19(2) exemption would
29 have been required. Was it explored? Was a 19(2)
30 exemption explored with the Commonwealth?
31 A. We did a very rough back-of-an-envelope sort of
32 costing of what potential revenue could be generated
33 through the 19(2) model for billings that that GP might
34 undertake, but, you know, it in no way offset the costs,
35 but it would have contributed to offsetting the costs.
36
37 I guess, for us, the thing we didn't explore was the
38 legality, because whilst we were potentially paying the GP,
39 they were actually working in the GP practice in Coomealla,
40 and so are we entitled to the 19(2) revenue, or are
41 Coomealla? And we didn't even get as far as exploring
42 that, really, from a legal standpoint, but even our very
43 preliminary sort of exploration of what the section 19(2)
44 revenue might have looked like was nowhere near what we
45 would have needed to run the service, and I guess that's
46 the challenge in some of these small communities, is that
47 a GP practice based entirely just on MBS billings is not

1 sustainable. And I think that's what we've seen while
2 we've seen the situation that we have in a lot of small
3 rural communities: whilst they need a doctor, the Medicare
4 revenue associated with that GP practice doesn't help to
5 sustain it.
6
7 Q. Whilst it might not be cost neutral, the idea that any
8 community of a reasonable size is not able to sustain
9 a cost neutral medical service misses out on stable primary
10 care is not a particularly palatable one, is it?
11 A. No, absolutely, agree.
12
13 Q. Particularly where many of the communities who might
14 fall into that category - and you have a more precise
15 understanding of it than we would - many of the communities
16 who fall into that category would be, by and large,
17 proportionally First Nations populations?
18 A. They would have a larger proportion, yes, and I guess
19 it does beg the question about whether you can cobble
20 together somewhat of an arrangement like this where they
21 spend some time in hospital services, which may well be
22 paid for out of LHD or state funds, and some delivering
23 GP-type services funded through the Commonwealth, and
24 potentially some other services which might be funded by
25 the ACCHO or ACCHO revenue does suggest that you could
26 construct a medical service that could work in that
27 environment.
28
29 Q. But its neutrality or otherwise from a cost
30 perspective is in some respects a function of the amount of
31 money that the ministry gives you as an LHD to deliver that
32 service, is it not?
33 A. Yes, correct, yes.
34
35 Q. So if the ministry took the view that it was an
36 important priority to deliver and ensure that primary
37 health care in a town like Dareton or Wentworth was not
38 fragile, or was existent in circumstances where it would be
39 otherwise non-existent, it could provide you with the money
40 needed to deliver that service and you would be, in
41 collaboration with CHAC, able to deliver it in a way which
42 most efficiently utilised the workforce across both the
43 hospital or small hospital facilities and the primary
44 health care facilities that exist in those areas?
45 A. And I guess given that many of the services in that
46 context would be primary care-type services, it's not
47 unreasonable to have an expectation that there might be

1 some Medicare dollars attached to that as well to establish
2 that.
3
4 Q. And to the extent that a 19(2) exemption might be
5 required in order to access that money, you have got no
6 reason to think, do you, that if a service was formulated
7 and the Commonwealth was approached, that it would not be
8 forthcoming?
9 A. Yes, yes.
10
11 Q. Without 19(2) exemption?
12 A. Yes.
13
14 Q. While we're on that page, I might quickly ask you
15 a couple of questions about aged care. You tell us in
16 paragraphs 81 and 82 about some of the challenges with the
17 availability of residential aged care beds. At first, in
18 relation to 81, you give us an outline of what you have
19 available within your own facilities, and I think you say
20 there are four aged care beds at Wilcannia MPS?
21 A. Yes.
22
23 Q. Are they all full?
24 A. No.
25
26 Q. Is there a reason for that?
27 A. Just the remoteness from Broken Hill. There doesn't
28 seem to be demand from the local community for aged care
29 beds in that context, so there is one resident in there at
30 the moment in those four beds.
31
32 Q. Do you have any sense of why there is not a demand in
33 those communities, or within that community, Wilcannia, for
34 aged care beds?
35 A. No, I would be guessing to answer that.
36
37 Q. What about Balranald, there are 15 aged care beds, you
38 tell us, in Balranald. Are they all full?
39 A. They are all full.
40
41 Q. In paragraph 82 you talk about the more than two-month
42 wait list to get access to the Southern Cross facility?
43 A. Yes.
44
45 Q. Are there beds available in that facility, insofar as
46 you are aware?
47 A. So the Southern Cross - they are spread across two or

1 three facilities, but all up, Southern Cross operates
2 I think it's 212 beds altogether. As we understand it, at
3 the moment, they've got about 50 of those beds closed
4 across their facilities. We're in regular - our team are
5 in regular conversation with the manager of the Southern
6 Cross service, Mr Nankivell, and have discussions with him
7 on a regular basis about when beds might be available for
8 people who are currently residing in our acute care beds.
9
10 The challenge for us is in the context of an acute
11 hospital, we have what we call ED accessible beds, and they
12 are the beds that we essentially manage our surgical
13 caseload and patients that come through the ED, so with
14 medical problems or whatever. In Broken Hill Health
15 Service, we've got 40 of those. We've got specialty beds
16 as well, so paediatrics and obstetrics and ICU, you saw
17 that the other day. We've got those beds as well, but in
18 terms of the beds that we manage our, I guess, unplanned
19 acute load, we've got 40 beds.
20
21 I haven't seen the number for today, but yesterday we
22 had 26 aged care patients in those 40 beds, so it makes the
23 juggling of our acute caseload very difficult. Two weeks
24 ago for the first time we had to cancel some elective
25 surgery, because we didn't have a post op bed for those
26 patients to go into. So some of those patients who had
27 been waiting for elective surgery had been waiting up to
28 365 days, which is in line with the clinical guidelines
29 that NSW Health has, but then to wait beyond that because
30 we haven't really got a post-op bed really creates an issue
31 for us. Our team at the moment is meeting two, three, four
32 times a day to juggle patients through those 13, 14, 16
33 beds that we have access to, and I guess have to be
34 particularly selective about patients who we then
35 ultimately admit from the ED if they can't be managed at
36 home or managed through the ED and embedded into an
37 inpatient bed.
38
39 So it makes the situation really difficult at the
40 moment for us to manage our acute load. The converse of
41 that, though, is our acute beds are not the ideal situation
42 for an aged care resident who may be demented, who may
43 wander, who may be very unsettled. Hospital wards are
44 noisy, lights are on probably 20 hours a day, there's lots
45 of activity going on and that's very disturbing and
46 unsettling, so it's not the ideal environment for someone
47 who needs nursing home care.

1
2 Q. Full of sick people?
3 A. That's right, and they are full of sick people and
4 they are full of risk. Our hospitals are generally not
5 safe places, but particularly for aged care residents where
6 they're not really receiving any active care. When I say
7 there are 26 patients there yesterday, they are patients
8 who have had all their paperwork done, all their
9 assessments done. If a bed was available, they could go
10 straightaway. And so they are really boarding with us in
11 many respects, and I don't mean to denigrate that, we
12 provide care to them, we feed them, we keep them clean and
13 we look after them, but it's not the ideal setting for
14 those types of patients.
15
16 Q. Do you have any sense of why the 50 beds are closed at
17 the Southern Cross facilities?
18 A. We've had numerous discussions with Mr Nankivell and
19 he's told us many things. They were audited by the
20 Australian Commissioner for Quality and Safety in Health
21 Care and had some issues of compliance with the
22 regulations, which they had to correct. Along the way,
23 because this is such a hot topic for us, I guess, we've
24 tried to escalate this as best we can.
25
26 Our LHD, and equally NSW Health, are not really in a
27 position to really do very much about the scenario, because
28 aged care beds are managed through and funded through the
29 Commonwealth. But we've escalated certainly to our
30 Ministry of Health, and they've been fantastic in
31 supporting us to engage with their Commonwealth
32 counterparts, so that we can have the discussion with the
33 Commonwealth Department of Health and Ageing and, also, the
34 Australian Commissioner for Quality and Safety in Health
35 Care around the scenario, and I guess make them aware of
36 the situation.
37
38 We've been told that they have they've got challenges
39 with workforce, and I'm sure they have.
40
41 THE COMMISSIONER: Q. Your own challenges with
42 workforce, though, aren't helped, are they, by your own
43 nurses in Broken Hill Hospital having to be aged care
44 nurses when --
45 A. Correct.
46
47 Q. -- that's not what they really were employed to do?

1 A. Not what they were signed up for. And we have had
2 instances, particularly of agency nurses, who have come out
3 expecting to be working on a surgical ward and finding
4 themselves managing a cohort of aged care patients, not
5 post-surgical patients, so we have had that scenario occur,
6 which has made it difficult for us to attract agency
7 nurses. We, on a routine basis - probably every day at the
8 moment - we have between 50 and 60 agency nurses working
9 for us in order to continue our services, and there are
10 certainly agency nurses available, so I would have thought
11 that they could get agency nurses to work at Southern Cross
12 if they sought them.
13
14 We've also been told that there are issues around the
15 size of the rooms and compliance with the new aged care
16 regulations, and in the evidence yesterday you heard some
17 discussions about the Monash Medical Model and if Broken
18 Hill was a different rating, then that would relax some of
19 those requirements, and that's certainly the case.
20
21 MR MUSTON: Q. I will ask you a quick question about
22 that. I think the Commissioner asked yesterday, or asked
23 this morning, I should say, of the board, whether any
24 advocacy has occurred as between the LHD and the ministry
25 to get that changed. I think the board was not aware of
26 any, but are you aware of any --
27 A. We've certainly had discussions with the regional
28 health division about that. It is an anomaly. You heard
29 Mr Green talking yesterday about the Rural Health Workforce
30 Incentive Scheme and, when that was initially rolled out,
31 the size of the incentive that could be paid to
32 a particular staff member was determined by the Monash
33 Medical Model, and so Broken Hill - we could actually pay
34 someone a greater incentive to work at Menindee than we
35 could to work at Broken Hill, yet Broken Hill was the core
36 of where we had specialty staffing needs.
37
38 We got dispensation from the ministry to allow us to
39 pay the same incentive across the district, so I guess
40 relaxed the reliance on the Monash Medical Model for our
41 incentive, but that's an internal thing to NSW Health.
42 That's not really - they were using the Monash Medical
43 Model as a measure of remoteness, but Broken Hill became
44 a bit of an anomaly in that.
45
46 So we've certainly had that discussion with the
47 ministry, and whilst they accept our argument and they

1 understand it and, you know, we've got a really good
2 working relationship with the regional health division, the
3 Monash Medical Model rating system is administered by the
4 Commonwealth Department of Health and Ageing, and so it
5 takes further escalation to them to have changes made.
6
7 Q. That's - the two don't necessarily need to happen
8 together, though, do they? There is a question --
9 A. No.
10
11 Q. -- that might arise as to who has to bear the gap
12 while the full bridge of that negotiation runs its course?
13 A. Exactly.
14
15 Q. But I gather, from what you say, the Commonwealth
16 administers that scheme and so the moneys paid by the
17 Commonwealth to ministry in respect of facilities like
18 yours are based on an assumption that Broken Hill is like
19 Katoomba?
20 A. Yes.
21
22 Q. That does not actually mean that the ministry has to
23 pay you on the basis of that same --
24 A. No.
25
26 Q. -- obviously flawed assumption, does it?
27 A. No.
28
29 Q. And the way it currently works, if they do, pending
30 some agreement with the Commonwealth to change it, it's the
31 people of Far West LHD who have to suffer the loss as
32 opposed to the ministry?
33 A. The Monash Medical Model rating doesn't have a huge
34 impact on our budget directly, though, I would suggest.
35
36 Q. Has anyone done the maths?
37 A. No. Not that I'm aware of, anyway.
38
39 Q. So, in terms of dollars, your assumption is it doesn't
40 make a big difference.
41 A. Yeah, I think it's --
42
43 Q. What are the big differences, if any, that it would
44 make if the assessment were more in line with what a walk
45 up and down the main street of Broken Hill would suggest is
46 reality?
47 A. Yes, I understand that it does have some impact on

1 some of the payments to medical staff, but again, I'm not -
2 I couldn't comment on that with any great knowledge. That
3 would be the main area, I think, that it would apply, yes.
4
5 Q. Just coming back very briefly to Southern Cross and
6 the aged care beds that are closed, is the reality in a
7 community of the size and remoteness of Broken Hill, that
8 whilst aged care might be regarded as a Commonwealth
9 responsibility, local collaboration between the LHD and the
10 aged care provider is something that might more usefully
11 cut through some of these challenges?
12 A. Yes, I guess so. I mean, we try to maintain our
13 relationship with Southern Cross Care and we certainly meet
14 with them and talk with them on a regular basis. They are
15 two separate systems in many respects and, yes, for the
16 community in Broken Hill, I think it's not unreasonable
17 that they have an expectation, if they have lived in Broken
18 Hill all their lives, that when they require aged care,
19 that there should be a bed available for them locally.
20 I guess the challenge, as flagged there, is if there is not
21 a bed available in Broken Hill, that there is a significant
22 distance to the next nearest aged care bed.
23
24 Q. If the reason that a bed is not available to them in
25 Broken Hill is contributed to, at least to some extent, by
26 workforce issues, has there been any discussions with
27 Southern Cross around opportunities for shared positions
28 across their system and yours, for clinical roles and
29 student placements?
30 A. We've talked - there's been discussion around that,
31 but in the context where we're currently employing 50 to 60
32 agency nurses and equally Southern Cross could access
33 agency nurses if they so chose, should we employ more
34 urgency nurses into Broken Hill in order to supplement
35 Southern Cross Care? To me, that doesn't appear reasonable
36 for us to incur that cost when Southern Cross could equally
37 engage agency nurses themselves.
38
39 Q. That might not be the outcome of good collaboration
40 though, necessarily. It might be that the reliance that
41 both parties need to place on agency nurses could be
42 reduced by a shared workforce or sharing across the
43 workforce?
44 A. Equally, if we could attract the nurses, yes, we could
45 certainly explore all of those things, and I - yes.
46
47 Q. Can I come back to deal with the collaboration with

1 some of your other key collaborators, so, for example,
2 Coomealla, Maari Ma and RFDS. How is, in a practical
3 sense, that collaboration happening at the moment?
4 A. Look, I think on the ground there is good discussions
5 between the various teams in both those services, partners
6 with all those services. Certainly we have contractual
7 arrangements with Maari Ma and RFDS, which govern some of
8 those discussions. I think there's opportunities for us to
9 work much more closely with those three agencies. We've
10 been trying to do that down in Coomealla particularly
11 around some of the sort of scarce resources.
12
13 There's quite a scarcity for allied health staff, for
14 instance, in that patch, and so we've looked at ways that
15 we can potentially develop a full FTE role out of a couple
16 of halves that might sit with us and with them, for
17 instance, around how we might attract occupational
18 therapists or speech pathologists, or whatever.
19
20 The discussions with Maari Ma I think are probably
21 relatively early days. You heard some discussion this
22 morning about the relationship with Maari Ma and I guess --
23
24 Q. I think it was described as something of a stand-off,
25 or it had reached the point of a stand-off might have been
26 a more accurate way of --
27 A. Look, I think there has been a long history, and
28 certainly from my knowledge as somewhat of an outsider but
29 spending time in Broken Hill, there has been a long history
30 of quite a vexed relationship between the two organisations
31 and I think it's - I don't think that's unfair to say that,
32 and it was largely around personalities who are now
33 departed the scene completely.
34
35 Certainly me being relatively new in this role and
36 Richard Weston being relatively new as the CE of Maari Ma,
37 we've sought to leave history to be history and try to work
38 out how we can work together going into the future. Our
39 board and Maari Ma board had dinner together a few weeks
40 ago as a way of breaking the ice and having some
41 discussions, and that was highly successful. Our executive
42 and the Maari Ma executive had lunch together last week,
43 more as a get-to-know rather than a working lunch, but so
44 that you could put names to faces and you could build some
45 familiarity around people and the roles and how we work
46 together. So it's - you know, in many respects, I think
47 for both of us it is early days, but I think there are lots

1 of opportunities that we can explore.
2
3 I think, though, the recent Maari Ma - the opening of
4 the recent Maari Ma centre at Wilcannia I think is a really
5 good lever for us both to talk about how we work together
6 to provide services into that community. Just as a simple
7 example, a patient who might be coming to the Maari Ma
8 clinic for a regular clinic appointment who suddenly takes
9 ill, we need to have a mechanism for them to get to the ED
10 that we operate in the Wilcannia MPS in order for them to
11 receive that emergent care. So we need to work up some of
12 those pathways along the way.
13
14 Q. Fully recognising that it's not in your gift to give,
15 perhaps less so than anyone's, do you see that it might
16 be - there would be utility in having, almost as an
17 ex officio member of your LHD's board, whoever happens to
18 be the head of Maari Ma and Coomealla at any given time,
19 and perhaps RFDS?
20 A. Yeah, for sure.
21
22 Q. Would that facilitate, to a greater extent, that close
23 level of collaboration between your respective
24 organisations?
25 A. Yes, absolutely, and you heard the board members this
26 morning talking about our Aboriginal health and workforce
27 committee, which is a relatively new iteration of that
28 committee, which was really commenced as a recognition from
29 both the board and the executive that we needed a point
30 where a lot of the activities in that space could come to,
31 and certainly we've given an invitation to Richard Weston
32 to attend that committee on a regular basis so that he's
33 involved in the discussions that are going on there. A lot
34 of the focus is around workforce and their shared
35 opportunities.
36
37 For instance, the TAFE program, training Aboriginal
38 health workers and practitioners is shared - the cohorts
39 are essentially shared between our two organisations here
40 in Broken Hill at the TAFE. So there are lots of
41 opportunities, I think, for us to share many of those
42 plans.
43
44 Q. You touched on this earlier, but in addition to the
45 collaboration around service planning that we talked about,
46 there is also a need for ongoing collaboration and
47 engagement about the extent to which the services are still

1 fit for purpose and as good as they could be. That's time
2 consuming.
3 A. Yes.
4
5 Q. Because it has to happen really on
6 a community-by-community basis?
7 A. (Witness nods). Yes.
8
9 Q. And probably needs to happen more regularly than
10 a once-a-year catch-up?
11 A. Yes, yes.
12
13 Q. And to the extent that - or do you think you have
14 capacity within your budget realistically to fund how ever
15 many FTE would be required to - in a way which is adequate,
16 undertake that collaboration with communities and
17 community-controlled health organisations that might work
18 into them and the RFDS?
19 A. Look, I think we should. I think, you know, that
20 we've got roles within our organisation which have
21 a function of service planning and, you know, so on. So --
22
23 Q. Just to be clear, when you say "I think we should", it
24 is we should have, that is, they should give us enough
25 budget to do that, or they do and we think we can manage
26 it?
27 A. Either. I mean, we should be more active in that
28 collaboration space, I believe anyway. Yes, if someone
29 wants to give us money to make it easier, then absolutely.
30 But, equally, I think there is a role for us to plan our
31 services better between our agencies anyway.
32
33 Q. It's not picked up by any sort of activity-based
34 funding?
35 A. No.
36
37 Q. And it's not really picked up by any sort of block
38 funding of hospitals?
39 A. No.
40
41 Q. Is there any particular program funding that you
42 receive which is targeted or well facilitates that
43 collaboration that needs to occur with communities and the
44 various entities that provide health services into those
45 communities?
46 A. We've got resources - we've got staff in our service
47 that have a role in community engagement, and they are the

1 people that would go out on that annual basis and meet with
2 the Aboriginal working parties, for instance, they have a
3 role in meeting with the LHACs on a regular basis. So we
4 have some resources already in that space.
5
6 Q. But the annual meeting is not really enough to have
7 that meaningful engagement, is it?
8 A. It allows us to lay out the plans for the upcoming
9 year, and I guess it's a point to check back about how did
10 you go last year. You know, in the ideal world I guess you
11 would meet more frequently or more regularly.
12
13 Q. But you would need to meet more frequently and
14 regularly, wouldn't you, to enable that collaboration to
15 work through each of those stages of "Here's the plan. Is
16 it the right plan? How should we change the plan to make
17 it the right plan if it's not, implement the plan, is it
18 working, a short time later is it still working", that's
19 definitely more than a once-a-year engagement, isn't it?
20 A. Yes, the annual planning process does occur already to
21 a certain extent with the community working parties and the
22 engagement we have with them. I guess it is that regular
23 check-back piece that we don't necessarily do routinely at
24 the moment. You know, the communities are not backward in
25 coming forward if they think something is not right, and so
26 we will hear through various channels along the way if they
27 are not getting what was expected.
28
29 Q. You would hope that you do.
30 A. But that piece - the piece connecting with our
31 partners I think is the missing bit at the moment, I guess,
32 in working with CHAC or Maari Ma or RFDS, or whoever it
33 might be to map out who is going to do what in that space.
34
35 Q. I acknowledge it is not in your LHD, but last week in
36 Dubbo we heard some evidence from the Murdi Paaki group and
37 a group of chairs of the community working parties, and
38 that evidence came as a significant surprise to the LHD,
39 which suggests, without for one moment wanting to express
40 a view about where things actually lie between those two
41 very different perceptions of a situation, that you can't
42 safely assume that the community will just tell you
43 whenever they have a problem with something?
44 A. No, fair comment. But I guess - I can't speak for
45 what happens in Western New South Wales, but we do have
46 that annual process meeting with the community working
47 parties, we have community action plans in place for all of

1 those communities except Ivanhoe, and that's waiting to be
2 signed off, but we do have them associated with all of
3 those communities. I guess, for us, because we have
4 arguably slightly more discrete communities, with not a lot
5 of overlap between them, it could be argued that that's
6 a bit easier, in that you are only engaging with that town.
7 But certainly we have those community action plans in place
8 following those discussions with the local community
9 working parties.
10
11 Q. To the extent that some of those communities, or many
12 of those communities, have a very high percentage of First
13 Nations people living in them, that meaningful engagement
14 which ensures that the services that are being delivered
15 are the right services and are being delivered in the right
16 way really is mission critical in terms of closing the gap,
17 isn't it?
18 A. For sure, yes.
19
20 THE COMMISSIONER: I might - can I just interrupt for
21 a minute? You mentioned to me earlier you might finish by
22 5 today. Is that --
23
24 MR MUSTON: That's still on the cards. I note the time.
25 It might be a useful time for a break
26
27 THE COMMISSIONER: I was just going to suggest maybe we
28 have a break in any event now for 10 minutes.
29
30 MR MUSTON: Yes.
31
32 THE COMMISSIONER: We will take an adjournment to give
33 everyone a break. It is effectively 4 o'clock now, so
34 10 past 4. We will adjourn until them.
35
36 **SHORT ADJOURNMENT**
37
38 THE COMMISSIONER: Yes, Mr Muston, when you are ready.
39
40 MR MUSTON: Thank you.
41
42 Q. Perhaps we could open up the service development
43 priority focus areas March 2024 document again. That's the
44 [MOH.9999.1283.0000], and if we could jump forward to
45 page 9 of 40, in the internal numbering, just under that
46 heading "Case For Change", you tell us a little bit about
47 what the former planning process or models were. Just

1 perhaps tell us, in a practical sense, what is it that you
2 see as being the strategy that is going to be employed over
3 the next 10 years?
4 A. So the piece of work that was done that culminated in
5 this document was really us looking at where we had got to,
6 so looking at our current strategic plan and whether it was
7 still right, but also collecting our thoughts about what
8 would guide both future capital developments and service
9 developments into the future. So we undertook this piece
10 of work which was, I guess, a whole range of internal
11 conversations about services and service needs and so on,
12 with the intent that in the next 12 to 18 months we'll
13 undertake a proper clinical service plan exercise, which we
14 haven't done for - or the district hasn't done for some
15 time.
16
17 We've done elements of clinical services planning
18 associated with our current capital projects, and you've
19 heard all about the projects, but in order to determine
20 what - as an example, in order to determine what we were
21 going to build at Wentworth, we needed to have a think
22 about what services we envisaged that Wentworth Hospital
23 would deliver in the future, how that fitted with the
24 services that the community currently accesses across the
25 river. So, for instance, the Wentworth community rely
26 entirely on Mildura for emergency services, entirely on
27 Mildura for surgical services, and whether we had a part to
28 play into the future in some of those spaces.
29
30 So in the planning for Wentworth Hospital, we decided
31 that, ultimately, we would like to have not a full-blown
32 emergency department but an urgent care function there, so
33 that people who had a range of conditions that required
34 urgent care could access those services rather than go to
35 Mildura and so access those services close to home. So as
36 we develop the Wentworth Hospital facility, we will start
37 to develop those services.
38
39 So the day that Wentworth opens, the urgent care
40 service won't be there, but we will be planning how we're
41 going to implement it. We will have the space, but we need
42 to get staff, we need to get equipment and so on and so
43 forth to implement a service that hasn't existed on that
44 campus. So, as an example, they were some of the
45 discussions that we had about what we needed to do.
46
47 But we do need to go down the full clinical services

1 plan pathway, which we will rely on the health information
2 unit at Western to provide us with baseline data and a lot
3 of community consultation.
4
5 Q. When we were in Western, we heard some evidence to the
6 effect that the more traditional facility-based service
7 planning approach should potentially, at least in areas
8 like Western, and perhaps yours, give way to more of
9 a place-based planning approach, which looks at all of the
10 health needs of a particular community and identifies
11 exactly how they are to be met by the patchwork of services
12 available, including acute care and hospital-based services
13 to the extent needed.
14 A. Yes.
15
16 Q. Would you agree with that?
17 A. Yes, absolutely, and I think, you know, contemporary
18 thinking is that there is a role range of services that had
19 in the past been delivered in a hospital which don't need
20 to be delivered in a hospital and should in fact be
21 delivered in the community. They should probably be
22 delivered by primary care, and that presents for us
23 somewhat of a challenge, but nonetheless they still should
24 be delivered into community, and so we may well have to
25 supplement that because, you know, of the issues around
26 general practice that we've talked about in some depth, but
27 nonetheless it doesn't mean that we shouldn't still deliver
28 those services in the community.
29
30 Q. Because that silo-based service planning where one
31 organisation such as an LHD plans services to be delivered
32 through a hospital setting, while another organisation
33 makes plans about the delivery of services in, say, primary
34 care settings very greatly exacerbates the risk that gaps
35 will not only exist but be overlooked?
36 A. Yes, absolutely. And I think - but I think in our
37 district, we're at least familiar with working with our
38 partner organisations, and so I think, as we go through
39 that service planning exercise, some of those discussions
40 will occur about who is best to do that, rather than the
41 LHD has to do it all, because that's absolutely not the
42 case, and it doesn't necessarily match our skill set.
43
44 You heard from Mission Australia yesterday, and they
45 are very adept at delivering many of those mental health
46 type services, and it would be crazy for us to try and take
47 that over.

1
2 Q. I think at page 10 of 40, under the heading
3 "Networking Partnerships Within the LHD/SN", you see at the
4 foot of that page the document speaks of a closer
5 integration --
6 A. Yes.
7
8 Q. -- or an anticipation of a closer integration with
9 those various collaborators?
10 A. Yes.
11
12 Q. Then, if we go over to the very top of the next page,
13 there is reference to the need - a potential need to
14 consider a potential place/precinct model. So we make sure
15 we're talking about the same thing, what do you understand
16 the document to be referring to when it talks about
17 a place/precinct model?
18 A. I mean, I think a really good example of that, and we
19 feel it's a really mature facility, is Menindee where, on
20 any given day, there may be people from RFDS delivering
21 clinic inputs there, there may be people from Maari Ma
22 delivering clinic, our staff are manning the emergency
23 department, our staff are driving the ambulance, but, you
24 know, there is also the facility for other agencies to
25 deliver services, and so we do have not probably as
26 frequently as we would like but periodic visits from a
27 private podiatry service, for instance, to provide podiatry
28 services to the community.
29
30 So I think it's a very good example of how they can
31 all be delivered out of the one facility without
32 necessarily any sense of one group owning or having
33 proprietary control.
34
35 You know, I think the really good example is the
36 Aboriginal health practitioners from Maari Ma routinely
37 work out of that facility. They have their offices there
38 side by side with our community staff. And it's, you know,
39 pretty seamless, really, in the way that the services
40 operate out of that facility.
41
42 Q. Can you jump over to page 14 of 40, where it's dealing
43 with priority 2, which I think we touched on in some detail
44 already, developing purposeful partnerships. Do you see at
45 the top of that page under the heading "Case For Change",
46 the "Problem/Opportunity", there is in the second
47 paragraph an observation that there are no mechanisms by

1 which various organisations that are the key collaborators
2 can exchange consistently to enable shared or strategic
3 planning and knowledge sharing. Is there any mechanism
4 between any of the various collaborators at the moment for
5 that sort of process to occur, in a formal sense?
6 A. Sorry, what process are we --
7
8 Q. Sorry, have a look at that second paragraph commencing
9 "At present".
10 A. I would say there is probably not. Certainly we have
11 discussions with the other agencies around services and
12 service provision. Data sharing is a challenge. And you
13 probably heard at Menindee about some of the challenges
14 around data sharing, and it's been an issue in this
15 district for - I've been involved in it, one way or
16 another, for probably over 12 years in trying to fix the
17 sharing of patient data on that one campus, and in saying
18 it's a good example of how those services can work side by
19 side, we still have the situation that we have three
20 services there with three different medical record systems
21 that don't really talk to each other, and the only way to
22 get a collaborative medical record for a particular patient
23 is to print them all out on to paper and then bundle them
24 all up into a chunk. So that's a major issue, which
25 technically hasn't been able to be resolved.
26
27 I think we're in a climate now, the relationships with
28 our partners are stronger than they have probably been for
29 some time, and some of that is around, not to put too fine
30 a point on it, some personalities having left
31 organisations, but also, I think for us, a major factor is
32 that we've got a consistent permanent employed executive
33 team, and so we're all starting to work in the same
34 direction. You don't have acting actors in the roles who
35 are perhaps not quite as committed to making things happen
36 as someone who is in a role permanently.
37
38 Q. In addition to the commitment issue, is it also
39 a reality that in order to build the trust and relationship
40 that one needs to build in order to have good collaboration
41 potentially with some of your First Nations collaborators,
42 it takes time?
43 A. Oh, yes, it does. It absolutely takes time and, you
44 know, we talked about - and I don't want to labour the
45 point but we talked about our relationship with Maari Ma
46 which has been challenged for, quite frankly, decades.
47 You're not going to undo that, fix that, in two days. So

1 it does take time, and it takes time on both sides. There
2 are still staff in both our organisations who lived through
3 that era, and so it's a changed thinking and a somewhat
4 changed culture that gets to the point to say, "We need to
5 work together".
6
7 The other thing I think that's come into play is the
8 whole COVID experience. With the benefit of a little bit
9 of hindsight, it's a bit of a black hole in many respects
10 in that the focus of so many services was just on managing
11 COVID and its impacts and implications, that many of these
12 things were just set aside, and - but I think the other
13 thing that's happened out of that, and I alluded to this in
14 talking about the GP climate, is that I think the climate
15 that we find ourselves in now might be the new normal. You
16 know, we have talked and you would have heard Apsara talk
17 about it and others talk about it, the situation we find
18 ourselves in with nursing staff now, I've got a sneaking
19 suspicion that that's going to be the new normal, that
20 we're going to be reliant on a transient fly-in fly-out
21 non-resident workforce in many of our areas, and that's
22 just going to be the normal business, and so the
23 landscape's changed. The resources we've got at our
24 fingertips has changed, and so it makes it even more
25 imperative that we work with our partners, you know.
26
27 You heard Sarah talking about medical services.
28 They've been relatively stable, albeit that prior to COVID,
29 they were largely a fly-in fly-out workforce anyway, but
30 I think what we're seeing now is that other aspects of our
31 overall workforce are fly-in and fly-out as well, or you
32 know, transient, let's call it. But it makes it even more
33 important that we work with our partners around the gaps.
34
35 Q. If we scroll down in the document to the small
36 subheading "Service Change (Actions)" do you see there:
37
38 *A priority area will be built on the*
39 *existing corporate relationships that the*
40 *LHD has with district health service*
41 *providers through the creation of*
42 *a regional health services forum, a shared*
43 *governance structure to provide the formal*
44 *mechanism for service planning and*
45 *knowledge sharing purposes on a regularly*
46 *scheduled basis.*
47

1 It sounds great on paper. What is it actually going to
2 look like?
3 A. The statement is a bit aspirational as we sit here
4 right now, but we've certainly started to have very early
5 preliminary discussions about doing exactly that, all
6 getting around the table and talking about what service
7 needs there are, who is best to deliver them, where the
8 gaps are, and how we can fix it. You heard yesterday from
9 Deb Jones about the First Nations Research Network, and
10 that's a first step in that space in getting all of those
11 key organisations around the table to talk about -
12 particularly about research, but there is no reason that we
13 shouldn't be applying that same rationale to start looking
14 at service planning.
15
16 When we've got the data at our fingertips that we need
17 around needs and needs assessment, then I think it's time
18 that we had those agencies around the table.
19
20 One of the things we have had discussions with the
21 PHN - and, again, very early days and the PHN has had a bit
22 of a changing of the guard, I suppose, would be the best
23 way to describe it recently - was around them helping us
24 with some of that service needs analysis into the different
25 communities, because that, again, as I understand it, is
26 a deliverable for them under their Commonwealth funding.
27 They are well placed to do that, and so I think the other
28 thing is that they are relatively neutral, so they have got
29 the ability to engage with all aspects of a community and
30 not be seen as "Oh, it's the LHD again", or "It's Maari Ma
31 again", or whoever coming and asking us what we want, they
32 can be relatively neutral in some of those discussions.
33 We've certainly explored that with them as an area that we
34 can do some shared work together and I think that that's
35 a part of the way forward for us.
36
37 Q. It's been almost 20 years since Tom Calma AO made
38 recommendations in his social justice report to the effect
39 that there should be, in effect, a collaboration between
40 all of the various providers of health services to
41 Indigenous people and effective pooling of resources, and
42 we have had since I think 2009 an annual Closing the Gap
43 report. I don't for one moment, having regard to your
44 short tenure in the office, suggest that this is down to
45 you, but do you have any sense of why it is only now that
46 these embryonic steps are being taken to give effect to
47 that in your LHD?

1 A. I think in the health sphere we're very good at taking
2 a project or program - and I don't mean just NSW Health,
3 I mean across the whole spectrum - taking
4 a project/program-based approach to how you fix a problem.
5 So "Here is a problem, here is some money, go fix it", but
6 that money only goes so far and we heard - I can't remember
7 who it was now - mention about consistency of budgets and
8 longer than 12 months lead times around budgets. But we've
9 been very good at almost segregating funding streams and
10 saying "Here is some money for that project and here is
11 some money for that project", and almost never the twain
12 shall meet.
13
14 You know, it its even within our health service where,
15 you know, we've got examples in the mental health space
16 where a lot of these programs are funded on an incidence
17 basis. So you might have an incidence of a particular
18 issue, let's take suicide as the example of so many per
19 thousand population, and then it's funded on that basis,
20 and for us that means you get 0.4 of a project officer to
21 work on that. So that's two days a week to solve youth
22 suicide in this community. Then you get 0.2 of an FTE for
23 some other project.
24
25 And so we've had to take the approach internally to
26 our service that bundling some of those things together,
27 where you can bundle them together, to create at least
28 a full-time position, but equally it doesn't always work
29 that way and sometimes you get an outcome where you've got
30 someone who has got 10 streams that they are meant to
31 respond to, so that doesn't work either. And I think
32 that's the same across the board with all of the various
33 providers, we're often funded probably not enough - well,
34 on the measures that are used to provide the funding, you
35 are given the right amount of money, but it is whether the
36 measure is right.
37
38 We have an issue here about some of the quality and
39 safety indicators where we're measured against the KPI of,
40 now, incidents per 10,000 bed days. What that translates
41 to for us is that in some of those KPIs we've only got to
42 have 0.6 of an incident and we've over the threshold for
43 the measure, and so if you have one incident, you know, in
44 the whole business of the hospital in a month, you show on
45 the KPIs as being terribly over the threshold. You know,
46 that's the problem in small communities like this, is that
47 a lot of the traditional measures don't work. So I think

1 it was Sarah said, Sarah Wenham said this morning, some of
2 it is about what do we need the funding for, and then
3 looking at how you can deliver that, rather than using
4 a rate-based application of a funding algorithm.
5
6 Q. Is a way of summarising a lot of what you have just
7 said that all of the good intentions and effort that often
8 go into these objectives get burned up in the process
9 before you actually get to the point where that process is
10 producing, or capable of producing, any outcomes?
11 A. Yes, somewhat. If we take an example like suicide,
12 I think we get some funding, and I'm sure that Maari Ma
13 gets some funding, and RFDS probably gets some funding
14 through their various funding lines. None of it is
15 probably enough to have - none of it is enough for any of
16 those individual services to have a viable service on the
17 ground, but if we were to pool that funding and provide
18 a comprehensive service, using all that funding, then the
19 community would get what they need.
20
21 Q. And that starts with sitting down around a table with
22 the people who have the services and the funding and
23 working out how best to deploy the pooled resources?
24 A. Exactly. And, you know, I also think it is us as the
25 organisations not being too precious about the boundaries,
26 and it might be that whilst we've got funding of X number
27 of dollars, we're not best placed to deliver that service
28 and we should be comfortable enough with our partnership
29 with our other agencies that we are prepared to see that
30 the need is to deliver that - to give that money to the
31 other service in order for them to deliver the service,
32 because that's where their expertise is, and it's not
33 always with us.
34
35 Q. At a practical level, the way in which the funding
36 works, do you currently feel that it's open to you to do
37 that? If you were having these nice roundtable meetings
38 with Maari Ma, CHAC, RFDS, Mission Australia, you'd all
39 tipped your notional funding into the bucket, if a decision
40 was made as between you that some of the money that
41 notionally had the LHD's name on it would be better spent
42 through CHAC, say, do you feel comfortable that the funding
43 mechanisms that at least constrict you would enable you to
44 say "Okay, yes, you can take this money and deliver that"?
45 A. Sorry, I was smiling because I'm not sure whether to
46 answer as Brad or as an officer of NSW Health. If I was
47 answering it as Brad, I'd feel utterly comfortable to do

1 that, because that's what the community needs.
2
3 Q. The distinction might be, I guess coming back to my
4 question, whilst Brad would happily and comfortably do that
5 because it is what the community needs, is it something
6 that the officer of NSW Health can do having regard to the
7 current funding structures that bind him or her?
8 A. I think we could, yes. I don't think there is
9 sufficient restrictions to say "No, you can't possibly do
10 that". You know, we would rely on being able to construct
11 a good case why we would do that, but that's not really
12 a major hurdle, I wouldn't have thought.
13
14 Q. To the extent that there are any hurdles, are there
15 any that you think we might be able to lower to make that
16 process work better?
17 A. I mean, we touched on this through our discussion
18 today and I think a couple of the other witnesses today and
19 yesterday to a certain extent touched on this, in many
20 respects - I will probably get drummed out of the CE's
21 union for saying this, but in many respects, we've got
22 funding sufficient to deliver services. The restrictions
23 on our ability to deliver services is probably around being
24 able to access workforce, but I don't know that we've got
25 sufficient funds to do that really proper, thorough
26 planning, and that's probably where we don't have the
27 resources, both capability as well as financial resources.
28
29 It's a very skilled piece of work, and we would need
30 to engage someone with expertise in order to do that to
31 bring the three, four, five, whatever it is, agencies
32 together and have those discussions. I don't know that any
33 of us have got the monetary resources or potentially the
34 capability to actually do that.
35
36 Q. When you say "to do that", the monetary resources that
37 you would need to fund that coordinator?
38 A. Yes, that planning and coordination piece.
39
40 Q. You have raised with us some of the issues around the
41 need to account for funds. Is that a barrier that might
42 stand in the way of collaboration or pooling of resources
43 of the type we have discussed, or would the process of
44 building the case and getting access to the funding for
45 that particular purpose --
46 A. I would like to think not. I think we talked earlier
47 about this region being quite a useful test tube or Petri

1 dish, whatever term you want to use, and I think we still
2 have that facility, and I think in that context, I think we
3 could well and truly justify sharing resources like that.
4
5 Q. In terms of FTE, what do you think would be needed in
6 order to fund that collaborator or the coordinator role?
7 A. There would be a piece of work in the initial stages
8 of physically doing the planning, doing the consultation,
9 both with the agencies, but arguably with the community or
10 the community groups, so there would be a burst of activity
11 associated with that.
12
13 In an ongoing way, though, I would hope that if you
14 build a sufficiently robust plan and, you know, as an
15 example, let's say Maari Ma is going to deliver all of the
16 mental health services for the remote sites and that's all
17 according to our plan, then it's really only checking that
18 back against the plan. So I don't think the resources
19 required for that ongoing monitoring and so on is quite as
20 large.
21
22 You would need to have some resource to do a check
23 back in with the community on a regular basis, but I don't
24 think you are talking about an army of staff to do that,
25 I think it is a relatively small group.
26
27 Q. Is another role that that small group could
28 potentially play the coordination of different branches of
29 government in terms of the way in which people within the
30 community interact with them having regard to what we've
31 heard from many people about the social determinants of
32 health and the whole of government response that's required
33 to deal with them?
34 A. There's certainly some blurry edges around which arm
35 of government is responsible for what and, again, I think
36 it's a coordination thing and it's equally - there is
37 a certain level of accountability, too, I think. If we're
38 able to crack the health funding bit between all of the
39 various funders, then that's at least state and federal -
40 as big funders of health services - aligned. Some of those
41 social determinants I think are potentially harder to
42 crack, things like education and housing and employment and
43 access to regular clean water and some of those things,
44 which is a factor for our communities, is perhaps not quite
45 so easy to crack.
46
47 Q. Longer term projects in a population-wise sense, but

1 potentially lots of small wins along the way for
2 individuals who interact with any of those services, if the
3 particular whole of government needs of the individual who
4 comes into contact with one or other of those services can
5 be identified and met by whichever department is best
6 placed to do it?
7 A. Yes.
8
9 Q. So, for example, the patient who comes into one of
10 your emergency departments, but really has a housing
11 problem, could be referred quickly off, if there was good
12 coordination, to someone who could deal with that problem,
13 which might have the knock-on benefit of improving their
14 health problem, or overcoming it?
15 A. And some of those things aren't as difficult to fix as
16 we might think. Sometimes it's just having a list of phone
17 numbers of people you can ring who can fix something then
18 and there.
19
20 Q. How is that coordination working within your LHD, to
21 the best of your knowledge?
22 A. I'm sure there is pockets of our staff and staff of
23 the other agencies who know who to ring in housing or who
24 know who to ring in transport or who know - but I wouldn't
25 suggest that that's common knowledge across a service.
26
27 Q. Is there something more that you think could be done
28 systemically, at least within your LHD, which probably,
29 although large, has the luxury of probably a pretty small
30 workforce of people who need to be ringing one another
31 across that area.
32 A. Yes.
33
34 Q. Is there more that you think could be done at a system
35 level to improve that coordination and potentially bring
36 a slightly more whole of government approach to the care
37 that's delivered to patients?
38 A. Intuitively, yes. I don't know where you would start
39 with that. I'm aware of examples in other jurisdictions or
40 other states or other countries where that's been done
41 where you basically sort of develop a one-stop shop.
42
43 (Pause for technology - room blackout)
44
45 MR MUSTON: I don't mind if the livestream is not going,
46 as long as we're still catching the transcript. We can
47 keep going with our discussion if you are happy to

1 continue, Commissioner.
2
3 THE COMMISSIONER: I am.
4
5 MR MUSTON: I would not want to drag everyone back
6 tomorrow morning for the sake of an internet issue in
7 remote New South Wales. We could be here for ever.
8
9 Q. Sorry, you were just telling us about the attempts to
10 set up one-stop shops. I didn't really have in mind so
11 much a one-stop shop where a consumer might go in and have
12 whatever problem they possess solved by whoever it might
13 be, but rather just that level of slightly more structured
14 coordination between the agencies.
15 A. Mmm.
16
17 Q. Where perhaps, even just at a personality level,
18 people know one another.
19 A. Mmm.
20
21 Q. Everyone's in the luxurious position of the select few
22 that you refer to who know who to call.
23 A. Yes, yes, absolutely. I mean, the models that I was
24 referring to were - I'm aware of work that has been done in
25 New Zealand, for instance, where they have established for
26 want of a better word, my word really, a one-stop shop
27 where a client can come in and there are representatives of
28 health there, but there is also housing or justice or
29 police or family services or whatever. So that whilst they
30 might come in with a health-related issue, there is an
31 underlying other issue going on which can be addressed by
32 some of those other agencies while they are in attendance.
33
34 Q. There is one other issue I should have raised with you
35 in relation to your collaboration with Maari Ma. At least
36 one thing that we were told by them when we spoke to them
37 earlier in the week was that they had a sense that their
38 First Nations people who came into the facilities and had
39 any issue - for example, a transportation issue or the
40 like - were being told, "Just go down to Maari Ma and they
41 will sort that out for you", which they regarded, I think
42 it would not be unfair to them, as more of a cost shifting
43 than a diversion of a patient from one service to a more
44 appropriate service. Do you have any sense of whether that
45 is a practice or whether that is an issue that has been
46 looked at by the LHD previously?
47 A. I wouldn't have thought it is a practice and I can't

1 imagine even a scenario where it would occur. Certainly,
2 there had been discussions about transport of the dialysis
3 patients from Wilcannia, for instance, and Maari Ma were
4 expressing challenges in being able to continue that
5 service, which is why we picked it up. But I wouldn't have
6 thought that it's a routine practice for us to say "Go to
7 Maari Ma and they will sort it out".
8
9 Q. I think the particular issue, in fairness to them,
10 that they identified was First Nations consumers who are
11 referred to a specialist appointment somewhere a long way
12 away, who say "Well, I can't get to Adelaide", or "How am
13 I supposed to get to that appointment in Dubbo", at least
14 their perception was there was a cohort of those patients
15 who were being told that they needed to speak to Maari Ma
16 who would help them sort that out.
17 A. I wouldn't have thought that's the case. I mean, we
18 have a lot of IPTAAS funds which we apply very routinely,
19 obviously in accordance with the policy, but pretty openly
20 we provide those funds to support transport for people to
21 and from - Adelaide is the classic example. I wouldn't
22 have thought that we would have directed anyone away from
23 the IPTAAS service to Maari Ma in order to access
24 transport. I would have thought that that would have been
25 a routine approach that we would have taken and assisted
26 with funding.
27
28 Q. At a mechanical level, how does that IPTAAS funding
29 work? If I'm a patient who has presented and needs to go
30 and see a specialist in Adelaide, do I have to organise
31 transport and accommodation and then seek reimbursement
32 or --
33 A. It can work both ways, so we can pre-approve. As with
34 everything, there is a form to fill out, but there is
35 assistance to fill those forms out and, you know, we've
36 had - we had many instances where we have pre-approved
37 transport prior, likewise accommodation, or alternately
38 reimburse after the fact.
39
40 Q. Have we got our ability to get documents up on the
41 screen again? Perfect. Could I ask that the safety and
42 quality account be brought up, which is
43 [MOH.9999.1282.0001]. That will appear in a moment. Do you
44 recognise that document?
45 A. Yes.
46
47 Q. If we could jump forward to page 71, and scroll down

1 just to the bottom there. You see "National Safety and
2 Quality Health Service Standards", and in the first
3 paragraph under that heading:
4
5 *Far West LHD is committed to providing*
6 *a culturally safe health care service free*
7 *from prejudice and inequity for Aboriginal*
8 *people. We acknowledge a holistic view of*
9 *health that encompasses mental, physical,*
10 *cultural and spiritual health.*
11
12 Can I just ask in relation to that, cultural safety really
13 is - it sits at the same level as clinical safety, does it
14 not?
15 A. Yes. Yes.
16
17 Q. And just as it would be the case that if, say,
18 workforce challenges meant that the only way that you could
19 operate a facility would be to have a clinically unsafe
20 person delivering services in that facility, you wouldn't
21 operate it. So, too, surely it must be right that if the
22 only way that, having regard to workforce challenges, you
23 could operate a facility would be if there was a culturally
24 unsafe person delivering that service --
25 A. Correct.
26
27 Q. -- it would not be acceptable and it simply should not
28 be delivered at all --
29 A. Correct.
30
31 Q. -- unless and until a culturally safe person can be
32 found to deliver it?
33 A. Yes.
34
35 Q. We heard some evidence during the board's evidence
36 about it being very much a personal attribute, that
37 cultural safety, one can deliver cultural awareness
38 training and the like to staff members, but there is an
39 extent to which some are more or less receptive than others
40 to that training?
41 A. And it's particularly challenging for us. We talked
42 a lot today about the transient nature of our staff, and so
43 we have a bit of a revolving door of staff coming through
44 the organisation, so it is a challenge to, I guess, get all
45 of those staff to undertake the mandatory component of, you
46 know, cultural awareness training. We're certainly taking,
47 I guess, a broader view of that for the organisation, and

1 I think this morning our board members talked about some
2 cultural awareness training that we did between the board
3 and the executive team, which included a walk on country
4 and, you know, which was undertaken with an Indigenous
5 guide and so on and so forth, but equally, we've done
6 cultural awareness, if you like, didactic training as well
7 around that topic.
8
9 We're rolling that down through the organisation. Our
10 next target group is our, I guess, for want of a better
11 word, tier 2 managers, which is a much larger group in our
12 organisation than simply the executive, but again,
13 undertaking the cultural awareness training, walk on
14 country, it may not be necessarily the same location so
15 that it's accessible for our staff scattered across the
16 district, but certainly that's a commitment of ours to
17 conduct this week - not this week, this year, with that
18 group of staff and then further on down through the
19 organisation, so that there is I would hope a growing
20 awareness amongst all levels of our staff about cultural
21 appropriateness, what's culturally correct, what's
22 culturally acceptable.
23
24 Hand in hand with that, though, is our aspiration to
25 increase our Aboriginal staffing in general across the
26 organisation. Some of that relates to growing our own, but
27 also relates to specific Aboriginal employment roles, and
28 we've talked a bit about those today. We're in the process
29 of appointing a manager Aboriginal workforce development
30 function, and again that's looking at workforce across all
31 the settings in the organisation.
32
33 We've recently elevated our director of Aboriginal
34 health and community relations to the exact same level as
35 all the executive in terms of salary and grading and all
36 the rest of it, and that gives, you know, I guess an
37 external view of parity of that role with the rest of the
38 organisation, the rest of the executive.
39
40 It is a bit of a never-ending journey, though, and
41 we're very conscious of that. We're implementing a range
42 of strategies within our clinical services as well. We're
43 trialling at the moment, and we're doing it in two ways,
44 one is as a trial to make sure it works, but also we're
45 conducting research that, you know, capital R research
46 project as well about making an Aboriginal health worker or
47 a practitioner available for every Aboriginal client that

1 comes through the ED, if they choose, to sit in on all
2 their consultations with them, to help if there are
3 explanations required or, you know, discussion around the
4 material that is presented by the clinician, that there is
5 a familiar face or a familiar person with them to help with
6 that. That's been very well received. We can't
7 unequivocally prove it, but we believe our "did not wait"
8 data for our ED has improved since we've landed that. We
9 believe it is partly a function of that anyway.
10
11 So we're doing a range of strategies around that
12 space. As our Aboriginal health workforce increases,
13 there's more familiarity amongst our patients with staff.
14 I think it was David yesterday mentioned that our staff are
15 our community in many instances, and that's particularly
16 the case in the smaller communities. So it's something
17 that we're very aware of and are very focused on.
18
19 Q. To the extent that you can make an assessment of
20 cultural safety, it really informs part of the measures
21 that you had in place for assessing patient experience more
22 so than, say, those more traditional clinical metrics of
23 bad outcomes that are able to be objectively measured
24 through medical routes?
25 A. Yes. You know, we do take note of the Bureau of
26 Health information survey data, for instance, and they do
27 specific surveys around Aboriginal experience, particularly
28 in ED, but equally, they do surveys of all patient
29 experience. And we should be mindful of both. But they
30 are data tools that we've got available to us, which we can
31 certainly look at.
32
33 Q. Can we jump back to page 33 of the safety and quality
34 account that we've got open there. One of the ways that
35 you are able to make an assessment of patient experience is
36 through complaints, an assessment of complaints.
37 A. (Witness nods).
38
39 Q. If we scroll down to the foot of that page, though,
40 you tell us in 22/23 the LHD received 99 complaints, which
41 was thankfully a decrease, apparently, on the prior period,
42 but 99 complaints out of how many patient interactions, in
43 a ballpark sense?
44 A. Oh, it would be several thousand - several thousands.
45 I couldn't tell you the number off the top of my head, but
46 I think our presentations to ED, for instance, at Broken
47 Hill were something like 2,500 last year. I might be wrong

1 so - yes.
2
3 Q. Whilst the complaints is a useful tool to identify
4 where people choose to speak up, something that they might
5 have been unhappy with, they are not really the best
6 measure of patient experience?
7 A. No, no.
8
9 Q. If we turn over to page 35, I think some of the other
10 tools that are used are the patient experience survey,
11 which I think you might have mentioned a moment ago. You
12 tell us in the highlighted section there that in March
13 2023, 77 per cent of paediatric surveys were completed. Do
14 you have a sense on a broader scale within the LHD of how
15 many patients who interact with the health service complete
16 their patient experience survey, as a percentage?
17 A. Yes, I couldn't tell you that off the top of my head.
18
19 Q. If it was a high number, it would likely have been put
20 in bold in this document, wouldn't it?
21 A. Yes. I mean, I think conventional wisdom, if you get
22 35 per cent or something, that's probably a good result.
23 BHI do conduct a range of patient surveys and it's not as
24 if they are always - it is not as if the paediatric one is
25 run annually, they are on a cycle, so that was probably the
26 most recent particular survey that was conducted.
27
28 Q. In the bottom right-hand corner, you've got the Go
29 Share Bundle, where we're told that of the 5,000-odd that
30 were sent out, 40.6 per cent of them were opened. Out of
31 the 40.6 per cent - or 40.7, in fairness, that were
32 opened - 45 per cent of the consumers who did so said the
33 information was helpful, but again, that's, when we take
34 those percentages and stack them on top of one another,
35 a pretty tiny handful of patients.
36 A. Yes, yes.
37
38 Q. Is there anything else - you have referred to the
39 patient experience officer, but is there anything else that
40 is being done to measure, as best as you can, the extent to
41 which First Nations people who are interacting with the
42 health service find it to be culturally safe and
43 appropriate?
44 A. There's probably nothing definitive. I guess we are
45 conscious that access to Aboriginal health workers,
46 particularly Aboriginal liaison officers through the
47 hospital, is seen very favourably, which is why we continue

1 to focus on increasing the staff in that space. For those
2 staff working in those roles, they are very, very keen and
3 interested in also having a career path, and we're working
4 on that as well. So we're in the process of creating
5 a team leader position to, I guess, manage those staff,
6 which is another measure of cultural appropriateness within
7 the hospital, rather than having them report to the
8 director of nursing and, again that adds another level of
9 cultural safety, cultural comfort, I think.
10
11 Q. A number of issues have been raised with us over the
12 past few days, one of which was the 1800 number that's
13 required for access to dental services it's been suggested
14 to us is something that First Nations people, by and large,
15 were not using. Is that something which you have heard?
16 A. I have - I heard it during the evidence. That's
17 a statewide model, though, to have a call centre
18 arrangement. It happens that that call centre is operated
19 out of Western New South Wales but, you know, a call centre
20 can sit anywhere, quite frankly. It is a way for people to
21 book in and get access.
22
23 Interestingly, I was looking at the data around our
24 oral health activity and it's, I'm sure, purely
25 a coincidence, but about 13.3 per cent of our appointments
26 for dental were Aboriginal people through the clinics that
27 we offer, and some of those are clinics that we offer in
28 town here, but also the remote clinics which are delivered
29 by RFDS. So it's a mix. But the subscription seems to be
30 at least equivalent to the representation of Aboriginal
31 people in the general community.
32
33 Maari Ma do offer dental services as well and part of
34 that is sort of supported by us through an agreement with
35 RFDS, and we've also undertaken, once we get them
36 stabilised, to also try to assist in the delivery of
37 clinics there by working with Sydney University for
38 students, for instance, to conduct clinics at the Maari Ma
39 clinic. We've got chairs in all of our facilities across
40 the district, so each of our facilities has got at least
41 a chair, fully equipped sort of dental clinic, so it is
42 available to provide a service.
43
44 Q. You would hope that access issues like that, to the
45 extent that they do exist in pockets, might be better
46 identified as part of this ongoing process of collaboration
47 that's occurred?

1 A. Yes, yes, for sure.
2
3 Q. Another issue that has been raised with us, both here
4 and in other LHDs, is the challenges that arise out of the
5 one-way nature of a lot of health travel - that is to say,
6 if you find yourself particularly unwell in your community
7 and are transferred to Broken Hill or Dubbo or Adelaide for
8 treatment, once you are well and discharged, it's suggested
9 that people are discharged and left to make their own way
10 home. Is that an issue that the LHD has looked at?
11 A. It's certainly an issue that we're aware of. As I've
12 got no doubt you have heard, our main referral pathway out
13 of Broken Hill for patients that need care beyond the level
14 that we can provide is to Adelaide. Our team here have
15 done a lot of work, particularly with the Royal Adelaide,
16 because the large portion of our patients go to the Royal,
17 around patient flow and patient movement. Our staff now
18 sit in on the Royal Adelaide patient flow meeting on
19 a regular basis, and part of that is to discuss patients
20 that we might have in Broken Hill who we're planning to
21 send, but equally, patients in Adelaide that are ready to
22 come back.
23
24 So we have - we're certainly working with both MedSTAR
25 and RFDS. If there is an empty plane coming to Broken
26 Hill, we fill it up when we've got beds, and that's
27 a challenge at the moment about repatriating patients from
28 Adelaide, but certainly IPTAAS payments apply to returning
29 to Broken Hill just as much as they do about getting to
30 Adelaide, and we're certainly trying to work with our
31 partners in Adelaide around discharge processes so that
32 someone's not simply just discharged into the street; that
33 if they are supposed to come back here, that there is
34 a pathway that we can do that.
35
36 Q. What about patients who might have been brought into
37 Broken Hill for treatment from more remote areas who are
38 then --
39 A. Equally, we do try to assist them to get back to their
40 home base, where we can. I mean, I've heard the anecdote
41 that people have been discharged at 2am. I would really be
42 surprised if that's happened. We tend to hold people in
43 the ED if we haven't got a bed rather than put them out in
44 the street, and I would be very - there might have been
45 isolated incidents some time in the past, but I would be
46 very surprised if it was recent. If there was cases
47 recently, we would love to know about them so that we can

1 fix it. But certainly it's not been brought to our
2 attention, except through this pathway.
3
4 MR MUSTON: I've probably got about five or 10 minutes to
5 go, Commissioner. I do note the time. I'm looking with
6 hope at the stenographer that she will forgive me if we do
7 push on.
8
9 Q. Could I ask you to go to paragraph 63 of your
10 statement?
11 A. Yes.
12
13 Q. You tell us there that the ABF model is not the
14 appropriate funding methodology for Broken Hill. We've
15 heard some evidence today to similar effect. Did you catch
16 that evidence when it was given?
17 A. I saw some of it, yes.
18
19 Q. To the extent that you think it covers effectively
20 what you would say in relation to that, don't feel the need
21 to repeat any of it, but is there anything else that you
22 would want to say about the inappropriateness of the ABF
23 model for Broken Hill Hospital?
24 A. I think for us we have a lot of fixed costs in just,
25 if you like, the costs of keeping the doors open. Now, in
26 particular services like maternity or ICU or paediatrics,
27 where the volume of activity is fairly fluid, you know,
28 we'll have the maternity unit staffed, because we never
29 know when a mother is going to come in to deliver, but
30 there will be times when the staff are sitting there with
31 no patients as well. But we still incur that cost.
32
33 So, in that context, we've got fixed costs which are
34 a function of our low activity. In other organisations
35 where they have higher activity, more births, for instance,
36 you know, their maternity staff will be well occupied
37 delivering babies, whereas ours are often waiting for mum
38 to arrive, as an example of fixed cost.
39
40 There is certain instances where we can deploy those
41 staff, but particularly in the maternity space, many of our
42 staff now are qualified as midwives but not as RNs, so we
43 can't simply move them to work on the medical ward or the
44 surgical ward, because they are not qualified to do that.
45 So for the maternity services, it is particularly relevant.
46 Certainly in the paediatric space, we can redeploy those
47 staff, but again, we might have one patient and we've got

1 to have two staff there for that because of the staffing
2 requirements.
3
4 Q. Could we quickly get Ms Pearce's outline up on the
5 screen, it's [MOH.9999.1245.0001] at page 0008. Just a
6 little bit earlier you expressed a view that you didn't
7 think that the classification of Broken Hill as something
8 other than remote would necessarily make a big difference
9 in terms of the funding dollars but that there might have
10 been other issues. I just invite you to have a look at
11 paragraphs 61 and 62, in particular, paragraph 61. Do you
12 see there she expresses a view --
13 A. Yes.
14
15 Q. -- that a different allocation might result in a
16 loading increasing from 8 per cent to 22 per cent. Without
17 pretending to be across the number that that loading would
18 be applied to, a lift from 8 to 22 per cent, particularly
19 if applied to a large number, has the capacity to be
20 a pretty significant figure?
21 A. True. True. Yes.
22
23 Q. Could we quickly go now to paragraph 92 of your
24 statement. It may well be, just looking at that first
25 sentence, that this is just a more elegant way of
26 expressing what I've referred to on a number of occasions
27 as a lack of head room. Could you just indicate what it is
28 exactly that you had in mind when you were referring to the
29 funding models?
30 A. Paragraph 92?
31
32 Q. Paragraph 92, that first sentence.
33 A. I think this is what I was alluding to earlier, where
34 the funding methodology says that if you've got a certain
35 number of cases per thousand population, then you get this
36 many dollars or this many FTEs. For an LHD like ours,
37 which has the smallest patient base in the state, that
38 incidence will be low and so we will get a fraction of an
39 FTE through that allocation methodology, which is then very
40 hard to recruit to. And whilst you might be standing up
41 a specialty service where you need specialty skilled staff,
42 it's going to be very difficult to attract a 0.1 or 0.2 FTE
43 person to deliver that service, and as we've discussed,
44 ideally, you would want that person to be face-to-face, but
45 that's not always possible.
46
47 Q. Particularly if the reality is that those 100 cases of

1 a particular illness that might have given you the 0.1 of
2 an FTE might be spread evenly between Bourke and Wentworth?
3 A. Yes, for sure, yes.
4
5 Q. In terms of the funding model for the delivery of
6 health care in your LHD, not only acute health care but
7 more generally, if you were given a blank sheet of paper
8 and an opportunity to sketch out what you thought a perfect
9 funding model for meeting those health needs would be, what
10 would the sketch look like?
11 A. Oh, that's a really good question.
12
13 Q. I probably should have warned you about that one and
14 you could have scratched it out for me over the luncheon
15 adjournment.
16 A. Yes, of course.
17
18 THE COMMISSIONER: A great question at 5.09.
19
20 THE WITNESS: There is a few things I think are really
21 significant factors for us, one is the remoteness and the
22 ability for us to attract staff to live and work in town is
23 really challenging. You heard David Green talking
24 yesterday about the incentive scheme and that that has not
25 made really an appreciable difference to us, to our ability
26 to attract staff, so that's a challenge.
27
28 I think part of the message in that is that the thing
29 that attracts staff to come and work in an LHD like ours is
30 not just monetary. So I don't know that throwing more
31 money at trying to recruit staff or incentivising staff is
32 necessarily the answer. But there are other factors,
33 I think, that could come into play, and we heard somebody,
34 I can't think who it was, I think it was Sarah Wenham,
35 saying today that the ability for us to support staff to go
36 home and see their family, for instance, and some of those
37 factors, could potentially make working here more
38 attractive.
39
40 So in terms of a funding model, we've got what we've
41 got. I think that there is potential for greater
42 recognition of the remoteness factor for us. Yes, the MM
43 comes into that, but I think what regularly happens when we
44 have people come to visit is they don't - they really don't
45 realise how remote it is. Even if it is only flying from
46 Sydney to Broken Hill, the fact that you can fly to
47 Auckland quicker and cheaper, people don't recognise that.

1 And so that represents a challenge for us, and for us to be
2 able to attract staff is an ongoing challenge and an
3 ongoing cost.
4
5 We bear a lot of cost for accommodation, for flights,
6 for our staff, because otherwise they won't come, and we've
7 had instances where nursing agencies have said "If you're
8 not going to pay for the flights and accommodation, we're
9 not going to send anyone to you". So we're held over
10 a barrel at times. I'm not sure whether Apsara talked
11 about the volume of housing that we provide in town, but
12 it's significant - either owned properties or rented
13 properties, or motel/hotel rooms. That's a cost to us
14 which just becomes part of the costs that we bear. And I'm
15 not sure that that's recognised.
16
17 The question of the revenue budget came up in Apsara's
18 evidence earlier, and I think the way that many of those
19 budgets are allocated is it's last year plus or minus
20 a bit. And if the landscape significantly changes, and
21 that's the situation with us with that revenue budget, the
22 current model doesn't have a way of dealing with that. The
23 revenue which contributed to our target being the size that
24 it is, or the way of generating revenue, just doesn't exist
25 and will no longer exist for us, and so we will not have
26 those processes in place to generate that volume of
27 revenue, and so we will just bear that as a deficit.
28
29 So I think rather than talking about a funding model,
30 I think being able to have meaningful discussions about
31 some of those changes would assist us greatly. The issue
32 for us in that revenue space is about between 2 and
33 3 million dollars, that revenue target, which we will never
34 be able to generate, and that's not a lot in the great
35 grand scheme of things of the budget of NSW Health, but in
36 the great grand scheme of things of the Far West LHD
37 budget, it is. And I think that's the factor for us, is
38 that many of these things don't sound like a lot of
39 dollars, but out of the budget that we're operating on,
40 they are significant. I don't know that I have answered
41 your question.
42
43 The funding methodology for our smaller hospitals is
44 not unreasonable. We're taking up an issue where we don't
45 understand for what reason, but, for instance, Buronga and
46 Balranald is seen as one facility and I don't know why that
47 is, and no-one seems to be able to tell us why that is, and

1 we're trying to prosecute that through our current service
2 agreement discussions. The impact for us of that is about
3 $900,000.
4
5 MR MUSTON: Q. In terms of a lot of these issues around
6 the revenue target being unachievable, the other issue you
7 have just identified, I think when it was raised with
8 Apsara, she said, "Well, it's been heard and noted" but, to
9 be blunt about it, is the sense you get that heard and
10 noted but perhaps not really listened to, or perhaps I
11 could put that a better way. You have seen no sign at your
12 end which would suggest it's been listened to and acted
13 upon?
14 A. I guess within the context of the current financial
15 year, no, it hasn't been acted upon. We would hope that
16 there is some action next year, because we've raised these
17 issues pretty much across every forum, but I think in some
18 respects, once the budget is set, the budget is set, and
19 that's - you know, barring small adjustments through the
20 course of the year, what is a relatively large adjustment
21 to our revenue budget of excusing, let's say, $2.5 million
22 within the year is probably pretty difficult. We're
23 hopeful that it will be actioned next year, but I guess
24 that remains to be seen.
25
26 Q. Next year is six weeks away. Have you been given any
27 indication that there is good news on the horizon on any of
28 those fronts?
29 A. Not yet, but I think that's also a function of the
30 discussions between the ministry and treasury, and so those
31 discussions - they don't really know what the funding
32 envelope from treasury is yet, and that's a function of
33 ongoing discussions between those two agencies.
34
35 MR MUSTON: Thank you, Commissioner, I have no further
36 questions for this witness. Thank you, Mr Astill.
37
38 THE COMMISSIONER: Mr Cheney, do you have any questions?
39
40 MR CHENEY: No.
41
42 THE COMMISSIONER: Thank you very much, Mr Astill. We're
43 very grateful for your time. You are excused.
44
45 **<THE WITNESS WITHDREW**
46
47 HIS HONOUR: So that means we're adjourned until --

MR MUSTON: 10 o'clock.

THE COMMISSIONER: On Monday, 3 June, is it?

MR MUSTON: 3 June in Sydney.

THE COMMISSIONER: Let's make it Monday, 3 June, in Sydney. We'll adjourn until then.

AT 5.16PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO MONDAY, 3 JUNE 2024 AT 10AM IN SYDNEY

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