

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

**At Batemans Bay Soldiers Club
6 Beach Rd, Batemans Bay, NSW, 2536**

Thursday, 15 August 2024 at 10am

(Day 047)

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

Also present:

Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning, everyone. I think before
2 we begin today, we have Rod Slockee to welcome us to
3 country.

4
5 UNCLE RODRICK SLOCKEE: Gadu Walawaani. Can everyone say
6 "Walawaani"? Walawaani means safe journey, when you come
7 to Walbunja country and you just put down that mother
8 tongue language in yourself, it actually provides that safe
9 journey throughout country and on country. My name is Rod
10 Slockee. I am a Walbunja man, and I would like to welcome
11 country to us, as we are the living life force that
12 sustains country. So today I'd like to welcome the sun
13 that energises. And we are a very visual people where we
14 are on our country, and today, being the Aboriginal person,
15 I put that responsibility on everyone else to be the
16 Aboriginal person and sustainers of country and people that
17 live on country.

18
19 Today, we are talking about health, and one of the
20 health things that I have in my statement would be our food
21 is part of our health system, because that is what sustains
22 us as humans or as people. So when I looked at our ocean,
23 at Gadu, and Gadu was like one of our sustainers, the sun
24 is, you know, one of our sustainers and the earth is one of
25 our most important sustainers, that we have that life force
26 on it. And in our welcome, when we eat the fish of the
27 Gadu and we eat the animals and the plant life of growth,
28 the land, it keeps us in check/balance with the earth and
29 the country which we sustain in.

30
31 So around here, I probably tend to eat, going after it
32 this week, actually, is my local fish is groper, and it has
33 a different Omega 3 than any other fish that can get in it,
34 and it is the fish that is closest to the land, so it is of
35 abundance. And when I sustain my body with that, it gives
36 me the right oils and nutritions that I need in my body,
37 and then I'm eating the plants that are coming in season.
38 So my winter plants sustain me right up until now, and now
39 the spring is starting to break early, you can actually see
40 it in the wattle. So the wattle tells us about the sea,
41 and the wattle is white, it is a mullet season because that
42 strong white meat. When it turns yellow, the salmon will
43 start coming in because they have a very yellow and orange
44 roe, which is their eggs.

45
46 Walawaani, everybody. May your meeting be successful.
47 May it produce the outcomes for our people that sustain our

1 country. Thank you. With the welcome, I am going to play
2 yidaki. Yidaki gives us the sound of the earth. The earth
3 is spinning in a vibration. The yidaki.
4

5 Walawaani: [Yidaki played].
6

7 THE COMMISSIONER: Thanks very much, Rod. Yes, Mr Muston?
8

9 MR MUSTON: I acknowledge that we are meeting in the
10 country of the Walbunja people and pay our respects to
11 their Elders past and present, and to all Walbunja people
12 who have so warmly welcomed us to their country today.
13

14 Over the past three days, we have visited facilities
15 across the vast district that is the southern
16 New South Wales Local Health District. It covers an area
17 in excess of 44,000 square kilometres, which in and of
18 itself traverses areas which are part of the traditional
19 lands of what, at least in contemporary times, are
20 described as the Yuin people, being a large number of
21 different language groups that extend up and down the
22 coast, so the strip that we have traversed from Eden up to
23 where we are standing today in the land of the Walbunja
24 people. As you move across to the west of the local health
25 district, we have lands which were traditionally
26 traditional lands of the Gandangara people, the Ngunawal
27 people, and the Ngarigo people. To the extent that we were
28 welcomed on to each of their countries and walked upon them
29 and had the opportunity to view health facilities that are
30 in existence on those lands, again, we were truly fortunate
31 and we pay our journey and respects to their Elders past
32 and present, and to all of those first nations people in
33 those areas who continue to make use of the health
34 facilities we visited.
35

36 We were shown the South Eastern Regional Hospital in
37 Bega, where we were given a tour of some of the facilities
38 and conducted round table to discuss a number of the
39 particular challenges faced by that facility in that area.
40 It was participated in by clinicians and a number of other
41 people involved in the delivery of public health services
42 in the region. We then moved west into Cooma, where we saw
43 the Cooma hospital and conducted another round table there.
44 One of the striking features of that visit was the
45 information shared about the very high load of trauma cases
46 seen by that hospital coming from both the snowfields and
47 mountain bike enthusiasts who use the mountains in summer,

1 which is, we are told, a genuine challenge and stretches
2 the capacity of what is a relatively small facility
3 relative to the number of presentations that it sees.
4

5 We then moved to Bombala MPS, which although very
6 small and in a fairly remote town, has managed to overcome
7 or set themselves apart from a number of other equivalent
8 facilities that we have seen in our travels around regional
9 and rural New South Wales, in that they have a largely
10 permanent workforce, nursing workforce, which has
11 substantially reduced the need to rely on agency staff,
12 which is something that I think most facilities like it
13 aspire to, we are told. This has been complemented by a
14 co-located GP facility on the same site, which, again,
15 through the management of the general practitioner, who has
16 taken over the operation of that, would seem to be able to
17 operate and provide good primary care to people within that
18 small town in a way which is not heavily dependent upon
19 locum use, which again is something which I think many
20 towns like Bombala, equivalent towns to Bombala would
21 aspire to. That is not to say it is without its
22 challenges, and the current situation in Bombala, I think
23 it would be fair to say, is relatively fragile and is
24 dependent upon the continuing efforts of some really great
25 people who have made it work there in the way that it is
26 working.
27

28 Yesterday, we had a productive meeting with the -
29 productive meetings with two Aboriginal medical services
30 that provide care to people within the local health
31 district, the Katungul Aboriginal medical service in
32 Moruya, and the Winnunga Nimmityjah - I apologise for my
33 pronunciation - which is in fact a Canberra-based
34 Aboriginal medical service that provides medical care to
35 First Nations people not only within Canberra, but also
36 provides a clinic within the Alexander Maconochie
37 correctional facility in the ACT. But also, having regard
38 to the fact that there is no Aboriginal medical service
39 physically located within the western half of this LHD, it
40 provides care to a large number of people from within this
41 LHD who travel to Canberra to make use of the services
42 which they provide.
43

44 It is anticipated in relation to the Aboriginal
45 medical services that at a later stage in the inquiry, we
46 might have a day where, in something of a round table, we
47 call together all of the Aboriginal medical services and

1 NACCHOs that we have engaged with and invite them to come
2 and share with us some of the challenges, and share with
3 one another some of the challenges that they face and look
4 at ways in which those challenges might best be addressed
5 by local health districts and the ministry in an attempt to
6 collaborate in the delivery of healthcare to the consumers
7 that they serve.

8
9 Finally, yesterday, we met with a group of residents
10 in Batemans Bay who have shared with us their concerns
11 about the location of the new hospital which is being
12 developed in Moruya, and the allied proposal that once
13 that new hospital is opened, the emergency department at
14 Batemans Bay Hospital will be closed and repurposed as a
15 community facility. Each of them has provided statements
16 in which they set out their concern. We understand that
17 those statements will be tendered and the extent of their
18 evidence. We understand that neither the ministry nor the
19 local health district wishes to cross-examine them on those
20 statements, and in those circumstances they won't be called
21 to give any further oral evidence, but their statements and
22 their story has been heard and is part of the evidence of
23 the Commission.

24
25 THE COMMISSIONER: Yes.

26
27 MR MUSTON: The picture that has emerged over those
28 three days suggests that this LHD experiences most of the
29 same significant challenges that we have been told about in
30 our travels across rural and regional LHDs over the past
31 several months. Perhaps some of the unique features of
32 this LHD which exacerbate some of those challenges, at
33 least in pockets of it, is the particular challenges,
34 geographical challenges. When I say "geographical", I am
35 not only referring to the topography, which as we
36 discovered driving from the coast up to Cooma, is
37 challenging - the climate is challenging - it means we are
38 told that facilities which might potentially appear close
39 together and therefore have the capacity in some other
40 areas to consolidate services in certain ways can't
41 realistically consolidate the services, for example,
42 maternity services, where what might be a relatively short
43 distance to drive in summer is a relatively long trip if
44 you have climatic conditions like snow and ice that make it
45 impractical to travel. So there are certain services that
46 a lot of these smaller facilities in this LHD need to
47 continue offering, we are told, that other LHDs are able to

1 consolidate in ways which perhaps render it more
2 financially viable. So that's one challenge.

3
4 The other geographical challenge is a population-based
5 one, and that is in both the western area through the ski
6 season and in the coastal area through the summer months we
7 see, we are told, an enormous influx in the population
8 through tourism, which creates its own challenges for the
9 delivery of public health where the population fluctuates
10 so wildly, you do get a situation where relatively small
11 facilities staffed in a particular way might have a great
12 capacity to deal with the needs of a relatively small
13 population but where that population expands by upwards of
14 a million people over a holiday period, then that creates
15 quite significant stresses in the system, but nevertheless
16 is a reality --

17
18 THE COMMISSIONER: It fluctuates wildly and people are
19 doing dangerous things while they are here.

20
21 MR MUSTON: Certainly in the west we are told, for what it
22 is worth, contrary to what might people think, mountain
23 biking is more serious than skiing.

24
25 THE COMMISSIONER: Yes.

26
27 MR MUSTON: I guess it depends on how steep the hill is.

28
29 THE COMMISSIONER: And your age, probably.

30
31 MR MUSTON: No doubt. So that's the first, they are some
32 of the geographical challenges. The next challenge, which
33 is a little bit unique to this LHD, at least when compared
34 with a number that we have visited, is the absence of a
35 tertiary referral facility within the LHD. That creates
36 challenges both in terms of patient movement, but it also
37 creates challenges in terms of workforce, and your ability
38 to build and maintain a specialist workforce to serve the
39 people throughout the LHD, which probably ties in nicely to
40 the third of the not entirely unique, but relatively unique
41 in terms of the way it plays out, challenges which are
42 faced by this LHD, which are inter-border or cross-border
43 issues.

44
45 This LHD has two borders that it deals with, both
46 Victoria and the ACT, and in particular the ACT is an area
47 where there is a very high degree of connectivity between

1 tertiary health services provided within the ACT and
2 patients who are transferred through facilities on the
3 coast. Now, that not only means a patient who may have
4 experienced an acute episode requiring tertiary care is
5 transferred from a facility here into Canberra, but it also
6 means specialist care being provided outside of the acute
7 setting is routinely accessed through Canberra, which,
8 whilst perhaps closer than Sydney for some within the LHD,
9 is still a relatively long way away. And so, one of the
10 great challenges that is faced by this LHD is looking for
11 ways to develop some of that clinic-based out of hospital
12 specialist care for people who live within the LHD, often
13 quite a long way away from centres where that sort of acute
14 care - not acute - specialist care is located.

15
16 We have a pretty busy schedule over the next two days.
17 I don't think you need to hear any more from me.
18 I'll throw it over to Mr Glover, who is going to call the
19 first witnesses this morning.

20
21 MR GLOVER: Thank you, Mr Muston. First up this morning,
22 Commissioner, we have I think witnesses from the South
23 Eastern New South Wales Primary Health Network,
24 Prudence Buist and Andrew Gow, being called together.

25
26 <PRUDENCE BUIST, AFFIRMED [9.49 am]

27
28 <ANDREW GOW, AFFIRMED

29
30 <EXAMINATION BY MR GLOVER:

31
32 MR GLOVER: Ms Buist, if we start with you, can you state
33 your full name.

34
35 MS BUIST: Prudence Buist.

36
37 MR GLOVER: And you are the chief executive officer of
38 Coordinaire Limited, which operates the South Eastern
39 New South Wales Primary Health Network, correct?

40
41 MS BUIST: Correct.

42
43 MR GLOVER: To assist the commission in its work, you made
44 a statement dated 14 August 2024?

45
46 MS BUIST: I did.

47

1 MR GLOVER: For the purposes of the transcript, it's
2 SCI.0011.0351.0001. Do you have a copy of it there with
3 you?
4
5 MS BUIST: Indeed, I do.
6
7 MR GLOVER: And although you only signed it yesterday,
8 have you read it again this morning?
9
10 MS BUIST: I have indeed.
11
12 MR GLOVER: And are you satisfied that it is true and
13 correct to the best of your knowledge and belief?
14
15 MS BUIST: I do.
16
17 MR GLOVER: Mr Gow, if I turn to you, could you tell us
18 your full name, please?
19
20 MR GOW: Yep, Andrew Gow.
21
22 MR GLOVER: And you are the director of strategy and
23 performance of Coordinaire?
24
25 MR GOW: Yes.
26
27 MR GLOVER: And you have held that role since about July
28 2015?
29
30 MR GOW: Yes, that's right.
31
32 MR GLOVER: And you also have prepared a statement dated
33 14 August 2024. For the transcript, it is
34 SCI.0011.0379.0001. And have you read your statement again
35 this morning?
36
37 MR GOW: Yes, I have.
38
39 MR GLOVER: And although signed yesterday, you are still
40 satisfied that it is true and correct?
41
42 MR GOW: I am, thanks.
43
44 MR GLOVER: Ms Buist, if I start with you and I take you
45 to paragraph 5 of your statement, there you describe some
46 features of the area that falls within your PHN's
47 footprint. You have heard Mr Muston describe some of the

1 challenges of the region this morning, but from your
2 perspective, can you tell us some of the challenges in
3 delivering healthcare across the vast region that your PHN
4 covers?

5
6 MS BUIST: Yes, sure. Just for clarity, our PHN runs from
7 Helensburgh in the north right down to the Victoria border
8 and then around the ACT and pretty much through to the
9 Murrumbidgee. So we are one of the only PHNs in both
10 metropolitan, regional and rural setting. In the region,
11 we have got 642,000 people across the whole region.
12 222,000 of those are in the southern region. We have about
13 719 general practitioners in the region, and they are
14 distributed throughout, but not equally. There is a little
15 bit of - a few issues with distribution of those general
16 practitioners.

17
18 MR GLOVER: We will come back to GPs in a moment.

19
20 MS BUIST: Of course.

21
22 MR GLOVER: Other than - are there any particular other
23 challenges faced by - in delivering healthcare for the
24 region, other than the GP factor, which we will explore
25 shortly?

26
27 MS BUIST: Yeah, look, there has been a significant
28 increase in the population post-COVID. The other issue
29 that's a bit of an emerging issue at this point in time is
30 homelessness, and certainly that's faced a lot in
31 Wollongong and we have also got quite a lot of diversity in
32 terms of ethnic background.

33
34 MR GLOVER: Mr Gow, do you wish to add anything to what
35 Ms Buist has said?

36
37 MR GOW: Definitely the geography and topography of this
38 region is a particular challenge. I think it was well
39 explained earlier on. In terms of workforce, allied health
40 is certainly a challenge for people, particularly in
41 regional areas, getting - of our PHN catchment, so getting
42 access to allied health in the private market is the
43 challenge, particularly in those more outlying areas.

44
45 MS BUIST: Might I also just add, certainly specialist
46 access as well is a big issue, as well.

47

1 MR GLOVER: We come to paragraph 7 of your statement,
2 Ms Buist, and you tell us there about the role of the PHN
3 and that it works with government and not profit healthcare
4 providers, et cetera, to commission, coordinate and
5 capacity-build local health services.
6

7 MS BUIST: Yes.
8

9 MR GLOVER: We have heard some evidence in other regions
10 about other collaborative commissioning initiatives, and
11 you tell us about some of those in your statement, but
12 I want to explore with you this morning the role of the PHN
13 in, firstly, coordinating health services across the
14 region. Can you tell us what steps the PHN takes to help
15 coordinate services across the vast region it covers?
16

17 MS BUIST: Sure. So I might get Mr Gow to start talking
18 about our population health profile, because that's one of
19 his areas of expertise, and then I can carry on.
20

21 MR GOW: Okay, yeah. So we have a population health
22 profile that we develop and operate as a live document, so
23 that's really understanding what are the demographics, what
24 are the service utilisation patterns, what are the
25 socioeconomics of the region, and we use that to inform our
26 needs assessment. And we do that as well, we also bring in
27 the other stakeholder inputs. So there is a quantitative
28 aspect and there is a qualitative aspect to that work.
29

30 MS BUIST: So we are advised by two clinical councils. We
31 have two groups of general practitioners and
32 physiotherapists and psychologists and what have you, who
33 give us clinical guidance. We have also got a community
34 advisory committee and an Aboriginal health committee, and
35 we have recently split those so that there is a north and a
36 southern aspect to those for assistance.
37

38 MR GLOVER: Mr Gow, in terms of the population health
39 profile, how is that pulled together?
40

41 MR GOW: Generally, it is using publicly accessible data
42 but we then localise that in terms of the local geography.
43 So we try and present that in as granular as geography as
44 is possible. We also pull in some of the data that may not
45 be as easily publicly accessible, looking at service
46 utilisation data as well. So that's from a range of
47 sources. And so, I mean, what we aim to do is keep that as

1 updated and as current as possible. So when new data
2 releases are available, we incorporate that into our
3 population health profile.
4

5 MR GLOVER: And - sorry, I didn't mean to cut you off.
6 Continue.
7

8 MR GOW: I was just going to mention the qualitative
9 aspect as well. So whenever we are doing stakeholder
10 consultation, and that's not necessarily in large forums,
11 that can be in smaller forums as well, we record the
12 findings of that consultation and then incorporate that
13 into - as a companion piece, I suppose, to the quantitative
14 data that's in a population health profile.
15

16 MR GLOVER: When you say "stakeholder consultation", who -
17 give us some examples of the groups or providers who you
18 might be drawing information from to inform you of that
19 analysis?
20

21 MR GOW: Yeah. Well, it is a fairly diverse group. So it
22 can be - the methodologies that we have used in the past,
23 it might be surveys, and that survey might be to community
24 members or it might - they are all community members, but
25 some in their capacity as community members while other
26 people in their capacity as service providers. We also -
27 often when they're developing a particular service, we will
28 then co-design that service with community groups and
29 stakeholders from the local area. That again includes
30 service providers. So it is very much an iterative
31 process. So we would try and work within local networks to
32 get interested parties from the local region to actually
33 contribute that information.
34

35 MR GLOVER: You mentioned in an earlier answer that the
36 population health profile feeds into the needs analysis.
37 Can you just then tell us how that process flows through.
38

39 MR GOW: Yes. So one of the processes that all PHNs have
40 to do is a needs assessment report on a three-year basis,
41 and it is updated on an annual basis as well. So we use
42 the quantitative data that's in the population health
43 profile to identify at a high level where we see needs and
44 gaps, also to identify where things are working well as
45 well, and then from that, take on board feedback from, and
46 as was mentioned earlier, the clinical councils; we have
47 got all of those advisory groups that give us really

1 insightful information on local needs and requirements.

2
3 And then we use that information - as opportunities,
4 funding opportunities come up, we use that information to
5 then guide where we will commission services, but it's not
6 just around commissioning as well. It is also what are the
7 types of work we might do in terms of supporting general
8 practices and also any of the collaborative work that we
9 need to do, together with other stakeholders, including the
10 local health district.

11
12 MR GLOVER: In completing the health needs analysis, does
13 the PHN engage with other stake holders and providers
14 within its region?

15
16 MR GOW: Normally, we do that as part of - so the
17 consultation that I mentioned earlier, when we're - what we
18 try not to do is keep going back and asking the same
19 communities the same questions. So we're trying to look
20 for knowledge gaps and ask questions that will address a
21 knowledge gap and then incorporate that into the needs
22 assessment and the prioritisation process.

23
24 What - sorry, there was a second point I was going to
25 add in there, and it's just --

26
27 MR GLOVER: That's all right. If it comes back to you,
28 let us know.

29
30 MR GOW: Yeah.

31
32 MR GLOVER: For example, does the PHN engage with the two
33 LHDs that it deals with --

34
35 MR GOW: That was the second point that I was --

36
37 MR GLOVER: -- to develop and then finalise its needs
38 analysis?

39
40 MR GOW: We do. We do. And not just on that formal needs
41 assessment report. We actually do that as a matter of
42 course. So, for example, with our commissioning process,
43 we're commissioning at different times throughout the year.
44 Before we would commission a new service, we generally have
45 discussed that with different representatives of the LHD.
46 We also at various times meet with - at a senior level,
47 there is the strategic alliance. And then we also have

1 more sort of focused meetings, I guess you would say, or
2 topic-specific meetings at different levels as well.

3

4 MS BUIST: I should just say by way of a practical
5 example, we are currently reviewing our complex mental
6 health services and we have been working with the LHD in
7 the community to try and get a really good understanding
8 and of any gaps in the service so that we can co-design
9 those going forward.

10

11 MR GLOVER: So that is an example where the PHN has worked
12 with the LHD to identify a need for care in the community
13 and is designing a service to meet that need; is that
14 right?

15

16 MS BUIST: Yeah. And I suppose it is really important
17 just to note that we are working towards a data sharing
18 agreement, because that has been one of the issues at this
19 point that we obviously haven't been able to share a lot of
20 that data.

21

22 MR GLOVER: You have given us one example where the PHN
23 and the LHD work together to identify a need and then
24 design a service to meet it. Is there more work that can
25 be done, in your view, along those lines?

26

27 MS BUIST: Yeah, absolutely. I suppose the difficulty is
28 that a lot of the funding that comes through from the
29 Department of Health that we are largely funded by is quite
30 descriptive, and so, you know, the opportunities that we
31 have identified, we therefore don't have funding to be able
32 support those initiatives. So that's one of the
33 challenges.

34

35 MR GLOVER: When you say funding is quite prescriptive,
36 can you explain describe what you mean?

37

38 MS BUIST: Yep, sure. So, I mean, we will get funding for
39 complex mental health or for homelessness or after-hours
40 services, but, you know, it is only a set range and they've
41 got really tight descriptive factors that we need to meet
42 in order to be able to commission services.

43

44 MR GLOVER: So the PHN will receive funding for acute
45 mental health services?

46

47 MS BUIST: Yes.

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MR GLOVER: And then that funding can only be deployed for those services?

MS BUIST: Yes.

MR GLOVER: But is the point you are identifying for us that, well, perhaps there might be a need for another issue within the community, but the PHN can't commission that service because it doesn't have the funding to do so?

MS BUIST: Yes. So, I mean, the way we try and work is, on the ground, you know, with place-based solutions, and so that, you know, we don't look at each community as, you know, the same. And so, you know, the idea is that we can try and make sure that each of the population or the community in those regions have access, you know, to care that meets their needs, and so having a solution specifically for them is sometimes warranted.

MR GLOVER: Ought not that need be identified first and then funding obtained to target that particular needs way, as you have described?

MS BUIST: Yep. And, look, there are opportunities to do that. IMOC grants are probably one good example. We do have a little bit of what we call "flexible funding", which we are able to, you know, put together or commission services based on the needs of the community, but it is only a very small amount of our current funding pool.

MR GLOVER: In your statement, you tell us that there would be benefit from greater flexibility in funding. Is this the issue that you are driving at when raising that point?

MS BUIST: Yeah, absolutely. Funding schedules that Mr Gow also touched on, trying to make sure that all of the funding schedules align, because quite often the funding that we receive, although it's, you know, fantastic, it is only for a finite period, so two or three years, which makes it quite difficult to plan services.

MR GLOVER: Tell me if I have misunderstood you, but do we take it that you would see as great benefit to the work of the PHN to be able to deploy funding to target particular needs in a place-based way with funding delivered over a

1 longer period than is currently available?
2

3 MS BUIST: Yeah, absolutely, and that is something
4 certainly the Department of Health are aware of and that,
5 you know, we've fed back at numerous different forums,
6 including my other colleagues from the other 31 PHNs.

7
8 MR GLOVER: Mr Gow, do you wish to add anything?
9

10 MR GOW: Nothing in particular there. That describes the
11 issue well.
12

13 MR GLOVER: I will ask you about the engagement with the
14 LHD. Does the PHN engage with Aboriginal community
15 controlled health organisations and AMSs firstly for its
16 needs analysis work?
17

18 MS BUIST: Its needs analysis work?
19

20 MR GOW: We engage - we do engage, definitely, and we
21 engage through contract management, and in the course of
22 when working with and through Aboriginal Health Council as
23 well, so there are many different mechanisms. We have
24 previously also had other Aboriginal health service
25 advisory groups as well that have given us input into our
26 needs assessment. And we have - one of the things that we
27 also try and do is, just in the course of our daily
28 interactions with the services that we work with, including
29 the Aboriginal services, is to just identify what are the
30 emerging issues just through the course of conversation.
31 So we don't necessarily do all of these things in a one-off
32 standalone consultation. It will be something that happens
33 through the course of our business where we will record the
34 issues that are arising and use that to inform what's in
35 our needs assessment as well.
36

37 MS BUIST: One of the things that we have just identified
38 as part overlook of our governance committees is the need
39 to diversify the membership, particularly on the Aboriginal
40 Health Council. So where traditionally it was only the
41 A-list CEOs that sit on it that form part of the council,
42 we are now looking at that as part of the social wellbeing,
43 you know, committee members to be able to gain insight and
44 knowledge of the community needs.
45

46 MR GLOVER: Mr Gow, in your statement, I might just take
47 you to it, in paragraph 24 to 29 you tell us a little about

1 this topic. And in 25, you tell us that the PHN, like
2 others, receives funding to commission services
3 specifically for Aboriginal people, and the PHN engages
4 ACCHOs and AMSs to deliver those services, correct?

5
6 MR GOW: Yes, that's right.

7
8 MR GLOVER: Are the ACCHOs or AMSs involved in the design
9 of those services?

10
11 MR GOW: Absolutely. Within, of course, as was mentioned
12 sometimes the program areas actually have specific
13 guidance. So we also have to work with the guidance that's
14 given to us in terms of the funding parameters. So I'm
15 thinking there, for example, there is a program called
16 "Integrated Team Care" which is a care coordination program
17 that has program guidelines that come to us from the
18 department of health and ageing, so - and aged care, so we
19 of course need to work with providers in line with those
20 program guidelines.

21
22 But we've - generally speaking from our perspective,
23 I would say that we allow that to be a co-designed process
24 so that the services can best meet the needs of local
25 communities. There are some really specific examples too
26 with the specific drug - alcohol and other drug treatment
27 program. We have worked with the Aboriginal community
28 controlled organisations around what service model would
29 actually work for them rather than us designing that, and
30 that's where our brokerage service came from, and that
31 service is still in operation.

32
33 MR GLOVER: In paragraph 26 of your statement, Mr Gow, you
34 tell us that there has been consideration at the national
35 level to change the funding arrangements. Can you just
36 describe what that discussion is and what it might look
37 like if it were changed?

38
39 MR GOW: Yeah. So there has been quite an extensive
40 process at a national level with some - working with
41 consultants who have conducted a lot of consultation around
42 the country and proposed some possible different models so
43 that rather than, as I mentioned, those specific provision
44 coming through PHNs, we then commission the AMSs or other
45 Aboriginal organisations to deliver these services; that
46 that would - that the money would flow through directly to
47 Aboriginal community controlled organisations. There are

1 various options, whether that's with flow at a national
2 level or at a state level or at a regional level, they are
3 all matters that are under consideration, I believe, at the
4 department's end.

5
6 MS BUIST: I think we were waiting for that last year, and
7 we've got an additional one-year contract for funding for
8 ITC and NT health, Aboriginal health, services, and then
9 I think there is a plan going forward. I just would really
10 like to make note that there is only four AMSs in our
11 region and there are some large geographical areas that
12 they don't cover. And so it is really important that the
13 services that we provide for our community actually
14 encompass areas where they don't have an AMS available to
15 them, so providing culturally appropriate care and general
16 practice.

17
18 MR GLOVER: For example, in the western part of this
19 region?

20
21 MS BUIST: Yes.

22
23 MR GLOVER: We have been that told people travel into the
24 ACT to get their care.

25
26 MS BUIST: Correct.

27
28 MR GLOVER: Does your PHN liaise a with care providers who
29 might be resident or situated in the ACT but provide care
30 to people within your region?

31
32 MS BUIST: Yeah, look, we work really closely with the
33 Capital Health Network, which is the ACT's PHN, and we work
34 on a number of different programs, health pathways, all
35 those sorts of thing, that try and integrate services for
36 people in the region.

37
38 MR GLOVER: I will take you, Ms Buist, to paragraph 10 of
39 your statement.

40
41 MS BUIST: Yes.

42
43 MR GLOVER: And there you describe the mapping process for
44 GPs in the area. So that is from the Helensburgh in the
45 north to the border in the south and across to the ACT,
46 correct?

1 MS BUIST: Yes.

2

3 MR GLOVER: And when you say there is presently a
4 20 per cent deficit against population health needs, how
5 was that figure arrived at?

6

7 MS BUIST: So, I mean, that's a coordinated estimate. So
8 we have a group of members in our team called "HCC", so
9 health care consultants, that's correct, and these
10 wonderful individuals work really, really closely with
11 general practitioners at all level, so not only with
12 general practitioners, but practice managers and the
13 nurses. And so, that's just from intel on the ground from
14 talking to the general practitioners, plus based on
15 feedback from the general practitioners around wait lists
16 that they have currently got to see patients.

17

18 MR GLOVER: Is that partly explained in paragraph 11 of
19 your statement?

20

21 MS BUIST: Yes.

22

23 MR GLOVER: And in paragraph 13, you tell us that you
24 expect the deficit will only get worse. Do you have a
25 sense of how much worse?

26

27 MS BUIST: So, certainly talking to other general
28 practitioners, and one of the things that we have done
29 really well with LHDs with health medical engagement
30 dinners. So you have heard in the last couple of days that
31 the general practitioners work not only in their own
32 practice but also in the LHDs in the aged care, and
33 certainly the feeling that we get from looking around the
34 room and hearing from them is that they are all very, very
35 close to retirement.

36

37 I have spent a number of months driving around the
38 community, talking to those general practitioners, and
39 they - a lot of them have signalled their intention to
40 retire or are trying to reduce the number of hours that
41 they are working, but that's not currently possible because
42 they can't recruit any new doctors into the region.

43

44 MR GLOVER: In paragraph 16, you tell us that the PHN is
45 attempting to provide support to general practices to
46 recruit?

47

1 MS BUIST: Yes.

2

3 MR GLOVER: Can you just describe to us what that work is?

4

5 MR GLOVER: That's something we're actually currently not
6 funded to do, but I think it is really important. It is
7 something we are hearing from the local GPs, is that there
8 is a deficit in that, I think, Medicare locals had more of
9 a recruitment focus than PHNs. And so, we have put
10 together a website where we highlight or put an area of
11 focus on the southern or the coast. We put videos from a
12 number of GPs that talk about their experience working in
13 rural and regional areas, and then try and encourage,
14 obviously, registrars and what you have to come and work in
15 the area. We are also working with the LHD on a single
16 employer model as well that we have been trying to promote
17 with the region, and I think we've got three new doctors
18 that are going to come as part of that program.

19

20 MR GLOVER: Is there anything that can be done at a system
21 level, Commonwealth or State, to attempt to alleviate some
22 of these challenges with attracting and retaining general
23 practitioners in regions like this?

24

25 MS BUIST: Yes, I think there are a number of things.
26 I certainly don't think that currently the funding that is
27 available for general practitioners, so you know the
28 bulk-billing is just not viable going forward. Coupled
29 with New South Wales tax or payroll tax issue, I have heard
30 specifically that there is a number of practices that have
31 already spoken to corporate practices to try and sell,
32 because that's going to put additional pressures on them.
33 So we need to look at rural and regional opportunities to
34 recognise and support, financially support, those practices
35 so that they remain viable going forward.

36

37 MR GLOVER: Mr Gow, in your statement from paragraph 16
38 onwards, you highlight some potential solutions, including
39 in relation to funding models. Can you just describe in
40 practical terms what you see as being some opportunities in
41 funding models to support general practice?

42

43 MR GOW: I think if there was a model that actually
44 shifted the balance from so heavily reliant on
45 fee-for-service to actually include some sort of block
46 funding component or hybrid component, particularly in
47 rural areas. A number of the peak bodies have also

1 identified this - and others - have identified that that
2 sort of funding would at least provide some stability and
3 enable more of a focus on multi-disciplinary team care
4 rather than that requirement to churn, and this is a crude
5 way of describing it, but churn through seeing patients and
6 not having that flexibility and that ability to bring in
7 other multi-disciplinary teams.

8
9 THE COMMISSIONER: That, is that block funding
10 Commonwealth sources?

11
12 MR GOW: Potentially, if there is some way of doing that,
13 yes.

14
15 THE COMMISSIONER: Well, it's primary care we are talking
16 about --

17
18 MS BUIST: I think one of the --

19
20 THE COMMISSIONER: -- so apparently the Commonwealth does
21 primary care.

22
23 MR GOW: Yes, that's right.

24
25 MS BUIST: I think Denmark is a really good example of a
26 system where they have funded primary healthcare at a
27 significant rate and they are now actually closing
28 hospitals because primary healthcare is so successful.

29
30 MR GLOVER: Mr Gow, in an earlier answer you mentioned a
31 hybrid model. What might that look like?

32
33 MR GOW: That would be where that is that component of
34 block funding, so rather than being solely reliant on
35 fee-for-service, where there is some block funding, whether
36 that's - and there are some trials of elements of that, so
37 the My Medicare process and the upcoming initiatives where
38 GPs will receive a certain amount of funding for the
39 patients that are enrolled with them, particularly around
40 older patients.

41
42 MS BUIST: Yes.

43
44 MR GLOVER: More a capitated model? Is that what you were
45 describing?

46
47 MR GOW: Look, potentially along those lines. There are a

1 few different ways of looking at it, whether it is even to
2 support infrastructure. I think the example with the
3 urgent care centres, for example, is that there is a fixed
4 component and there is a fee-for-service component in the
5 funding there as well.

6
7 MS BUIST: With the 19(2) exemption that the urgent care
8 centres and urgent care services have been able to get.

9
10 MR GLOVER: I might turn to urgent care centres now. In
11 paragraph 19 and following of your statement, Ms Buist, you
12 tell us a little about the urgent care clinical centre that
13 has been opened here.

14
15 MS BUIST: Yeah.

16
17 THE COMMISSIONER: Can you just describe - sorry, just
18 before we leave that.

19
20 MR GLOVER: Yes.

21
22 THE COMMISSIONER: Can I ask Mr Gow, the Danish hybrid,
23 how long has that been in existence, do you know?

24
25 MR GOW: I'm sorry, off the top of my head, I cannot
26 answer that one.

27
28 THE COMMISSIONER: Do you know what the model was before
29 that model was introduced?

30
31 MR GOW: Essentially, it was - again, I'm sorry, I don't
32 have the details at hand specifically.

33
34 MR GLOVER: Paragraph 19, Ms Buist, can you just tell us
35 in your own words what the purpose of an urgent care
36 clinical centre is?

37
38 MS BUIST: Sure. So an urgent care centre is for patients
39 to attend to receive medical treatment for urgent but
40 non-life threatening illnesses. So broken bones, burns,
41 something where you need to see a doctor within 24 hours.

42
43 MR GLOVER: But only to a certain level?

44
45 MS BUIST: Yes. So category 4s and 5s are currently the
46 treatments for urgent care centres and urgent care
47 services.

1
2 MR GLOVER: So it's not a substitute for an emergency
3 department?
4
5 MS BUIST: No, absolutely not. So I suppose the point is
6 to try and remove a lot of the stress on the current EDs.
7 I certainly know there is a significant delay to attend
8 most of the EDs in the region. The urgent care services
9 are there to take the minor cases that are fast throughput,
10 that quite often sit in the EDs for a significant period of
11 time, but also a number of the cases potentially could be
12 seen by general practitioners because they don't have X-ray
13 facilities or suturing or, you know, cast facilities.
14
15 MR GLOVER: So it sits in between a GP practice and an
16 ED --
17
18 MS BUIST: Yes, so they take those.
19
20 MR GLOVER: -- to take those lower acuity patients, is that
21 fair?
22
23 MS BUIST: It complements things, yes.
24
25 MR GLOVER: Yes. And in that sense, it is not a
26 substitute for primary care?
27
28 MS BUIST: No, it certainly isn't a substitute. Certainly
29 in the Batemans Bay region where we have opened the urgent
30 care service, we've got two new doctors that have moved to
31 the region. Since it opened on 4 December, I think they
32 have seen 6,900 patients, so an average of 29 patients a
33 day. One of their busiest days was New Year's Eve, where
34 they saw 61 patients, and the Batemans Bay/Moruya area
35 there is commonly a six-week wait, and I think in the last
36 couple of days I drew your attention to a six-week --
37
38 THE COMMISSIONER: A six-week wait to see a GP?
39
40 MS BUIST: Yes. I think I drew your attention to the fact
41 that one of the Moruya general practices, when I met with
42 one of the principals, had said that three of his lead GPs
43 had actually gone on maternity leave and they weren't able
44 to backfill them, so that just compounds the issue.
45
46 THE COMMISSIONER: What is the staffing level at the
47 clinics? Is it two doctors?

1
2 MS BUIST: No. So we get funding component which allows
3 for one GP and one nurse, two working per shift.
4
5 THE COMMISSIONER: They are employed?
6
7 MS BUIST: Yeah, they are employed. In the local example,
8 I think we've had Malaysia and the UK where the doctors
9 have come. They'll work 12-hour shifts, so 8 till 8. The
10 new request is so that we're actually increasing the hours
11 till 10 o'clock, which is actually going to make it very,
12 very difficult to schedule shifts for nurses and doctors to
13 cover that --
14
15 THE COMMISSIONER: Sorry, I thought the urgent care was
16 open from 8 to 6 pm.
17
18 MS BUIST: It's 8 to 8, and then by June next year we've
19 got to go 8 till 10.
20
21 THE COMMISSIONER: Right. And that is one doctor?
22
23 MS BUIST: One employed doctor. Yes, absolutely.
24
25 THE COMMISSIONER: Full-time, obviously?
26
27 MS BUIST: Full-time, yes.
28
29 THE COMMISSIONER: And seven days a week, they don't get a
30 day off, is that?
31
32 MS BUIST: That's why you have got two doctors.
33
34 THE COMMISSIONER: There's two doctors?
35
36 MS BUIST: They have two employed doctors, and they work
37 12-hour shifts.
38
39 THE COMMISSIONER: Got it, yep.
40
41 MS BUIST: And then they do use other locums and things,
42 should they - you know, people go on leave or if there is
43 illness and what have you. So I suppose that is certainly
44 one of the things that, you know, during periods of flux in
45 Batemans Bay, when we've got a significant amount of
46 people, we probably need to increase those services, you
47 know, to make sure that we've got the right care and people

1 don't have to wait like an ED.
2
3 MR GLOVER: And I think you said from June next year, it
4 will go 8 till 10?
5
6 MS BUIST: Yes.
7
8 MR GLOVER: And is it currently 8 to 8 or 8 to 6?
9
10 MS BUIST: 8 to 8.
11
12 MR GLOVER: Was the PHN involved in designing the service?
13
14 MS BUIST: Yes. So we've got to - just to highlight that
15 in the region, we've got five current urgent care centres,
16 and we've got another one - sorry, urgent care and urgent
17 care services. So the urgent care services are State
18 funded, and then we have got the Commonwealth funded. So
19 in my --
20
21 MR GLOVER: Is there a difference?
22
23 MS BUIST: Yes, through is.
24
25 MR GLOVER: What is it?
26
27 MS BUIST: So if I run you through the regions, so we've
28 just opened urgent care service in Queanbeyan, we have got
29 an urgent care service which is also the Commonwealth one
30 in Batemans Bay. In Goulburn we just opened an urgent care
31 service which is State funded. We have got an attendant
32 urgent care service in Nowra. We've got --
33
34 THE COMMISSIONER: If the word "service" is used, does it
35 mean it is New South Wales, and if it is "clinic", it is
36 Commonwealth; is that right?
37
38 MS BUIST: Yes. And then in the Wollongong region is
39 where it gets really complex, because we have the LHD
40 funded Bulli service. We opened the Commonwealth urgent
41 care service in Corrimal and then Dapto when we opened it
42 initially was a state-based one. So we had three very
43 close in proximity services which have slightly different
44 models. They are urgent care in that they see the same
45 categories of patients, but with the State-funded services,
46 what the patients are intended to do is to ring Health
47 Direct and be triaged by a nurse and then have an

1 appointment made for them at the urgent care service if
2 that's required, or would be referred to another telephone
3 line or something should they need to. With the urgent
4 care centre, it is a walk-in, but you've got to meet
5 certain criteria so that you are actually treated,
6 otherwise you are turned away and you are told to go to
7 your general practitioner.

8
9 MR GLOVER: So the service and the centre are intended to
10 capture the same category of patient?

11
12 MS BUIST: Yes.

13
14 MR GLOVER: The difference is the mechanism in which the
15 patient walks through the door, either via appointment or
16 walk-in; is that a summary?

17
18 MS BUIST: Yes. We have got a number of them in the
19 region. As you heard, we probably have the most urgent
20 care centre and services from the PHN perspective in
21 New South Wales.

22
23 MR GLOVER: In paragraph 28 of your statement, you tell us
24 that when the PHN was tasked with assisted in the
25 commissioning of the centre here in Batemans Bay --

26
27 MS BUIST: Yes.

28
29 MR GLOVER: -- there was work done with the LHD in order
30 to ensure the clinic was designed to meet the needs of the
31 region.

32
33 MS BUIST: Yes, so --

34
35 MR GLOVER: Can you describe that work and in particular
36 engagement with the LHD on that issue?

37
38 MS BUIST: Of course. So we were notified by the
39 Department of Health that they were wanting us to put an
40 urgent care centre in the regions. We put out a tender
41 with a number of criteria that we were instructed to do.
42 The tender only got one or two tender submissions, and
43 neither of those met the criteria. So we went out and did
44 some public consultation with all the general
45 practitioners, looking and asking, you know, what they
46 needed. Because we were not able to find a solution,
47 I worked with Margaret Bennett, the CE at LHD, and we did a

1 direct approach for a corporate service, and then we've - I
2 got permission --
3
4 THE COMMISSIONER: Just so I understand it, the tender is
5 addressed to what people?
6
7 MS BUIST: The general practitioners, AMSs.
8
9 THE COMMISSIONER: This is GPs, to set it up?
10
11 MS BUIST: Yes, an urgent care service. There were quite
12 specific requirements in that --
13
14 THE COMMISSIONER: You just said "service". Is it a
15 clinic or a service? Is this Commonwealth?
16
17 MS BUIST: Sorry, this is a centre.
18
19 THE COMMISSIONER: Yeah, so it's Commonwealth?
20
21 MS BUIST: Commonwealth.
22
23 THE COMMISSIONER: Yeah.
24
25 MS BUIST: Sorry, it's very confusing.
26
27 THE COMMISSIONER: No, that's - you didn't make this up,
28 so - yeah. Can I just ask you on this, Mr Glover just took
29 you to paragraph 28. Can I just ask you about
30 paragraph 27, where you have raised the petition with
31 18,000 signatures, people opposed to the closing of the
32 emergency department at Batemans Bay Hospital.
33
34 MS BUIST: Yes.
35
36 THE COMMISSIONER: That sort of numbers tells me at least,
37 prima facie, if I use the term "social licence", it's not
38 statutory and it's probably not a Commonwealth concept, but
39 that seems to indicate to me, prima facie, that the
40 community haven't completely accepted that it is a good
41 idea for the ED to close, even with some other clinic or
42 centre --
43
44 MS BUIST: Yes.
45
46 THE COMMISSIONER: -- urgent care centre, replacing it,
47 and tells me that there still exists a real problem of

1 community acceptance for these decisions. Is that your
2 feeling as well?

3

4 MS BUIST: Absolutely. I mean, I suppose that's - to put
5 this, 17,000 people in the Batemans Bay community but
6 18,000 signatures. So it shows you how much --

7

8 THE COMMISSIONER: I think I have been told, without it
9 technically being evidence, that because of the number of
10 tourists and because of a number of people have both their
11 family home but also a holiday house here --

12

13 MS BUIST: Yes.

14

15 THE COMMISSIONER: -- that there are people outside of
16 what I will call the permanent residents of Batemans Bay
17 that have signed that petition. But you are right, as an
18 observation, it is still over about 100 per cent of the
19 residents, of the permanent residents. So it does
20 indicate, I guess, a lack of acceptance by both the group
21 that constitutes the permanent residents and those that
22 spend a significant amount of time here because they have a
23 holiday house, for example.

24

25 MS BUIST: Yeah, absolutely. And, you know, the issue for
26 Batemans Bay is that they have had the hospital here for a
27 number of years, but they have also got an elderly
28 population, and so it is a significant concern for them to
29 lose those services.

30

31 THE COMMISSIONER: This is not directed at you. I know
32 this is certainly not your fault. It is also not a finding
33 that I am making at the moment, but based on that petition
34 and some of the documents I have read, it would be open,
35 I think, for me at the moment, unless persuaded otherwise,
36 to draw a conclusion or inference that the people
37 responsible for this decision in terms of communicating the
38 benefits, or otherwise, to the public may not have done the
39 best job possible. Is that your feeling?

40

41 MS BUIST: It is a difficult one. I mean, I am not sure
42 about the communication process of what's actually
43 occurred, but I suppose the --

44

45 THE COMMISSIONER: Maybe it is a slightly unfair question,
46 because I am asking you to potentially finger people and
47 you may not feel comfortable with that, and I don't need

1 you to do that. I think I can leave it with your agreement
2 that the community as a whole are not on board with this
3 decision yet; you agree with that?
4

5 MS BUIST: They are 100 per cent not on board, which is
6 one of that - you know, the offerings that I am trying to
7 sort of close the gap with the community, with the 24-hour
8 urgent care service, which, you know, would offer emergency
9 care to those for categories 2s, 3s, 4s and 5s, 24 hours a
10 day without the need to be transferred anywhere else. And
11 if we could add on services like outpatients appointments,
12 where a number of patients would obviously have to travel
13 to Moruya, then it would be a good offering but not the
14 ideal solution.
15

16 THE COMMISSIONER: I think, look, of the 18,000 people,
17 I am sure some are in the category of being concerned and
18 there would be others that are in the category of being
19 outraged.
20

21 MS BUIST: Yes.
22

23 THE COMMISSIONER: But those concerns and that outrage may
24 in time, I suppose, dissipate, but there is certainly some
25 work still to be done for the community in terms of
26 acceptance that they are getting the healthcare services
27 they need.
28

29 MS BUIST: Yes, I have definitely brought it to the
30 attention of both the federal health minister and the
31 New South Wales health minister and a number of different
32 opportunities to talk through the concerns of the community
33 and have raised my proposal with them and even brought it
34 to the prime minister's attention.
35

36 THE COMMISSIONER: Sure.
37

38 MR GLOVER: What role does the community have in the
39 design of services for its region, in your view?
40

41 MS BUIST: In terms of for?
42

43 MR GLOVER: Well, does the community have a role to play
44 in the design of health services to be delivered within its
45 region?
46

47 MS BUIST: Yeah, look, I think that the role the PHN plays

1 is an advocacy role, and so, you know, we are here to be
2 the voice, you know, to the people that make the decisions,
3 is probably a good way to put it. But I do believe that
4 they need to have a part of designing the services.

5

6 MR GLOVER: And how should that sensibly take place, in
7 your view?

8

9 MS BUIST: Look, I mean, if --

10

11 MR GLOVER: Accepting that you can't speak to everybody
12 about everything.

13

14 MS BUIST: I suppose the difficult thing is that if you
15 could meet everybody's needs, we wouldn't need hospitals or
16 general practitioners. So if money was finite, would you
17 probably look at the services and try and prioritise the
18 services that you need, and have them in each of the
19 locations that are required.

20

21 MR GLOVER: Is an important part of that process, though,
22 communicating clearly with the community what can and can't
23 be done within the resources available and the reasons why
24 decisions along those lines are made from time to time?

25

26 MS BUIST: Yes. I think that's correct. I think it is
27 probably a very difficult thing to be able to do some of
28 the time because, you know, the understanding of, you know,
29 fiscal budgets and what have you is pretty complex,
30 something that I don't even claim to understand fully
31 myself. So I have to believe in, I suppose, the elected
32 officials that are there to represent me in parliament.

33

34 MR GLOVER: But as a general concept, clear communication
35 about potential changes and then an explanation for them
36 once put into place are important parts of the process?

37

38 MS BUIST: Yes.

39

40 THE COMMISSIONER: Mr Glover, I am taking it you are
41 talking about a concept where, for want of a better
42 expression, community consultation commences before a
43 decision is made and continues after it is made?

44

45 MR GLOVER: Absolutely.

46

47 THE COMMISSIONER: Yes, okay.

1
2 MR GLOVER: Mr Gow, do you agree with that?
3
4 MR GOW: Absolutely, I agree with that.
5
6 MR GLOVER: Ms Buist, in answer to one of the
7 Commissioner's questions, you referred to a proposal to,
8 perhaps, alter some of the services out of the centre that
9 will be here in Batemans Bay.
10
11 MS BUIST: Yes.
12
13 MR GLOVER: You tell us about that in paragraph 30 of your
14 statement.
15
16 MS BUIST: Yes.
17
18 MR GLOVER: That would involve it being a 24-hour model,
19 correct?
20
21 MS BUIST: Yes.
22
23 MR GLOVER: And being able to accept a higher acuity of
24 patient?
25
26 MS BUIST: Yes.
27
28 MR GLOVER: Where is that process up to?
29
30 MS BUIST: So I have delivered the proposal to both State
31 and federal governments and have worked with all of the
32 local members of parliament, and I understand there are
33 discussions being made at both State and federal level with
34 the health ministers.
35
36 MR GLOVER: And in paragraph 33, you tell us that, in your
37 view, if the expanded clinic centre is not implemented,
38 once the ED closes the overall effectiveness of the
39 Batemans Bay urgent care centre will not be realised. Why
40 do you say that?
41
42 MS BUIST: Just because it is only opened for a short
43 amount of time and we've got limited resources, ie, one
44 doctor and one nurse.
45
46 THE COMMISSIONER: Can I just ask you, at paragraph 32,
47 you said there is a formal protocol in place that allows

1 patients to be seamlessly transferred between the two
2 facilities, that is, the urgent care centre and what will
3 be the new hospital, correct?

4
5 MS BUIST: Yes.

6
7 THE COMMISSIONER: You have only been CEO of the PHN
8 since January 2023, I appreciate that.

9
10 MS BUIST: Yes.

11
12 THE COMMISSIONER: Was there any discussion - do you know
13 whether there was any discussion between the PHN and
14 NSW Health about the choice of site for the new hospital?

15
16 MS BUIST: I'm not aware about that.

17
18 THE COMMISSIONER: Do you know, Mr Gow?

19
20 MR GOW: No, I am not aware of that.

21
22 THE COMMISSIONER: When you say a formal protocol is in
23 place that allows patients to be seamlessly transferred
24 between the facilities when - obviously, once the new
25 hospital is constructed, one of the concerns that has been
26 raised is actually transport.

27
28 MS BUIST: Yes.

29
30 THE COMMISSIONER: And, in particular, we've been told
31 that, you know, particularly in summer, the road is
32 incredibly busy and concerns have been expressed, including
33 by people with medical expertise, that, you know, if
34 someone was close by to Batemans Bay and, you know, very
35 acutely unwell or with a life-threatening condition, that,
36 even accepting that paramedics have great expertise in
37 stabilising people and keeping them alive, that given the
38 much larger population centre in Batemans Bay, which is
39 20,000 and Moruya where the new hospital build is, that
40 only 4,000 would have - we have 50,000 to 60,000 tourists
41 here in summer, that that 25ks or 30ks, whatever it is
42 between the two, could be the difference between life and
43 death. What do you mean by seamlessly transferred between
44 the facilities?

45
46 MS BUIST: So with that, what I am referring to there is
47 the co-location of a current urgent care centre with the

1 ED. And so, if you walk into the physical space of the
2 hospital, you walk straight ahead into ED, you have got
3 radiology in the middle, and then you have the urgent care
4 centre off to the side. And so, that allows for patients
5 between them.

6
7 THE COMMISSIONER: I am misunderstanding you then. In
8 this paragraph, are you not talking about a transfer
9 between the urgent care centre and what will be the new
10 hospital; you are talking about whilst the ED in
11 Batemans Bay is still open, there is a seamless transfer.
12 That, I understand.

13
14 MS BUIST: Yes. You know, going forward --

15
16 THE COMMISSIONER: That is a shorter trip.

17
18 MS BUIST: Oh, absolutely. But if we were able to open a
19 24-hour urgent care centre, ideally you would be able to
20 treat a lot more people in Batemans Bay without the need of
21 having to, you know, send people over. You know, one of
22 the issues, as you were drawing on, is that ambulance
23 services entered in, you know, in the last couple of years,
24 although they've done significant upgrades to the roads,
25 there's been significant delays with roadworks, and so it's
26 stopped. And then, you know, with the amount of traffic,
27 as you have correctly noted, it is a significant distance.

28
29 THE COMMISSIONER: Yes. And that - you are aware, though,
30 that is an aspect of the community's concern that has no
31 doubt led to the petition

32
33 MS BUIST: Absolutely.

34
35 THE COMMISSIONER: At least partly, yeah. Thank you.

36
37 MR GLOVER: When the Batemans Bay urgent care centre was
38 being established, did any part of the design of that
39 service take into account the looming closure of the
40 emergency department?

41
42 MS BUIST: A little bit. The co-location, certainly the
43 LHD and I partnered on that to try and find a location that
44 offered support with other general practitioners, but also
45 within the hospital boundaries was a benefit. I actually
46 did have to get formal approval for that to occur, because
47 it's not general practice that a Commonwealth funded

1 service would be run from a State service.

2

3 MR GLOVER: At paragraph 35 of your statement, Ms Buist,
4 and we touched on this topic a little - I don't want to
5 traipse over all the same ground - but I want to explore
6 some of the funding issues that you describe and, Mr Gow,
7 I will ask you to comment as well. In the second sentence
8 at paragraph 35, you tell us that existing funding models
9 prioritise activity rather than value-based care. In what
10 way do they do that, in your view?

11

12 MS BUIST: Well, with flexibility and certainty around the
13 funding, so, I mean, that would be a the finite period for,
14 you know, the funding service and the funding of services
15 that we currently run, and so we need to have more
16 flexibility around the types of services and funding that
17 we get.

18

19 MR GLOVER: In paragraph 35, are you speaking of funding
20 of - being commissioned by your PHN, or more broadly?

21

22 MS BUIST: Largely from the PHN, because that's what I can
23 comment on.

24

25 MR GLOVER: And in what way do the funding models that
26 apply to the PHN prioritise activity over value-based care?

27

28 MS BUIST: I think Australia is a difficult place to run
29 health services, because you have got federal-based funding
30 and then you have got state-based funding, and all of those
31 funding, all programs don't quite often align, which makes
32 it problematic for those of us that are trying to plan and
33 commission services or run health services.

34

35 MR GLOVER: Mr Gow, do you have anything to add to that?

36

37 MR GOW: Not to that point specifically, but potentially
38 more broadly, if?

39

40 MR GLOVER: Yes, please.

41

42 MR GOW: I think the point there just in terms of - well,
43 there is obviously the point that we touched on earlier
44 around the need for flexibility in funding, because in
45 focusing on an activity or fee-for-service kind of
46 arrangements, that gets in the way of innovation, adopting
47 new models of care, the move to multi-disciplinary

1 services, that sort of thing. So that's what I would add
2 there.

3
4 MR GLOVER: And they are some of the examples you have
5 given us earlier?

6
7 MR GOW: Yes, that's right.

8
9 MR GLOVER: Ms Buist, in paragraph 38, you tell us that on
10 occasions the LHD jointly contributes funding with the PHN
11 for place-based solutions.

12
13 MS BUIST: Yes.

14
15 MR GLOVER: And you give us one example. Are there any
16 others that you can draw to mind, where the PHN and the LHD
17 have come together to design and fund place-based solutions
18 in the region?

19
20 MS BUIST: So we have just collaborated with both
21 Illawarra Shoalhaven and southern New South Wales LHD.
22 We've, funded by the NSW Health, commissioned services
23 around COPD, so collaborative commissioning, which offers
24 integration between primary and secondary healthcare.

25
26 MR GLOVER: How does the funding that the PHN draws from
27 its sources interact with that type of approach, that is,
28 coming together with the LHD to design services? Is it in
29 any way hampered by the limitations or use of funding that
30 you have described earlier?

31
32 MS BUIST: So that's been a true partnership where the two
33 other - well, CEEs from both the hospitals and I have come
34 together and worked with a project lead to try and
35 implement this program and then seek funding. So we have
36 jointly co-designed it and then put a submission in to
37 NSW Health.

38
39 MR GLOVER: Can I ask you about the strategic alliance
40 plan --

41
42 MS BUIST: Sure.

43
44 MR GLOVER: -- that you tell us about in paragraph 42 and
45 following. One of the issues we have heard about in
46 evidence during this inquiry is the impact of the
47 fragmentation of the health system at various levels.

1 Mr Gow has just referred to it. Can you just describe from
2 your own perspective how fragmentation of healthcare, both
3 be it funding sources and delivery, can affect the
4 efficient delivery of healthcare in a region like this?

5
6 MS BUIST: I mean, I think we've got to take it right back
7 to a granular level, in that the reason we provide
8 healthcare is for the patient. I think we have lost focus
9 of the patient, in making sure that the system is easy to
10 navigate from primary to, you know, tertiary healthcare, it
11 is very, very complex for people. So we've got to keep
12 focus on the patient, I suppose, is the thing I'd like to
13 highlight.

14
15 MR GLOVER: And is that the aim of the one health system
16 approach that you describe as part of this plan?

17
18 MS BUIST: Absolutely.

19
20 MR GLOVER: How might the strategic alliance strive
21 towards that goal?

22
23 MS BUIST: The strategic alliance is, you know, the
24 joining of the LHDs and the PHN to try and collaboratively
25 work on specific issues, so in this case it is COPD, and
26 try and decrease gaps in service and make sure that it is
27 integrated and that the patient is kept at the forefront of
28 the service, I guess, for one specific, you know,
29 condition.

30
31 MR GLOVER: Do you say there is scope for it to expand
32 more broadly?

33
34 MS BUIST: Yeah, absolutely. So we've got, I think, three
35 years' worth of funding. We have even had to downgrade our
36 initial proposal just because of funding, but I think we
37 have got \$6 million for three years, which is a significant
38 investment for a proposed service.

39
40 MR GLOVER: What about bringing other stakeholders into
41 this one system approach? Is there scope for that?

42
43 MS BUIST: Yeah, absolutely. I mean, ideally, I'm trying
44 to bring in allied health services and really link in AMSs
45 and all sorts of things into the service.

46
47 MR GLOVER: Does the framework that you are establishing

1 here provide a fertile ground for expansion, in your view?

2

3 MS BUIST: I think it is a beginning for that fertile
4 ground.

5

6 MR GLOVER: Mr Gow, do you have anything to add to those
7 answers?

8

9 MR GOW: Agree that it is a beginning. One of the things
10 that we have talked about in that plan as well is to
11 consider how we can do a better job with regional planning,
12 joint planning as well, so not necessarily whole of region,
13 but it might be joint planning around a particular issue.
14 So even prior to that strategic alliance plan, we have
15 developed a regional mental health and suicide prevention
16 across the three organisations together. But we're now
17 considering, and we're just at the start of this piece of
18 work, but what else could we do in a similar way? What
19 might that look like? Even how do we do it, because
20 sometimes there are even logistical or administrative
21 barriers that might get in the way. Just on a very
22 operational level, like, different deadlines or different
23 levels of government, different priorities. So we have to
24 look at where the priorities align, and I think the point
25 of just starting with something that's achievable is a
26 really good place to start, because you want to be able to
27 succeed and then demonstrate success. That brings its own
28 momentum.

29

30 MR GLOVER: And joint planning between primary caregivers,
31 hospital services, allied health, Aboriginal medical
32 services, is important to overcome the hyper-fragmentation
33 of healthcare in this country, would you agree?

34

35 MS BUIST: Absolutely. So there is an integration.

36

37 MR GLOVER: And one of the roles of the PHN is to try and
38 achieve that through its coordination activities; is that
39 right?

40

41 MS BUIST: Yes.

42

43 MR GOW: Yes.

44

45 MR GLOVER: Thank you both. I have no further questions
46 for these witnesses.

47

1 THE COMMISSIONER: Thank you very much for coming, both of
2 you, we are very grateful and you are both excused.

3
4 MS BUIST: Thank you very much.

5
6 MR GOW: Thank you.

7
8 **<WITNESSES RELEASED**

9
10 MR GLOVER: The next witness is Jennifer Gordon.

11
12 **<JENNIFER GORDON, AFFIRMED** [12.18 pm]

13
14 **<EXAMINATION BY MR GLOVER**

15
16 MR GLOVER: Would you tell us your full name, please?

17 A. My name is Jennifer Jean Gordon.

18
19 Q. And you are the project manager of the SE NSW Regional
20 Training Hub?

21 A. That's right.

22
23 Q. And that is operated out of the School of Medicine &
24 Psychology Rural Clinical School of the ANU?

25 A. You've got it.

26
27 Q. You are also a board member of this local health
28 district where we sit today?

29 A. I am a board member, yes.

30
31 Q. You have been a board member since the beginning of
32 last year; is that right?

33 A. Yes.

34
35 Q. To assist the commission in its work, you made a
36 statement dated 12 August?

37 A. I did.

38
39 Q. And you have it there with you, do you?

40 A. I do.

41
42 Q. And you are satisfied that its contents are true and
43 correct?

44 A. I am.

45
46 Q. Can you just tell us a little about the function of
47 the SE NSW Regional Training Hub?

1 A. Okay. The regional training hubs are actually funded
2 through the Commonwealth Department of Health and Ageing,
3 and they're mostly located, co-located, in the university
4 sector all across Australia. And so we have a group of dot
5 points there, which is at section 13 in the statement,
6 which really is the high-level strategic goals of what a
7 regional training hub is.

8
9 In my own language, we are a joiner-upper
10 organisation. It is really not a word that's in the
11 English dictionary but it is a word that I really like.

12
13 Q. It is very descriptive.

14 A. Yes. So we don't have an awful lot of money, but we do
15 join up parts of the pathway, particularly for medical
16 training, and to identify gaps and do gap analysis around
17 the workforce for training positions in hospital and the
18 health sector for the medical workforce.

19
20 Q. A couple of those functions I just want to ask you
21 about, that you have pointed us to in paragraph 13?

22 A. Yeah.

23
24 Q. In particular, in relation to rural students and
25 training opportunities in subparagraph (b) there, you tell
26 us that one of the objectives is to identify students with
27 an interest in practice rurally and facilitate access to
28 network training. Do you see that?

29 A. Yes.

30
31 Q. And how does the hub facilitate that?

32 A. Well, the university facilitates that. I am the
33 joiner-upperer. So as the hub, I have a total of one FTE,
34 being myself, and two part-time project officers, with a
35 0.6 FTE in Bega and a 0.2 FTE in Goulburn, so they cover
36 northern and southern spaces. The reality is that as the
37 students come through and do their short-term and/or
38 long-term placements in rural and regional settings, we try
39 to make contact with the students, try to find those who
40 have a real passion and want to return to rural spaces, and
41 then make a connection so that we have an ongoing
42 relationship with those people throughout their student
43 years into their GMA years and up to PGY6.

44
45 Q. With a view to encouraging them to return to
46 Aboriginal rural locations?

47 A. Absolutely. I had a young man contact me this week

1 who has just finished his undergraduate degree, hopes to
2 get into medicine, and contacted me to ask about rural
3 generally, this young man, how does he get there, because
4 he comes from Cowra and that's what he wants to do.

5
6 Q. How long have you been in that role?

7 A. I've been in it now for just over five years.

8
9 Q. Do you have a sense of its success in luring those
10 students back to rural and regional areas?

11 A. I do have a sense of success, but an absolute sense of
12 frustration as well.

13
14 Q. We will start with the success and then I will come to
15 the frustration. We will start with the good bit first?

16 A. Okay. All right. So I think Coördinaire just spoke
17 about the young people who have actually come into the
18 single employer pathway, and those young people have
19 actually come through this system. So Steph is, you know,
20 one of our graduates who is - and in my discussions with
21 Steph, we actually mapped out how she would get from where
22 she was to complete PGY1 and 2 and then get into her rural
23 generalism pathway, which she is currently doing.

24
25 Q. Pausing there, do you see the single employer model as
26 being helpful in facilitating that type of engagement and
27 retention?

28 A. Absolutely. Absolutely. Young people are not the
29 same, have been raised very differently to our older
30 generations of GPs. So they don't use the language of "GP"
31 anymore, they use the rural generalism. They want to be
32 rural generalists, ie, a GP who actually has specific ASTs,
33 and with those advance skills, they can actually practice
34 into hospitals. They also want to have a lifestyle. They
35 want to have all of the benefits that you can actually have
36 as a public sector employee through the health system, but
37 they also want to be part of the community by being the GP
38 in a local community. So, yes, I think it is a brilliant
39 thing and, you know, our next door neighbours at
40 Murrumbidgee trialled it and it was really valuable.

41
42 Q. From that, do I take it that you see there being a
43 transition from the way general practice has been done
44 historically to what it might look like in the future, to
45 attract and engage with the next generation of medical
46 graduates?

47 A. Absolutely. Yes. Yes. But in that space, there

1 needs to be capacity and funding to enable the single
2 employer model to be implemented in each hospital setting.

3
4 Q. I took us down this pathway of talking about the
5 single employer model while you were describing some of the
6 successes of the program.

7 A. That's okay.

8
9 Q. Are there any others that you wanted to add?

10 A. For successes, absolutely. I've got one young woman
11 who is currently in a graduating class, and hopefully by
12 next year she'll be graduated and in a space. She is so
13 determined that she wants to be in a rural/regional space.
14 She wanted to stay in southern New South Wales LHD, but
15 can't because we are invisible under the HETI process. So,
16 she is actually - she has come through on a rural doctors
17 RDN cadetship program, and she is going out to Broken Hill.
18 So she sees herself now working in Broken Hill for the next
19 couple of years until she has completed her PGY1 and 2
20 program. But she did make advance to contact Broken Hill
21 Hospital and actually say to them (indistinct - Zoom
22 frozen) practicing in Sydney, I don't want to be there, and
23 I can learn what I need to learn in these rural networks.
24 And she has actually proven that with her - what she has
25 done in her fourth year studies at the moment.

26
27 Q. Is there more that can be done to support the program,
28 to attract medical graduates to regions like this one?

29 A. There is, but there is always a matter of, you know,
30 how much money is there for people to actually be able to
31 sit and engage and talk with the students.

32
33 Q. Let's assume the money was available, what could be
34 done in your view?

35 A. One of the things that I do do, and it's funded
36 through southern, but it's part of - you know, I don't get
37 paid by southern for this, but it is part of what I do, and
38 I have a dinner tonight. So we have the JMA wellness
39 program, and that happens in three locations across
40 southern New South Wales LHD, and I meet with the junior
41 medical officers, PGY1s and 2s every fortnight, and we have
42 dinner. And in that space, we talk about the positive and
43 the negative things that happen for them as junior doctors.

44
45 We also have a real focus on mental health. I'm psych
46 and general-trained, clinically, as a nurse. So we talk
47 about your mental health as a junior medical officer. We

1 talk about drug addiction, alcohol addiction, suicide
2 issues, and I always talk to - on our initial discussion,
3 I always talk about "This Might Hurt", which is a TV series
4 from the British system, where the young man is having --
5

6 Q. A couple of us are familiar.

7 A. Yeah. The young man is having a great thrust in life,
8 but the young woman, who is very quiet, ends up deceased,
9 having taken her own life. I also talk --
10

11 THE COMMISSIONER: Spoiler alert.

12 A. Spoiler alert, indeed. But our statistics for
13 Australia is - actually shows that our loss of junior
14 doctors through leaving the workforce and/or by suicide
15 attempt and/or successful suicide is actually rising, and
16 I think it's something that we need to take into account.
17

18 We also spend a lot of time talking about the
19 opportunities that you have in rural and regional
20 locations, and in that space, we talk about how, being in a
21 rural setting, your scope of practice is actually elevated.
22 So, you know, these GMOs come into the space, our students
23 come into the space. They have this elevated scope of
24 practice up to best scope of practice, and then they have
25 to return to the metropolitan hospitals and they get really
26 depressed. Our students particularly get really upset.
27 They are long-term students who have been long-term in
28 Goulburn, Cooma, Bega and Eurobodalla. We have some as
29 well at Cowra and Young, which are outside of this LHD.
30 They do get really depressed when they have to go back,
31 because instead of feeling like functional members of a
32 team, they have to go back into pushing a computer on
33 wheels, you know, being very much at the bottom of a chain.
34 So, yep.
35

36 THE COMMISSIONER: I didn't want to interrupt you, but
37 can I just go back to something you said earlier when
38 Mr Glover was asking you about successes of the program.
39 One of the things you said was, "We are invisible under the
40 HETI processes", which is something that you had mentioned
41 in your statement as well, similar terms in 24(f), about
42 the lack of visibility of the southern New South Wales LHD
43 on the HETI network. Can you just explain what you mean,
44 so I can understand what you mean by that?

45 A. Thanks. It has been my mantra for five years now.
46

47 THE COMMISSIONER: Yep.

1 A. Okay. So, for our junior medical officers, if you
2 actually try to find southern New South Wales on the HETI
3 network and in the networks of New South Wales Ministry of
4 Health, we don't exist. It is not there. So to go back
5 historically - and you will see historically I was --
6

7 THE COMMISSIONER: You don't exist. They exist, you don't
8 exist?

9 A. No, no. Southern New South Wales does not exist under
10 the HETI networks. It clearly doesn't. There is no
11 documentation anywhere to say that southern New South Wales
12 is part of any HETI network.
13

14 THE COMMISSIONER: And the consequences of that to you
15 are?

16 A. The consequences of that are that southern
17 New South Wales are counted as an ACT network by the
18 Ministry of Health in New South Wales, and the ACT network
19 is a very different process for junior medical officers
20 than what happens in New South Wales. So we don't have any
21 capacity, opportunity, or funding to go for rural
22 preferential recruitment in this region. We are - there
23 are several programs, they are documented, that we do not
24 have any capacity to access as health facilities in this
25 region and don't have the capacity to have junior medical
26 officers come and be New South Wales medical officers in
27 their facilities of Goulburn, Cooma, Bega, Eurobodalla -
28 or, like, the two in Eurobodalla - or Queanbeyan, because
29 they are counted as ACT facilities.
30

31 THE COMMISSIONER: Why? Why are they organised that way?

32 A. That is a really good question. I asked - at the
33 Regional Medical Training Forum, I actually asked in that
34 very high-profile forum, "Did somebody consult with the
35 Premier?", because I live in Goulburn in New South Wales
36 and I pay my New South Wales taxes and I have a
37 New South Wales number plate, and we all know that down
38 here is the same system. But some years ago, historically,
39 under the HETI networks, Canberra was: I'm going for the
40 sake of this conversation say it was network 16. It may
41 have been network 17. I don't know exactly the number.
42 And with Canberra being network 17 of the New South Wales
43 systems, southern New South Wales was counted into that
44 network. When Canberra Hospital Health Services separated
45 from the HETI network and created Canberra Region and
46 Medical Education Council, which is CRMEC there was a
47 memorandum of understanding, an agreement, signed between

1 ACT and southern that basically said, "Yeah, we'll stay
2 together with Canberra." Sadly, part of that - you know,
3 from my perspective, we cannot get anybody into this space
4 as New South Wales employees. We do not get any funding
5 for any of those JMO positions from Canberra. In actual
6 fact, southern New South Wales has to pay the Canberra JMO
7 salary, plus 10 per cent, plus provide accommodation and
8 two lots of travel per rotation, and they come out on
9 12-week rotations each year, each time.

10
11 MR GLOVER: We might break some of that up, Ms Gordon, and
12 deal with that now. You deal with this submission, if I
13 can take you to paragraph 24, but it starts perhaps a
14 little earlier where you refer to the secondment agreement,
15 and that was the arrangement that you were just describing
16 to the Commissioner?

17 A. Yes.

18
19 THE COMMISSIONER: This is the document that was handed
20 in?

21
22 MR GLOVER: It is. We've received a copy of. For the
23 purpose of the transcript, the document MOH.0010.0462.0001.
24 I don't propose to take Ms Gordon to it, in part because
25 I have only seen it for the first time this morning. That
26 is no criticism of anyone, because I think I only asked for
27 it at about 9.30 last night, but because I am in fact more
28 interested in Ms Gordon's fire power.

29
30 THE COMMISSIONER: You will be fine after morning tea.

31
32 MR GLOVER: Yes, that's right. And I am perhaps more
33 interested in Ms Gordon's description of how it operates in
34 practice rather than what it says on the page.

35
36 Q. Can we just step through, firstly, how the arrangement
37 would operate within other parts of New South Wales. So
38 HETI's role in placing interns for other LHDs for the
39 extent you have an understanding of?

40 A. Okay, so HETI has a group of programs specifically
41 supporting rural and regional junior medical officers, and
42 they are documented in here, which I don't know - I can't
43 remember the number. But there is the Aboriginal
44 Employment Program, there is the RPR program. There's
45 multiple programs through HETI, which actually has funding
46 from the ministry, which goes to the LHDs running those
47 programs. Because we don't have any connection with HETI

1 under the networks, and if you print out, you can go onto
2 the HETI website and print out all of the networks, there's
3 no sign of us. Because we don't have that connection to
4 HETI, we can't access any of those funds. We can't
5 actually keep people employed who live in our region, who
6 want to actually stay in our region. We can't employ them
7 as New South Wales employees, as junior medical officers.
8 They have to go into Canberra. They have to become ACT
9 health employees to do their PGY1 and 2, come out on
10 rotations as best they can, and I do have one really good
11 example where a young lady called Lisa did all of her PGY1
12 and PGY2 rotations in Goulburn, with the exception of a
13 paediatrics and a metropolitan ED rotation, which she did
14 in Canberra. She is now on her GP pathway, living and
15 working in Goulburn, but she was really determined that's
16 what she was going to do, but she had to have that break in
17 being an ACT health employee for the two years and then
18 move over and be, you know, on the GP pathway, but she is a
19 casual employee with southern New South Wales at the
20 hospital for Goulburn and Crookwell in that area.

21

22 Q. That is the issue that you speak of in
23 paragraph 24(a)?

24 A. Yeah.

25

26 Q. If you've got your statement there. Feel free to use
27 the hard copy if the screen is a little bit far away from
28 you, whatever is most convenient. But there, the first of
29 the practical implications of the secondment agreement you
30 tell us about, that ANU medical graduates seeking
31 pre-vocational training cannot return to this district
32 through HETI, they must go through the ACT system?

33 A. Absolutely.

34

35 Q. And that is because, as far as you understand it,
36 under that secondment agreement, the ACT is responsible for
37 placing pre-vocational graduates into southern
38 New South Wales LHD?

39 A. And they are our tertiary training facility connected

40 to this whole LHD.

41

42 Q. And the next of the practical implications you tell us
43 about in 24(b), and one you've mentioned to the
44 Commissioner, is that because of that, that is, because the
45 ACT is responsible for placing those PTY1s and 2s --

46 A. 1s and 2s, yep.

47

1 Q. -- into this district, if someone were to look through
2 the HETI network, a placement in this division would not be
3 a visible option?

4 A. Absolutely.

5
6 Q. And later down that paragraph, you tell us that
7 effectively removes the district from the intern
8 recruitment process. That's - you described earlier?

9 A. Yeah.

10
11 Q. But also, rural and regional pathways and procedures
12 and initiatives such as Rural Preferential Recruitment --

13 A. Yes.

14
15 Q. -- Aboriginal Medical Workforce, Direct Regional
16 Allocation, et cetera. What is the impact of the district
17 not having those measures available to it in terms of
18 attracting PGY1s and 2s?

19 A. It is a huge impact. We cannot have our own training
20 physicians located in our hospitals for PGY1s and 2s or for
21 anyone, really. But without PGY1s and 2s in the pipeline,
22 it severs the capacity of the hospitals to actually have a
23 pipeline of training from PGY1 up until the specialists.
24 It just creates havoc. It also has a financial implication
25 in that, as I have just pointed out, ACT Health doesn't
26 send any financial support around junior medical officer
27 training, and there is a caveat on that, is that
28 New South Wales does provide a small amount of funding for
29 the GPATs and we have two GPATS who are very part-time, one
30 located at Goulburn and one located at Bega, and I think
31 there is a part-time one as well at Eurobodalla.

32
33 Q. Sorry, you just used an acronym. What was it?

34 A. Director of pre-vocational education and training.

35
36 Q. Thank you. And is it the case that because the ACT
37 manages the placement of PGY1s and 2s into this district,
38 initiatives, funding sources, policies that would be
39 available in relation to equivalent graduates in other
40 districts aren't available?

41 A. Absolutely. Absolutely.

42
43 Q. The third of the issues that you refer to in
44 subparagraph (c) relates to the RDN cadetship program?

45 A. Yes.

46
47 Q. And there you refer to a return of service type

1 obligation?

2 A. Yeah.

3

4 Q. Is the issue you are pointing to there the fact that
5 if there was a graduate who had received - that was a
6 beneficiary of that program, they couldn't come to a
7 placement in this district because they would be deemed to
8 be engaged by the ACT system, not the New South Wales
9 system?

10 A. That's exactly the issue. The young woman who
11 I talked about who has a position for Broken Hill for the
12 intern program is under those circumstances. She has been
13 on an RDN cadetship, she is a young Aboriginal woman, and
14 she cannot do her return of service within this LHD
15 regardless of the fact that she's done her third year
16 long-term and was very innovative with the university, and
17 she and one other person have created a fourth year
18 long-term pilot program.

19

20 Q. Is that restriction a feature of the RDN's policies or
21 NSW Health's, to the extent you know?

22 A. Which came first, the chicken or the egg?

23

24 Q. Yeah.

25 A. I'm not sure. The reality is that the Rural Doctors
26 Network is funded through New South Wales, and
27 New South Wales has a requirement that the young people who
28 are on the cadetship programs, which supports them through
29 the university, have to do a rural payback which is fair
30 and reasonable to NSW Health. And they cannot do that in
31 Goulburn or Bega or the Eurobodalla, Cooma.

32

33 Q. What you are pointing to there is something we have
34 heard a little bit about this morning, that the funding for
35 programs like that, including delivered through the RDN,
36 is - comes with conditions?

37 A. Always.

38

39 Q. And perhaps the RDN is just passing on those
40 conditions?

41 A. Yes.

42

43 Q. I will come back to whether a number of these issues
44 have been raised, but has that particular one been
45 highlighted as a problem with either the RDN or the
46 ministry, to your knowledge?

47 A. It has. I have actually raised it with RDN. I have

1 raised it with the ministry. But because my role is as a
2 joiner-upperer and - it really isn't my battle to argue,
3 and so I've actually also handed it to the LHD to actually
4 have those discussions.

5
6 Q. And from that do I understand it you see it as being
7 the LHD's battle, for want of a better term?

8 A. Absolutely. Absolutely.

9
10 Q. The next issue you raise in subparagraph (d), do we
11 take it that is a subset of those that you have already
12 mentioned, that is, as you know about the fact that you've
13 got to go through the ACT system to get a placement in this
14 district, it wouldn't be a viable option for graduates,
15 including those who might have grown up here?

16 A. It's really important. Like, the ANU graduates are
17 aware of it, because it is something we talk about all of
18 the time and from my engagements with the students, but
19 it's graduates who leave this area and go to university at
20 other universities who aren't aware of the system, and
21 I know that in this year's graduating class engagement and
22 discuss about how to apply for intern positions, I actually
23 got our student's council to open that up to the University
24 of Wollongong as well, because a lot of our graduates
25 from - sorry, a lot of our residents from this footprint
26 who actually go to the University of Wollongong as well.
27 We've got quite a few who go into Sydney, but at the moment
28 I'm just, you know, engaged in the University of Wollongong
29 this year to help them to understand that if they want to
30 work in this space, they have to go through the ACT system.

31
32 Q. The next issue you raise in subparagraph (e) is a
33 practical one; that is, the ACT arrangement is unable to
34 send sufficient JMOs on occasion to fill PGY1 and 2?

35 A. Yes.

36
37 Q. And then you tell us that that has an impact on
38 service delivery, because they are an essential component
39 of the workforce here?

40 A. Absolutely.

41
42 Q. Is there anything else you wish to add to what you
43 have written in that subparagraph on that particular
44 document?

45 A. I have to share a story from this week.

46
47 Q. Please do.

1 A. I am an Aboriginal woman, I am a story teller. Sorry.

2

3 Q. No, no, that is why you are here.

4 A. I was talking with the students in the ANU building
5 this week in Goulburn, and one young lady who is called
6 Pip, who is just beautiful, you know, and she is a
7 long-term third year student. And she had been on the
8 wards, and she was talking with the nurses and they said
9 something about, "Oh, can't contact the doctor to be able
10 to", you know, do whatever it was. And she said but, you
11 know, have a look on the roster, see who is on the roster,
12 and so she - the nurses said, "Oh, you check the roster."
13 So she went over there and she's checked it, and she said,
14 "Yes," she said, "Dr Va-cant. Dr Va-cant is the person who
15 is here for this roster." And the nurses laughed at her,
16 so she was sharing the story as, you know, she'd felt
17 shamed. But the nurses laughed at her and said, "Have a
18 look at the roster again, Pip. There's four Dr Va-cants on
19 here." And if you read it carefully, it says "doctor
20 vacant". So the JMOs are quite lacking on rotations on a
21 regular basis, and that makes our - you know, if I put on
22 my nursing hat, if I put on my board hat, if I put on any
23 other hat, it makes the level of patient care incredibly
24 difficult, but it makes the workload for our senior
25 specialists hugely difficult because they have to do their
26 job. They have to do the job of the registrar or the JMO
27 who is not there, and it just becomes very - that creates
28 the issues around the pipeline of training.

29

30 Q. And this may be completely obvious, but it would
31 clearly be of benefit to the district to be able to draw
32 PGY1s and 2s from other areas to the extent that the ACT
33 arrangement can't fulfil the need in the region?

34 A. It would be really valuable to have PGY1s and 2s that
35 belong to NSW Health and belong to the LHD.

36

37 Q. The next issue you raise is, "The lack of visibility
38 of the district in the HETI network leads to struggles to
39 recruit and retain permanent appointments in PGY3 and
40 above"?

41 A. Absolutely.

42

43 Q. Why?

44 A. PGY3 and above, the young doctors who are in that
45 space use what's called our hospital to health check
46 system, which is a survey run by the AMA on an annual
47 basis. And the AMA runs a survey, publishes out the

1 information, and then they have a "Survey Outcomes" on the
2 back page which tells you, you know, which are the best
3 hospitals to go to for rostering and overtime, and there is
4 a group of five or six subsets. And the PGY3s and above
5 use that as, you know, "Let's check out where I'll apply to
6 go next year." And of course there is no mention of us
7 because we're not in the HETI networks. But if you check
8 the ACT network, there's no mention, because the ACT
9 network survey is a separate survey, and there's no mention
10 of the southern New South Wales hospitals on those surveys
11 either. So we become doubly invisible by the time you
12 become PGY3. And I know that southern New South Wales do
13 advertise through the NSW Health system, but when you're
14 actually invisible on both sets of AMA documents which the
15 young ones use for, "Where will I go next year?", nobody
16 will apply. So we get very few applications for those
17 positions.

18
19 Q. Has that been raised with the AMA, to your knowledge?

20 A. It has.

21
22 Q. And are you aware of what response has been received?

23 A. "We will try to include Goulburn and the other
24 hospitals into the ACT survey." I haven't seen that yet,
25 though.

26
27 Q. When was the last engagement with the AMA about that
28 issue?

29 A. One or two years ago.

30
31 Q. In subparagraph (g), you've touched on this earlier,
32 but you tell us that given that the district is part of the
33 ACT network, it doesn't have hospitals or positions which
34 are able to attract rural preferential recruitment medical
35 training funding from the Ministry of Health?

36 A. Yeah.

37
38 Q. Can you just describe what that funding package is
39 first, and then I'll ask you some other questions about it?

40 A. Because we're not part of it, it is very hard to
41 describe. I truly --

42
43 Q. Doing the best you can, what do you understand?

44 A. Doing the best that I can, because our hub - so the
45 regional training hubs are networked as a New South Wales
46 network of regional training hubs, then we have a national
47 network of regional training hubs, and we are very aware in

1 the discussions, particularly with the New South Wales
2 network, that those rural preferential recruitment funding
3 positions are allocated and the funding is distributed to a
4 whole group of hospitals. They're available on the HETI
5 website, if you have a look.
6

7 Q. But not those within district for the reasons you have
8 got --

9 A. No, there is nothing within this district because
10 we're not part of it. And I have also raised that with
11 HETI in writing, to actually say, "Is there any capacity to
12 have rural preferential recruitment for southern
13 New South Wales locations?", taking into mind that a town
14 like Bega with south east regional training hospital is
15 actually six hours' drive from Sydney, so, therefore, is of
16 equal remoteness to Dubbo and various other locations out
17 in the central west. I have also raised the fact that
18 there is an MMN1 hospital, a very big flash place, up near
19 the Queensland border that actually has 24 positions under
20 rural preferential recruitment and is funded as such.
21

22 Q. Did you get a response to HETI with the letter that
23 you have referred to?

24 A. And the emails? Not a thing.
25

26 Q. When did you send it? Again, doing the best you can.
27 It's not a memory test.

28 A. I would say at least two years ago, possibly a little
29 further.
30

31 Q. Thank you. Can I take you ahead to paragraph 26 of
32 your statement.

33 A. Yep.
34

35 Q. In this section, you tell us a little about the
36 challenges associated with the Aboriginal Medical Workforce
37 Pathway.

38 A. So the Aboriginal Medical Workforce Pathway under HETI
39 basically guarantees any Aboriginal person in
40 New South Wales that they can do their PGY1 and PGY2
41 training wherever they want.
42

43 Q. Do I take it from the way you have concluded that
44 answer, because of the secondment agreement --

45 A. They can't.
46

47 Q. -- they can't actually do it --

- 1 A. Quite literally, they cannot do that.
2
- 3 Q. I certainly - yes, I think that was the way you
4 understood my mangled question?
5 A. It is. It is, yes.
6
- 7 Q. You got a response from HETI?
8 A. Yes.
9
- 10 Q. Did you get a response from HETI to your email?
11 A. I actually keep all of those emails, so I have them
12 there.
13
- 14 Q. Someone might follow you up for a copy of that when we
15 conclude today.
16 A. The young - could I please provide a declaration that
17 the young woman who is the Aboriginal young woman who has
18 taken the position at Broken Hill is actually my eldest
19 daughter, so I have to put that in there, because I would
20 not like it to come back and say, you know, "You raised
21 this." So I just need that declaration. Sorry.
22
- 23 Q. No trouble with that at all. The limitation that you
24 have described in paragraphs 26 and 27, does it have the
25 practical effect that if a First Nations person grew up in
26 Batemans Bay, studied medicine, graduated, wanted to come
27 back to country as a PGY1 --
28 A. They can't.
29
- 30 Q. -- they would not be able to do so?
31 A. No, they can't. They can't unless they are happy to
32 go through the ACT system, but all the young people that
33 I know that are Aboriginal from this region, most of them
34 need to come through on the cadetship program. Their, you
35 know, financial cadetship.
36
- 37 Q. The RDN cadetship program?
38 A. Yeah.
39
- 40 Q. Which would encounter that other difficulty that you
41 mentioned?
42 A. Absolutely.
43
- 44 Q. In paragraph 34 and 35, you describe some potential
45 solutions.
46 A. Yes.
47

1 Q. Before getting to those, I think the Commissioner
2 might have asked you, and I have asked you in some discrete
3 ways about whether these issues have been raised, but
4 I take it that these challenges, these various challenges
5 over time, have been pointed out to the ministry, to your
6 knowledge?

7 A. Yes. I did have a discussion with the medical
8 workforce person from the ministry when I was at the RMT,
9 which is regional medical training group that I spoke about
10 earlier. So I did that at that point in time. And that
11 was actually when she made it very clear that it's not an
12 issue for the hub, it's actually an issue for the LHD.

13

14 Q. And that is why, as you described earlier, you passed
15 the baton to the LHD to take it up?

16 A. Absolutely.

17

18 Q. And has the LHD taken up the fight since you have done
19 it?

20 A. They're making changes, but you will have to ask the
21 LHD. Thank you.

22

23 Q. In paragraph 34, you describe some changes that might
24 be able to be made.

25 A. Yeah.

26

27 Q. Can you just describe in practical terms the structure
28 that you are drawing a comparison with in the
29 Albury-Wodonga health services?

30 A. So Albury-Wodonga health services was actually changed
31 from being part of the Greater Southern Area Health Service
32 to being Albury-Wodonga health service when I was actually
33 their manager workforce planning at greater southern, which
34 is actually eons back. So I actually had a conversation or
35 have had several conversations with Albury-Wodonga about
36 how come they have got HETI network status at
37 Albury-Wodonga, because it is the most similar place across
38 the whole jurisdiction of New South Wales. And so they
39 were really very valuable in telling us - telling me about
40 they've got a memorandum of understanding which states that
41 for their pre-vocational training, they would have -
42 they've got 30 positions. So they have 15 positions for
43 the Victorian program, they have got 10 positions for the
44 New South Wales HETI program, and they've got five
45 positions which they call the end-to-end program. So they
46 are local people who have done an extensive training at
47 Albury-Wodonga that they keep at Albury-Wodonga to complete

1 their PGY1 and 2 program. I think that is a really
2 valuable program which could be duplicated in this region,
3 particularly around splitting, you know, some positions to
4 the ACT and then having some New South Wales HETI
5 positions, and by having New South Wales HETI positions
6 those young people who have come through the cadetship
7 program would have capacity to stay and live and work here
8 and, you know, they could rotate to larger hospitals,
9 either back into Canberra or into the metropolitan Sydney
10 like the other networks do. But it provides an opportunity
11 and a recognition that the hospitals within this area are
12 actually New South Wales hospitals, not Canberra hospitals.
13 It really does become very confronting when, you know, you
14 look at the fact that from a New South Wales perspective we
15 are seen as ACT training network, but from a Commonwealth
16 perspective with the John Flynn program, the John Flynn
17 program is definitely, the Commonwealth says, no, there are
18 no ACT rural hospitals, so all of the John Flynn program
19 positions, which is fairly new, we are now accessing
20 funding for those through HETI in New South Wales.

21

22 Q. We have heard a little about the John Flynn program.
23 Can you just tell us how it operates in this district?

24 A. From my perspective, I love it. It gives us a
25 capacity to at least have some of our own people who come
26 and live and work in New South Wales on a New South Wales
27 training pathway through the John Flynn program. And the
28 John Flynn program is designed for people who haven't quite
29 decided yet whether they're going on a rural generalist or
30 a GP pathway, but it gives them the opportunity to also try
31 out some of the ASTs and in doing, you know, by doing an
32 extended period of time in the hospital system and rotating
33 out to the GP clinics, those hours are counted towards
34 their ACRRM fellowship, if that's the pathway they choose
35 later.

36

37 Q. In paragraph 35, you tell us that although the current
38 arrangements present some challenges and frustrations --

39 A. Yep.

40

41 Q. -- the district can't completely sever ties with the
42 ACT. Why do you say that?

43 A. In the medical world everybody knows that, you know,
44 like - it's quite - quite tribal. And so, from the
45 perspective of the referral pathways, patient services and
46 everything else, there's a lot of referral from around this
47 footprint into the ACT, because it is the "closest"

1 tertiary referral hospital.

2

3 Q. It's a practical reality of the region?

4 A. Absolutely.

5

6 Q. But from your evidence today, there are no doubt a
7 number of improvements that can be made --

8 A. Absolutely.

9

10 Q. -- whilst maintaining those linkages?

11 A. Yeah. Campbelltown is not very far from Goulburn.

12

13 Q. Thank you, Ms Gordon. I have no further questions.

14

15 THE COMMISSIONER: Do you have any questions?

16

17 <EXAMINATION BY MR CHENEY

18

19 MR CHENEY: Q. Ms Gordon, you were asked some questions
20 earlier about the PGY1 and PGY2 workforce and how they have
21 to be sourced through the ACT; do you recall that?

22 A. Yes.

23

24 Q. And I think you had answered to a question as to what
25 might be being done about that, you said that they're
26 making changes by reference to the local health district.
27 Are those changes to have a discussion with HETI to try to
28 bring the model in southern - make the model in southern
29 similar to what is in place in Albury-Wodonga?

30 A. Truly in - like, I'm not really privy to all of the
31 operational ins and outs.

32

33 Q. Right.

34 A. You know, I sit in my other space as a board member,
35 and as a board member, I don't have that operational
36 information.

37

38 Q. But as a --

39 A. But in this space, I am aware --

40

41 Q. Yes.

42 A. -- that there have been some preliminary discussions
43 with HETI about how might change happen.

44

45 Q. And those discussions are being carried out by
46 Dr Mullins as well as Dr Ayers of the LHD?

47 A. That's exactly right, yes.

1
2 Q. And as to PGY3, is the situation from next year
3 onwards that there would be - LHD will have access to
4 trainees that are through the rural acute care SRMO
5 program, that is part of the John Flynn program?
6 A. Yes, we have - there is a business case that went
7 forward to the LHD from SERH, and I have worked with
8 Dr Nathan Oates and around supporting, you know, how to get
9 that business case done. He has done all the work on it,
10 and the whole concept is if we could get that business case
11 through at the LHD level, that it should be duplicated for
12 Goulburn and the northern end. So rotating out to
13 Crookwell, yes.
14
15 Q. So at least initially, that's six additional training
16 places for the LHD?
17 A. Yeah.
18
19 MR CHIU: Thank you. No further questions.
20
21 THE COMMISSIONER: Thank you very much, Ms Gordon, for
22 your time. We are very grateful.
23 A. Thank you.
24
25 THE COMMISSIONER: You are excused.
26
27 **<THE WITNESS WAS RELEASED**
28
29 THE COMMISSIONER: So we might take the break now until
30 11.50.
31
32 MR MUSTON: I think that due to - to accommodate some
33 scheduling for the clinicians who are down as coming next,
34 it's 12.
35
36 THE COMMISSIONER: They were down at noon? Right, not
37 everyone's here. Why don't we see whether people are here
38 at 11.50, and we'll start at 11.50? If they're not - that
39 causes you a problem, yes?
40
41 MR CHIU: They have all been asked to be here at 11.45
42 anyway, Commissioner, but there is one additional thing I'd
43 like to raise with you, if I might.
44
45 THE COMMISSIONER: Yes, go ahead.
46
47 MR CHIU: Just from something that fell from you earlier,

1 it occurs to me that at present before the inquiry, there
2 isn't a complete chronological set of facts about the
3 consultation process that has occurred.
4

5 THE COMMISSIONER: No, there are some documents in the
6 tender bundle that I have seen that have got, like, fact
7 sheets, what we have heard, that sort of stuff. I don't
8 know whether it is complete or not and I may not have read
9 everything that's actually there in any event yet.

10
11 MR CHIU: I wonder if it would assist you for us to
12 compile a short statement that just sets out
13 chronologically by reference to the document what has
14 happened?

15
16 THE COMMISSIONER: I am sure it will assist me, and
17 probably will assist you too.
18

19 MR CHIU: I would refer also to a couple of - at least one
20 statement from the governance block of hearings that sets
21 out some of the background --
22

23 THE COMMISSIONER: Does it?
24

25 MR CHIU: -- to the development of the plan. I don't
26 think they were ever tendered.
27

28 THE COMMISSIONER: Right.
29

30 MR CHIU: One of them was an outline from Amanda Bock,
31 who was from health infrastructure.
32

33 THE COMMISSIONER: Right, okay.
34

35 MR CHIU: But I just draw everyone's attention to that.
36 It may be relevant.
37

38 THE COMMISSIONER: Thank you for that, because I have
39 completely forgotten or maybe I didn't know even at the -
40 but I guess I can have a look at those. Thank you for
41 that.
42

43 MR CHIU: I can speak with counsel assisting to try
44 identify any others.
45

46 THE COMMISSIONER: Thank you.
47

1 MR MUSTON: I have a feeling we may have - we,
2 collectively, have a feeling we may have tendered Ms Bock's
3 statement but not called her to give any oral evidence.
4 But if it wasn't tendered, to the extent that it is,
5 provides some relevant information in the context of this
6 issue that's been the subject of some discussion down here,
7 we will attend to that. Are the clinicians coming in
8 person, remotely or a combination thereof?

9
10 THE COMMISSIONER: There are two behind you, because I can
11 see them

12
13 MR MUSTON: All coming in person?

14
15 THE COMMISSIONER: Yes.

16
17 MR MUSTON: Excellent. Okay.

18
19 THE COMMISSIONER: I even recognise them without their gear
20 on. Let's now make it 11.55, and we will come back then
21 and hopefully we can start then. Right. We will adjourn
22 till then.

23
24 **SHORT ADJOURNMENT**

25
26 MR MUSTON: We have the next group of witnesses --

27
28 THE COMMISSIONER: Just before you call them, can I just -
29 the computer has just logged itself out. Mr Chiu, thank
30 you for reminding me about Ms Bock's statement, which the
31 Eurobodalla Regional Hospital redevelopment didn't seem as
32 important back in April as it does now. And it is covered
33 from paragraph 15 onwards in that statement. What - and
34 these aren't criticisms, but there is discussion in it
35 that, it doesn't matter whether technically, it wouldn't
36 have been admissible if anyone had worried about it. There
37 are some assertions there about community feedback. It
38 doesn't matter that it is not in admissible form; I am
39 going to accept it. But starting at paragraph 30, there is
40 a discussion about community consultation undertaken by
41 Health Infrastructure and the LHD here regarding the site
42 selection.

43
44 MR CHIU: Yes.

45
46 THE COMMISSIONER: What I would like is the supporting
47 documents. We will obviously serve a summons.

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MR CHIU: Yes.

THE COMMISSIONER: Because there is some comment about the community feedback, or there is a statement that community feedback was that Moruya was generally supported as the preferred site location. Now, we have got some evidence that that - whether that's true or not, who knows, and that there was dedicated Aboriginal consultation. So I think what we will ultimately ask you to do is produce for us the documents to the extent they exist regarding the entirety of that consultation process --

MR CHIU: Yes.

THE COMMISSIONER: -- leading up to where we are now, including not just the consultation process for site selection for the new hospital and all of that, but also the decision in relation to the ED closing at Batemans Bay and becoming the community centre and the urgent care.

MR CHIU: Yes, Commissioner. What I had in mind was a much more focused and detailed document than what you see there. That is much more of a high level which we put together, yes.

THE COMMISSIONER: Yes, and I am not making any criticism of that.

MR CHIU: No. Back in April --

THE COMMISSIONER: As I would have understood it at the time, that was like an overview of how things work without descending into the detail precisely about the real details about this particular project. So there is no criticism, but we will follow that up.

MR CHIU: Thank you.

THE COMMISSIONER: Because I think we have to, given the statements that are in.

MR CHIU: Yes, we will get that moving as swiftly as possible.

THE COMMISSIONER: Thank you. Yes, Mr Muston.

1 MR MUSTON: I think you had indicated, just to close that
2 off a moment ago, Commissioner, that in relation to
3 Ms Bock's statement, whilst it is not necessarily in
4 admissible form, that you would accept it.

5
6 THE COMMISSIONER: Oh, yes.

7
8 MR MUSTON: I presume what you meant, you would receive
9 it?

10
11 THE COMMISSIONER: I would receive it into evidence and
12 give it the weight that it deserves. Without that being a
13 critical statement.

14
15 MR MUSTON: Yes.

16
17 THE COMMISSIONER: But is going to be supported by the
18 additional material.

19
20 MR MUSTON: Yes. Next up is Dr Piper, Dr Stapleton,
21 Dr Oates and Dr Clarke, who have very conveniently and
22 coincidentally, serendipitously, perhaps, sat down in the
23 same order as I have them written down on my page.

24
25 <SUSIE PIPER, SWORN [12.03 pm]

26
27 THE COMMISSIONER: Dr Stapleton, oath or affirmation?

28
29 DR STAPLETON: I do.

30
31 THE COMMISSIONER: No, you just have to tell me first
32 whether you want to give an oath or an affirmation.

33
34 DR STAPLETON: I am happy to give an oath or affirmation.

35
36 THE COMMISSIONER: It is your choice. It is your
37 evidence, not mine. You're going to have to pick.

38
39 DR STAPLETON: I'll do an oath. There you go, you've got
40 the oath ready.

41
42 <STUART STAPLETON, SWORN [12.03 pm]

43
44 THE COMMISSIONER: Dr Oates, oath or affirmation?

45
46 DR OATES: An oath.

47

1 <NATHAN OATES, SWORN [12.03 pm]
2
3 THE COMMISSIONER: And Dr Clarke?
4
5 DR CLARKE: Affirmation, if you wouldn't mind.
6
7 <ANDREW CLARKE, AFFIRMED [12.03 pm]
8
9 THE COMMISSIONER: Yes, go ahead, Mr Muston
10
11 <EXAMINATION BY MR MUSTON
12
13 MR MUSTON: I might just quickly get each of you to
14 introduce yourselves. Dr Piper, first could you give us
15 your full name for the record?
16
17 DR PIPER: Susan Margaret Piper.
18
19 MR MUSTON: Can you tell us what role you currently hold
20 within the local health district?
21
22 DR PIPER: I am the district medical lead for paediatrics
23 for southern local health district, and I am a general
24 paediatrician doing my clinical work at South East Regional
25 Hospital.
26
27 MR MUSTON: How long have you held the role locally?
28
29 DR PIPER: So local role since March 2023, although I was
30 in the district medical lead role since 2021.
31
32 MR MUSTON: And I think from - based on a statement you
33 have given, were you in that role whilst at least
34 physically located within the Illawarra Shoalhaven Local
35 Health District.
36
37 DR PIPER: I was working in Wollongong and working for
38 southern LHD one day a week.
39
40 MR MUSTON: You have prepared a statement to assist the
41 inquiry with its work, dated 7 August 2024?
42
43 DR PIPER: Yeah.
44
45 MR MUSTON: Do you have a copy of that with you?
46
47 DR PIPER: I do.

1
2 MR MUSTON: Had you had an opportunity to review it before
3 today?
4
5 DR PIPER: I have, yeah.
6
7 MR MUSTON: Are you comfortable that, to the best of your
8 knowledge, it is true and correct?
9
10 DR PIPER: Yes.
11
12 MR MUSTON: That in due course will be tendered,
13 Commissioner.
14
15 THE COMMISSIONER: Yes.
16
17 MR MUSTON: I'll move on to you, Dr Stapleton. Could you
18 give us your full name for the record, please?
19
20 DR STAPLETON: Stuart Gordon Stapleton.
21
22 MR MUSTON: And tell us where you sit within the local
23 health district?
24
25 DR STAPLETON: I am currently the interim director of the
26 emergency departments in Eurobodalla Health Service, so
27 I cover both Batemans Bay and Moruya hospitals.
28
29 MR MUSTON: How long have you been in that role?
30
31 DR STAPLETON: I've been in the role full time
32 since February 2023. I had been doing part-time assisting
33 work from approximately April 2022.
34
35 MR MUSTON: And you've prepared a statement to assist the
36 inquiry with its work, dated 9 August 2024?
37
38 DR STAPLETON: That's correct.
39
40 MR MUSTON: You have got a copy of that with you?
41
42 DR STAPLETON: Yes.
43
44 MR MUSTON: You've had a chance to --
45
46 DR STAPLETON: I have reviewed it and I'm happy with it.
47

1 MR MUSTON: That will be tendered in due course,
2 Commissioner.
3
4 THE COMMISSIONER: Yes.
5
6 MR MUSTON: Dr Oates, your full name for the record.
7
8 DR OATES: Nathan Mark Oates.
9
10 MR MUSTON: We know what the next question is. What's
11 your role within the local health district?
12
13 DR OATES: Two roles. My clinical role is a VMO
14 anaesthetist, and I am also the director of pre-vocational
15 education and training at South East Regional Hospital.
16
17 MR MUSTON: How long have you held those two roles?
18
19 DR OATES: VMO anaesthetist since October 2016, and the
20 director of prevocational education and training since
21 around October 2019.
22
23 MR MUSTON: You've prepared a statement to assist the
24 inquiry with its work, dated 8 August 2024, you've got a
25 copy of it with you?
26
27 DR OATES: I do
28
29 MR MUSTON: You are satisfied that its contents are true
30 and correct?
31
32 DR OATES: Thank you, yes.
33
34 MR MUSTON: That will also be tendered.
35
36 DR OATES: Thank you.
37
38 MR MUSTON: Finally, Dr Clarke, your full name?
39
40 DR CLARKE: Andrew Charles Clarke.
41
42 MR MUSTON: And your role within the local health
43 district?
44
45 DR CLARKE: I am a VMO ED doctor at Cooma emergency
46 department and have been the acting clinical lead
47 since February this year.

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MR MUSTON: You have not prepared a statement for us, but we had the great benefit of speaking to you when we visited Cooma Hospital, and so I don't need to ask you whether the contents of your statement are true and correct?

DR CLARKE: I'm sorry, I am a ring-in, sir.

MR MUSTON: No. We run you in, don't you worry about that. Just so all of you understand the process, this is very much a conversational exercise. It is a little bit formal in the sense that your evidence is being taken down, but you should not feel constrained by the fact that a question might be directed at one or other of you. If any of you want to jump in and provide insights or an answer, or ask one another questions even along the way to try and flesh out the issues that we are talking about today, you should feel to do it. So don't feel that you need to listen carefully to the question that has been asked to one of you and answer with a "yes" or "no" and then wait for the next ball to come across the net; it is very much our opportunity to hear from each of you and all of you collectively just what some of the challenges within the local health district are, some of the ways in which you are going about meeting those challenges, and importantly, some of those things that, at least from your perspective on the ground, you think might be able to be changed or adjusted to better meet those challenges going forward. So, starting with the first challenge that I think each of you has touched on in your statement, and, Dr Clarke, you have spoken to us about workforce challenges within - starting with the medical workforce, what, each of you, do you perceive to be the fundamental workforce challenges which exist within your respective corners of the local health district? That's starting with you, Dr Piper, who I think has managed to overcome some of them.

DR PIPER: I guess - and I am sure it is a recurring theme: recruitment and retention is difficult, especially in an environment where you have to staff and cover on-call rosters, and if you haven't got permanent people to cover the on-call rosters you have to use locums, and the locums come at a premium cost and don't - I don't think represent good investment for the money you're paying. You need to get - you'll get better bang for buck out of permanent staff, but it is a challenge to recruit permanent staff in the market.

1
2 MR MUSTON: We take from that that there are funded FTE
3 positions within the local health district which, if people
4 could be found and kept, would be permanently recruited
5 into?
6
7 DR PIPER: Yes.
8
9 MR MUSTON: But at the moment those positions are either
10 unfilled or it is hard to keep them filled --
11
12 DR PIPER: Yes.
13
14 MR MUSTON: -- in a way that is presenting workforce
15 challenges?
16
17 DR PIPER: Yes.
18
19 MR MUSTON: You talked about the bang for the buck that
20 you get from a permanently recruited specialist or VMO
21 working into a position. What do you see - other than the
22 obvious benefits from clinical care of having a person
23 permanently there, what are some of the benefits you see
24 attracting people to that?
25
26 DR PIPER: One of the biggest benefits for my clinical
27 area is what we call continuity of care. We look after
28 children from infancy till they are adults. It is really
29 hard for those families if they have to see a different
30 doctor and go through the whole story every time with a
31 different doctor versus having a continuity of care with a
32 doctor who knows them. So continuity of care is important.
33
34 THE COMMISSIONER: Is that particularly so with children?
35
36 DR PIPER: I think so. But yeah, I would say for adults
37 with chronic and complex conditions, continuity is vital.
38
39 THE COMMISSIONER: Sure.
40
41 DR PIPER: Being part of the team is helpful. Even for
42 clinical dilemmas, a difficult patient I don't know what to
43 do, having another colleague that I can bounce that off of
44 or ask about is really helpful. And people who are
45 invested in the community, by living there and being part
46 of the community, they're going to be motivated to see good
47 health services for their local community.

1
2 THE COMMISSIONER: I am sure you are going to come to it,
3 but just while it is in my mind, I think it would be useful
4 to get on the transcript the evolution of the children's
5 ward, at this time. I am sure you're going to come to it.
6
7 MR MUSTON: I am literally just about to come to that.
8
9 THE COMMISSIONER: Great minds.
10
11 MR MUSTON: The way I was going to come to it, and you
12 now --
13
14 THE COMMISSIONER: You do it your way.
15
16 MR MUSTON: -- was do you see that there are benefits in
17 terms of recruitment and retention, that is to say benefits
18 to the team, of actually having those permanent members of
19 the workforce in place?
20
21 DR PIPER: It is much easier to recruit to a team where
22 someone - I'm recruiting and someone knows they are joining
23 a team, so they're not going to be on their own, than to
24 recruit to a solo position. And I think people's fear
25 about being recruited to a solo position will be that they
26 will be on their own, relentlessly on-call, working their
27 butt off and getting exhausted and they will burn out and
28 leave, versus knowing, "Okay, I am joining a team. My
29 on-call will be reasonable. I've got colleagues to share
30 the load." And there is a load. There is always patients,
31 problems, issues that are complex, difficult and hard, and
32 it is easier to look after that caseload when you know
33 you're not the only one doing it and everyone is sharing
34 the load.
35
36 THE COMMISSIONER: Can I just interrupt again, at the
37 risk - you used the term "burnout" then. Should
38 I understand that as something that's not just fatigue,
39 that's something far deeper --
40
41 DR PIPER: Yes.
42
43 THE COMMISSIONER: -- and more psychologically draining,
44 and a complete sort of - an adoption of cynicism as well as
45 things like fatigue? You tell me what you mean by the term
46 burnout.
47

1 DR PIPER: I would say that the danger of burnout is what
2 I call "compassion fatigue", where your compassion tank is
3 empty and you are based with yet another very difficult,
4 very complex, hard-to-solve problem and you realise your
5 tank is empty and you can't do it. And I think when people
6 have insight, they realise they are feeling like that and
7 they think, "I'm burnt out, I need to take a break," but
8 it's even more dangerous when people don't realise that
9 they are burnt out but they also have compassion fatigue.

10
11 THE COMMISSIONER: And that sort of mistake leads to risk
12 to both the practitioner, the clinician, but also the
13 patient?

14
15 DR PIPER: Yeah. Yep.

16
17 THE COMMISSIONER: Sorry.

18
19 MR MUSTON: You told us about the benefits from a
20 recruitment point of view of being able to recruit into a
21 position where someone feels that they will be supported by
22 an existing staff member, but from a retention point of
23 view, does it also have the same sort of benefit in terms
24 of if you are recruited into a team where there is at least
25 one other colleague?

26
27 DR PIPER: I think so. I don't feel as though I have been
28 at Bega long enough now to carry that through, but I can
29 say we've now had a stable team for more than 12 months
30 with no staff change over, with no locum use either during
31 that time, and so I hope that that situation continues.
32 But equally, if someone does say, "I'm going to retire", or
33 it's time to move on, when we do recruit to replace them,
34 I'm hoping it will be much easier to attract someone to
35 that team.

36
37 MR MUSTON: Could you maybe talk us through the history of
38 the paediatrics department down there at Bega from the
39 point perhaps before you arrive on the scene until the -
40 right now.

41
42 DR PIPER: Again, some of this predates me so I might not
43 be completely factually correct, but my understanding is
44 the hospital opened in 2016 and it had a new children's
45 ward, a paediatric on-call roster, and they had no
46 paediatricians, and so we are filling that roster with
47 locums. They did recruit a permanent paediatrician,

1 I think, in 2018 or 2019, but just the one. And so, that
2 one worked very hard for a couple of years, at which point
3 I think they were really tired and burnt out. And they
4 left sort of, I guess, a few months before I started. In
5 the 12 months before that, they had managed to recruit two,
6 and then when I came on board, I think they had two and a
7 half, and then myself and another colleague came on board
8 about the same time and we're at five now, and we've been
9 there since then.

10
11 MR MUSTON: And so, at the point at which you came on
12 board there was, I think you tell us in your statement, a
13 waiting list of some 400 patients who were in line --

14
15 DR PIPER: Oh, that's right.

16
17 MR MUSTON: -- to receive paediatric clinic?

18
19 DR PIPER: So the paediatric clinic at south east regional
20 is the only paediatric clinic between Nowra to the north
21 and Victoria to the south, so covering this huge area.
22 There is no other paediatric service or clinics. And
23 I would describe it as a bottomless pit of unmet need in
24 terms of referrals, but really limited capacity to see
25 those patients. So the waiting list was over 900 when
26 I started and we have now more than halved that, but that
27 means there are still 400 people on our waiting list, some
28 of people who have been waiting for a year or two to be
29 seen.

30
31 MR MUSTON: Does that mean that even with Bega firing on
32 all cylinders, really there is a need for more paediatric
33 care within the region?

34
35 DR PIPER: Yeah. I think we've got the new hospital
36 coming in Eurobodalla, and the plan is to have a paediatric
37 hub in Eurobodalla, and they will need a paediatric
38 workforce to look after the patients in that hub.

39
40 THE COMMISSIONER: Can I just ask, when you said some
41 people have been waiting for a year or two to be seen, a
42 year is a long wait, two is double. Can you give me
43 something more specific about that?

44
45 DR PIPER: I think - put it this way. Sometimes when I am
46 seeing new patients in clinic at the moment, the date on
47 the original referral will be from 2022.

1
2 THE COMMISSIONER: Right.

3
4 DR PIPER: But when I first started a year ago, we had
5 referrals from 2019 and 2020. I am pleased to say that it
6 is more like 2022 now, and when I say this - if someone is
7 an urgent patient, a little baby or anything like that,
8 obviously a category 1 referral, it gets squeezed in or
9 seen urgently.

10
11 THE COMMISSIONER: That was my next question.

12
13 DR PIPER: So these are the non-urgent, but there are lots
14 of them out there and I suspect it is a state-wide issue.
15 Probably the best description would be school-aged children
16 with learning development and behaviour problems.

17
18 THE COMMISSIONER: Okay. So you use the term
19 "non-urgent", but still ideally --

20
21 DR PIPER: I am sure it's urgent for the --

22
23 THE COMMISSIONER: -- the wait time is well beyond what it
24 would ideally be, correct?

25
26 DR PIPER: Yeah.

27
28 MR MUSTON: Well, urgent for the family and in terms of
29 the sort of conditions that these less urgent patients are
30 presenting with, would it be right that early intervention,
31 earlier the intervention, the better --

32
33 DR PIPER: Yes.

34
35 MR MUSTON: -- for some of them in terms of prognosis?

36
37 DR PIPER: Yeah. So one thing I have noticed since
38 becoming - moving rurally, so away from metro, out of
39 metro, is usually a child with significant developmental
40 delay will be picked up in the first couple of years of
41 life and linked in and referred, and accessing early
42 intervention. I have encountered a number of children in
43 my clinics in Bega that have made it as far as school or
44 the first year or two of school, and they have not been
45 identified and picked up in those early years, and that's a
46 complex issue that probably reflects socioeconomic
47 disadvantage, but also a lack of early intervention

1 services and things like that. But, yes, you sort of see
2 them when they are two years into their school journey, and
3 you think, "Gosh, if this child had been identified two or
4 three years ago, they could have been accessing early
5 intervention."

6
7 MR MUSTON: And every additional delay in that child's
8 pathway to care further entrenches some of the social
9 determinants and effects --

10
11 DR PIPER: Yeah

12
13 MR MUSTON: -- in a way that is not positive?

14
15 DR PIPER: Yes.

16
17 MR MUSTON: Coming back to the workforce issues that we
18 started with, we might come back to some of the paediatric
19 issues, but Dr Stapleton, in relation to the Eurobodalla
20 emergency department, has your experience been similar in
21 relation to workforce challenges? Or how does it play out?

22
23 DR STAPLETON: Yeah, so at the moment I am the only staff
24 specialist emergency physician in the coastal network, not
25 just Eurobodalla but also south east region.

26
27 MR MUSTON: So just so we can understand that, that is
28 from Eden to somewhere just south of Milton?

29
30 DR STAPLETON: Yes, that is the sort of geographically
31 area. Fundamentally, three hospitals. When I first
32 arrived here, we had had an exodus in the previous
33 12 months of our local GP VMOs or our registrars who had
34 been doing shifts at the hospital. They had all left for
35 various reasons. There was one left at Moruya.

36
37 MR MUSTON: Again, to interrupt you there, the VMOs, were
38 they - they were GP VMOs?

39
40 DR STAPLETON: GP VMOs. So they work in general practice
41 and they were picking up shifts for other experience in the
42 emergency department

43
44 MR MUSTON: At least to the extent that you had any sense
45 or visibility of it, was the loss of those GP VMOs to the
46 system referable to them retiring from medicine altogether
47 or just choosing to walk away from all of that?

1
2 DR STAPLETON: No, probably all of them were well
3 pre-retirement. There were a whole series of factors
4 related to it, and the question of burnout was real in some
5 of these people, particularly coming out of COVID and the
6 bushfires in the region, and their realignment of, you
7 know, what they wanted in life. So there was a large
8 component of that. There was also a lot of unhappiness
9 with a number of the administration processes in the
10 region.

11
12 MR MUSTON: What sort of processes?
13

14 DR STAPLETON: Look, I think there was a sense of - even
15 though there was the promise, and at that time it was still
16 an ongoing promise of a new hospital, there wasn't the
17 sense of progress that they felt was required for the
18 region, and working in general practice in the region, they
19 were acutely aware of what was required service-wise. So
20 I think there was a large component of that.
21

22 The Eurobodalla region, and this is my personal view,
23 has been resource-starved for 25 years. And there has been
24 a whole lot of, I think, things that have been put in as
25 patchwork, but the decisions about where those things were
26 put within Eurobodalla were not well thought out and
27 planned, and it has made a very difficult environment
28 culturally between Batemans Bay Hospital and Moruya
29 Hospital.
30

31 MR MUSTON: Just give some tangible examples of that.
32

33 DR STAPLETON: The fundamental one for me is approximately
34 10 or 11 years ago, the decision for an in-hospital CT
35 scanner was made and it was put into Moruya Hospital, and
36 you could have tossed the coin on which hospital you put it
37 in, I'll be honest at that time, but because of that, it
38 resulted in a situation where it immediately changed
39 patient flow requirements for people who required advanced
40 imaging with CAT scanning. So there were a lot of patients
41 at Batemans Bay being moved to Moruya who then require
42 ongoing care at Moruya for particularly surgical issues but
43 also medical issues as well. However, there was no
44 reconfiguration of the acute bed base to support those
45 increased flows. So we've sort of got Batemans Bay a
46 little bit pregnant as a level 2 hospital being able to -
47 having to look after things, but having to ship them down

1 the road for imaging and potentially shipping back, if
2 suitable. So it creates a very fluid and at times
3 potentially risky situation for both clinicians and
4 patients.

5
6 MR MUSTON: So, I was going to ask, there was an impact on
7 the patients in terms of their movement from if they be at
8 Batemans Bay-based person down to Moruya?

9
10 DR STAPLETON: I think at this point in time no, because
11 systems have matured around it. Things have changed in the
12 way we do business at Moruya as well. However, we still
13 have issues not infrequently where we need to support the
14 movement of the patients, and particularly through the
15 emergency department because that's the point of contact
16 they come to, which creates increasing problems for flows
17 within the emergency department at Moruya. Should they put
18 two CT scanners? No. There wasn't the workload and you
19 would never do it. So the decision for one, I believe, was
20 appropriate. But there wasn't the supporting bed base and
21 staffing behind it, which has created at times incredible
22 block in the ED.

23
24 For example, we just recently analysed the greater
25 than 12-hour stays in the emergency department at Moruya
26 for April and we looked back for this year and the previous
27 two years. In 2022, it was approximately, off the top of
28 my head, 12-14 patients in that situation. This April, it
29 is greater than 55.

30
31 MR MUSTON: Do you have any sense why that might be?

32
33 DR STAPLETON: There is not an increased bed base in the
34 hospital to admit patients to.

35
36 MR MUSTON: So the bed base hasn't changed. Presumably
37 that means that the inflow of patients has changed?

38
39 DR STAPLETON: Yes.

40
41 MR MUSTON: Do you have a sense of why that is?

42
43 DR STAPLETON: Part of it is the transfers. Part of it is
44 changes in protocols. For example, now state-wide stroke
45 protocols, you need to take patients to a CT scanner by
46 ambulance ideally, so that is an increased workload.

1 MR MUSTON: Just so we can understand it, that means if
2 someone presents up or down the coast, the Eurobodalla
3 coast, with symptoms of a stroke --
4

5 DR STAPLETON: If they meet criteria, as per the ambulance
6 protocol they should be transferred ideally to Moruya in
7 the first instance.
8

9 MR MUSTON: So they would not be taken, say, to
10 Batemans Bay emergency department?
11

12 DR STAPLETON: No. There is still a small group, as with
13 every system fall through the system, and so that then may
14 almost always require a secondary transfer for coming down
15 for assessment, imaging, and determination of definitive
16 care.
17

18 MR MUSTON: I think I interrupted you. The patient
19 transfers either from another facility or by ambulance from
20 wherever it is they have come into need. What are some of
21 the other factors that you think have increased the inflow
22 of patients into Moruya?
23

24 DR STAPLETON: Look, I think it's the gradual increase in
25 population without doubt. The increased requirements for
26 higher level observation. Batemans Bay, as a level 2
27 hospital, has minimal advance monitoring, advanced
28 observation facilities. So if we have people that require
29 ongoing cardiac respiratory monitoring, they need to come
30 to Moruya. And that, again, is a frequent source of bed
31 block for the close observation unit as it currently
32 exists. The surgery generally now is done at Moruya. The
33 only surgical procedures really done at Batemans Bay
34 theatres these days is scope work. So gastroscopy, urology
35 type work, and I think they still do a little bit of eye
36 work up there, but otherwise general surgeries as such have
37 to come to Moruya. With the gradually increasing
38 population there is a little bit of a bump, slow bump, in
39 the obstetric side of things, which all comes to Moruya.
40 So there is a whole series of factors which just gradually
41 increase the patient presentation mix.
42

43 MR MUSTON: I think I took you down the path of the
44 increased patients numbers from Moruya. From a workplace
45 point of view, you told us you are the only staff
46 specialist. How else is the workforce composed?
47

1 DR STAPLETON: Okay. So at the moment, the roster at both
2 sites works off a single doctor starts at 7 am. They have
3 a second doctor join them and that doctor works through
4 till 5 so they do a 10-hour shift. A second doctor joins
5 them at 10, they work till 8. Next doctor comes on at
6 midday until 10, and the night shift doctor comes - so they
7 go through to 10.30, they have an extra half hour, and the
8 night shift doctor comes on at 9.30 in the evening and
9 works through to 7am. And for me, that has been a point of
10 contention with me and the LHD since I started. To me,
11 we're a minimum of five doctor hours per day short. We
12 should not be in a situation where we have single doctor
13 cover for day and evening shifts. The workload at this
14 point in time, in either site, does not require more than a
15 single doctor for night shift. However, we are just pushed
16 back against that constantly. In fact, the quote I last
17 heard was, "We give you generous staffing."

18
19 MR MUSTON: So that's - are we talking JMO staffing, or --

20
21 DR STAPLETON: No, I'm talking - I'll go back a step. The
22 staffing we use at the moment is still a combination of GP
23 VMOs from the region or registrars from the region. At the
24 moment, that's a total of about 40 to 45 per cent of our
25 staffing. The rest of it is locum staffing. The locum
26 staffing that we used when I started was pretty much anyone
27 they could fill the roster with. After about three months,
28 being here full-time from February last year, I was able to
29 get control of quality on the locums by being able to
30 review all CVs, references, and approve whether they are
31 suitable. Because of the nature of the regional sites we
32 work in, you really need to have adequately skilled senior
33 doctors who can make decisions. So a simple rule set I use
34 is that I generally don't touch anyone who is under five
35 years post-graduate, and they ideally need to be in a
36 training program for something like emergency medicine,
37 anaesthetics and intensive care, or remote rural medicine.
38 So we established some quality rules around the locum set.
39 We have had positive feedback from the local GPs in what
40 they're seeing come back to them. So I think we are sort
41 of getting that balance right.

42
43 The next challenge is to increase the percentage of
44 local staffing and reduce the locum workforce, and at the
45 same time - and that's both in terms of GP level, we'll
46 call it, and a more specialised level with emergency
47 physicians.

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THE COMMISSIONER: Can I just ask you, when you said we should not be in a situation where we have single doctor cover for day and evening shifts.

DR STAPLETON: Yes.

THE COMMISSIONER: And, "The workload at this point in time at either site doesn't require more than a single doctor for a night shift. However, we are just pushed back against that constantly. In fact, the quote I last heard was, 'We give you generous staffing.'" Does that assertion come with more? In other words, when you are being told, "We give you generous staffing," is there then an analysis --

DR STAPLETON: That was verbal feedback from the person who controls the budget strings for me.

THE COMMISSIONER: Right. But is there any analysis provided to you? "The reason we consider we give you generous staffing is because"?

DR STAPLETON: Yes. The argument is, and it's based on a formula for staffing which is now probably about 35 years old. It was first developed by a guy called Greg McDonald in Central Coast who was the director of the ED then. And at that time, they came up with a formula of one doctor per patient per hour. Now, that was the set up in Gosford at the time when Gosford had JMO staffing present and trainees, plus consultants. So it was aimed at setting up the JMO junior registrar level. It does not take into account the situation in places like Eurobodalla, whereby we need to transfer out critically ill patients. One of those patients may tie up a senior decisionmaker for anywhere between two and six or eight hours, particularly if we're weather-bound and we cannot move the patient. So there's no, if you like, weighting factors involved in that formula. It is a very blunt tool. It does not take into account how we educate people. It is purely a formula that is designed around service, service, service. It does not take into account how we're going to educate support people, engage them in things that get back to that whole thing of retention.

THE COMMISSIONER: So you want me to understand that, in your view, the model at Gosford 35 years ago isn't

1 applicable to your sites in 2024, in the circumstances you
2 just described?

3

4 DR STAPLETON: No, I don't believe it is and I don't
5 believe it is applicable in any regional or rural area.

6

7 MR MUSTON: You heard Dr Piper tell us about the benefits
8 of building a critical mass of permanent workforce. Are
9 those views you share?

10

11 DR STAPLETON: Yeah, and I'll just divert a little bit
12 about what I see as how we need to move forward for the new
13 hospital, because at the moment trying to make any change
14 in Eurobodalla, you get told, "We'll fix it for the new
15 hospital." It is always a good line. We still have to see
16 patients for the next two and a half years, but we'll fix
17 it for the new hospital. I think that the advantages of
18 getting the team together for recruitment and retention are
19 just essential.

20

21 To get us to the new hospital, we have to be realistic
22 about the fact that just because you open a new hospital -
23 and I think it is fair to say south east region was a very
24 good example of this - you do not suddenly magically have
25 specialists trying to climb over each other and provide
26 services. It does not happen. And in a setting like this,
27 we need to be very cognisant of the fact that we need to
28 develop advanced rural generalist models. We are looking
29 to - and the model we are looking to try and develop the
30 ERH is a critical care service hub which then supports the
31 other services in the hospital.

32

33 To that end, it means we need to think differently
34 about who is a consultant. I won't use the term
35 "specialist", because that gets a bit too tricky in terms
36 of what the colleges think, but who can provide consultant
37 level decision-making and skills to support the other
38 clinicians and provide the best possible care to patients?
39 To that end, one of the goals is that over the next six to
40 12 months, hopefully, we develop a model, and we'll start
41 it in ED but will then move it to other areas, of ED
42 consultant who may be FACEM, ACRRM, FRACGP with appropriate
43 skills, and they become the clinical leads that then help
44 develop the critical care structure to move forward.

45

46 The new hospital is, and for political reasons, meant
47 to open on day one as a level 4 service with a level 4

1 intensive care. As I said, we're not going to see
2 intensivists walk through the door, so we have to bridge
3 that with the appropriately skilled generalists to keep
4 that moving forward to where we get to that true level 4
5 intensive care model. It has been done in the past in
6 multiple places around New South Wales and, in fact,
7 Gosford was probably one of the first that did it, followed
8 by Tamworth, followed by Coffs Harbour, followed by Orange.
9 The list just goes on. And I think it is one of those
10 things where we've got stuck in a bit of a model where our
11 clinical leads for southern LHD, up until recent times
12 where Susie has come on board for paediatrics. We still
13 don't have a clinical lead based in the LHD for emergency
14 medicine; everyone comes from the ACT. And that is
15 big-city mindset. It does not give the rural mindset that
16 is required to look at what you have, how you develop that,
17 and provide something good for the future.

18
19 An example where we are imploding at the moment is
20 oncology. Our oncology service, which is for the coastal
21 network, I think is severely under threat. We have the
22 loss of an oncologist at south east regional who has not
23 been replaced. The clinical lead for oncology and
24 haematology from Canberra has resigned from the job, so
25 there is no clinical lead at the moment. And I was in fact
26 talking to one of our staff specialist oncologists at
27 Moruya yesterday, and she is becoming incredibly stressed
28 and concerned about safety in the oncology service. And a
29 lot of it is to do with the fact that it has been looking
30 to get specialists into slots without thinking about the
31 overall service, and the planning for that service and the
32 support for that service has not occurred. And now we are
33 stretching people to the point, and we talk about burnout,
34 I am severely concerned that's what we're going to do to
35 our major oncologists in Moruya.

36
37 THE COMMISSIONER: There are a couple of things I just
38 need to understand from that answer.

39
40 DR STAPLETON: Please.

41
42 THE COMMISSIONER: I have seen - going back to what you
43 said about level 4 for the new hospital, I've seen, whether
44 this is a fair description or not, the publicity material
45 for the new hospital, that "level 4" is mentioned. You
46 said for political reasons it has to - what should
47 I understand by political reasons?

1
2 DR STAPLETON: I think it is fair to say it was a
3 political promise at the last election that the hospital
4 would open as a level 4 hospital with an intensive care
5 unit.
6
7 THE COMMISSIONER: Right.
8
9 DR STAPLETON: That was very much a political promise.
10
11 THE COMMISSIONER: Now, oncology "imploding" was your
12 word.
13
14 DR STAPLETON: Yes.
15
16 THE COMMISSIONER: I take from that you mean imploding in
17 the sense of a consultant shortage?
18
19 DR STAPLETON: Also other staff.
20
21 THE COMMISSIONER: And you mentioned safety as well. What
22 do you want me to fully understand about that?
23
24 DR STAPLETON: Look. I think one of the things we have,
25 again this gets back to how things have worked in the LHD
26 for many years. There's a lot of nurse-run services, with
27 very good nurses, but they have had minimal specialist
28 level support. Now, oncology is one of the ones that sort
29 of jumped up and suddenly started moving. Well, you've got
30 to. You've got to have someone who, I'll be flippant,
31 knows how to poison people properly. But what we are
32 seeing happen, and some of it is to do with the
33 organisational structure. There is no organisational
34 structure for oncology at the moment that gives them clear
35 lines of reporting for medical support through DMSs. It's
36 just not there.
37
38 THE COMMISSIONER: Whose responsibility is that, to have
39 the structure?
40
41 DR STAPLETON: Well, that structure comes from the LHD and
42 the LHD executive. That's all management. That's beyond
43 my pay grade
44
45 MR MUSTON: In order to deal with the particular
46 challenges of rurality that you have told us about, how
47 does that structure need to change, do you think? What is

1 it?

2

3 DR STAPLETON: Well, I think one of the things is there is
4 a number of things need to happen. I don't believe the
5 LHD, particularly in some of the particular regions, and
6 the services, knows how to work with specialists. For a
7 long time they have worked with a bit of fly in/fly out
8 specialist support, but they are not used to having
9 specialists with them as full-time employees, so they don't
10 quite know how to interact

11

12 MR MUSTON: In what sense?

13

14 DR STAPLETON: Well, in the oncology sense, there are lots
15 of things that are decisions that are made that should be
16 involving the medical specialists who know the field, but
17 they're not being either consulted or listened to

18

19 MR MUSTON: Who is making these decisions?

20

21 DR STAPLETON: I believe at the moment there is a clinical
22 lead through integrated health and care, which is the
23 directorate that they are under, and they make those
24 decisions.

25

26 MR MUSTON: What sort of decisions are we talking about?

27

28 DR STAPLETON: Well, one we discovered was who completes
29 the scripts for chemotherapeutic agents. And at the
30 moment, it goes up through the food chain to that level and
31 it is not necessarily going via the oncologist. So if the
32 patients had an ongoing treatment plan, there is a
33 potential loss of a review process about what the agents
34 are that the patient is receiving and reviewing is that
35 still appropriate. So it just keeps the cycle going of
36 treatment, of treatment, of treatment, which may or may not
37 be appropriate.

38

39 MR MUSTON: Is that because the oncologist who is on the
40 ground has at that point been removed from the
41 day-to-day --

42

43 DR STAPLETON: I don't think that has ever been set up in
44 the process, because historically - so our - we have two
45 oncologists fulfilling a single FTE at the moment. One of
46 them is 0.8 one of them is 0.2. The 0.8 person has
47 actually moved to the region, so she is planning to be here

1 long-term. The other one is still vacillating between here
2 and the ACT.

3
4 Prior to that, it was purely fly in/fly out services
5 where someone would come down and do one or two days of
6 clinic and see a massive number of patients, and that was
7 it. After that, it is a nurse-run service with telephone
8 consultation

9
10 MR MUSTON: So under that old model, you'd would get your
11 fly in/fly out oncologist, run a very busy clinic, propose
12 a course of action in respect of a cohort of patients, and
13 then the nurse-run service would deliver that action across
14 the next --

15
16 DR STAPLETON: Yeah.

17
18 MR MUSTON: -- one month, two month, three months?

19
20 DR STAPLETON: Through, years and it keeps going

21
22 MR MUSTON: And the adjustment that see hasn't happened is
23 you have an on-the-ground oncologist.

24
25 DR STAPLETON: Yeah.

26
27 MR MUSTON: That oncologist should actually be
28 continuing --

29
30 DR STAPLETON: Well, they are currently struggling to try
31 and get those things done. So, for example - look, I used
32 to work in Canberra. I had a bit of an idea how the
33 oncology service used to work there. An average clinic for
34 an oncology consultant would be 12 to 14 patients. Down
35 here, it is 18 to 22 in a day. Now, these are complex
36 patients with complex discussions. There is also limited
37 support. We have issues in terms of, say, in terms of the
38 nursing side on the unit. They have just lost their nurse
39 clinical coordinator, who would do a lot of the legwork for
40 things. So that person has now gone. They've got another
41 couple of people who are looking at leaving, they have lost
42 administrative staff, and our palliative care service,
43 which is obviously very important to oncology, the lead on
44 that is about to retire with no clear path forward.

45
46 So from my perspective when I look at these things,
47 these are things that have all been brewing for 12 months

1 but there is suddenly crisis; nothing being planned to
2 actively prevent that so that it would provide the best
3 care to these patients.
4

5 MR MUSTON: What would good planning have looked like at
6 this point of this crisis?
7

8 DR STAPLETON: At this point in time, it has reached a
9 point in time that I don't know the LHD can provide good
10 planning. That is my personal opinion of watching what's
11 happened. It requires an external review type of process,
12 and it needs to be done by people who have been involved in
13 setting up a regional oncology service, not someone who
14 comes from somewhere like Westmead or Canberra Hospital.
15 It needs to be that kind of review, to pick it apart at the
16 bones level and build it up again.
17

18 MR MUSTON: When you say that sort of review, what do you
19 have in mind as the outcome of that review, would I be
20 right in assuming, is the number of FTE of oncologists, a
21 number of FTE of --
22

23 DR STAPLETON: Nursing staff.
24

25 MR MUSTON: -- nursing staff.
26

27 DR STAPLETON: Nurse practitioners, support staff, how it
28 integrates with palliative care. All of those type of
29 factors need to be taken into account.
30

31 MR MUSTON: Just while we are dealing with workforce,
32 can I move to you, Dr Oates. You have told us in your
33 statement quite a bit about the challenges of filling
34 rosters within anaesthetics within the local health
35 district. What do you see is the real challenges to the
36 extent that they differ from those that your colleagues
37 have just spoken of?
38

39 DR OATES: So I think the themes are the same, and the
40 themes that I see are really around what a job looks like
41 from the inside, and for each different discipline, the
42 things that make a sustainable job, that if I was looking
43 at a prospective place to work, the specific things might
44 be a little bit different, but there is common things. And
45 so, some of those things are things like what does the
46 actual workload look like? And that includes, for someone
47 like me coming from a specialist anaesthetist background,

1 I want to do some things that are clinically interesting.
2 So the variety of work is important. The second thing is
3 what does the on-call look like? What is the frequency of
4 on-call, and then when I am on-call how much time am
5 I actually going to spend in hospital? And part of that,
6 what that looks like, is really determined by the
7 composition of the staff, and so that includes whether or
8 not there are junior members staff involved and at what
9 level they are at? So do I have PGY1 or 2 staff that are
10 going to be working alongside me? Do I have a registrar;
11 what stage are they at when I'm on-call? Do they then end
12 up being the first person that picks up the phone and then
13 I only get called once they have done some of the initial
14 work? Or, as was my experience when I first started in the
15 hospital, am I going to be the first person on-call and
16 maybe the first person on-call for things that I'm not
17 comfortable with or have less experience with? And I can
18 talk more about my initial experience if that would be
19 helpful.

20
21 MR MUSTON: That would be.

22
23 DR OATES: I think that is the general picture of what the
24 job looks like. And then for each different discipline,
25 the composition of the staff that make up the workforce
26 really determines then whether or not that looks like a
27 sustainable workforce for me to then say I am happy to be
28 part of it. It is great that the paediatric team have got
29 to, I think, that point. We are not quite there yet in
30 anaesthetics. We have moved quite a long way from where we
31 were when I first started, but we still have some work to
32 do.

33
34 MR MUSTON: In terms of work, is there a dialogue between
35 yourself and your colleagues, on the one hand, and the
36 hospital administration/LHD, on the other, about what that
37 sustainable workforce might look like in terms of numbers,
38 assuming you could fill them?

39
40 DR OATES: Yep.

41
42 MR MUSTON: How does that dialogue go down?

43
44 DR OATES: Again, I think most of the conversation is
45 around service provision, and it is really geared towards
46 how many operating lists do we have, what staff do we need
47 to fill those operating lists, rather than a conversation

1 around what is the community need, what should we actually
2 be doing, what should this hospital, this new actually very
3 nice facility be able to do within its level 4 kind of
4 umbrella? And as part of that, how do we think about the
5 future for our workforce? And, I guess, I'm very biased
6 with this. I think there's a growing amount of evidence
7 around the role of training, and the role of training
8 experiences that then lead people to choose to live and
9 work in the country down the track. I'm a product of that
10 as well, so I guess I feel that.

11
12 MR MUSTON: That is probably a useful segue to your
13 earlier experiences you were going to tell us something
14 about.

15
16 DR OATES: Yes. So I was - I am a graduate from the ANU,
17 now what is called the School of Medicine and Psychology.
18 It had a different name when I graduated. But I chose to
19 go to the ANU because of the rural program that they
20 offered. I didn't know anything about Bega, but ended up
21 getting sent to Bega back in 2006 for my rural year and had
22 a really fantastic experience there. I ended up with one
23 of the local - actually a GP anaesthetist who I work
24 alongside now as a mentor. And we've kept in touch over
25 the years, and that is the reason that I came back.

26
27 MR MUSTON: In terms of that, you started telling us a
28 little bit about your earlier experiences working as an
29 anaesthetist or JMO within the hospital setting. What was
30 that experience like as compared, perhaps with some of your
31 colleagues who had finished at ANU and gone to the Canberra
32 Hospital?

33
34 DR OATES: Maybe it will be helpful if I contrast the job
35 in Bega compared to the job in Canberra?

36
37 MR MUSTON: Yes.

38
39 DR OATES: So the job I went to in Bega in 2016, that was
40 my first consultant job. And so I had worked in a variety
41 of locations before, but when I came there, the hospital
42 was really just in that process of starting to grow into
43 itself. The anaesthetic department was looking after the
44 intensive care at that stage, and so, for example, the
45 on-call, because of the staffing numbers we had at that
46 time, I would be on-call every fourth or fifth day. We
47 didn't have any junior medical staff in the intensive care,

1 and so I remember looking back through my work timesheets,
2 feeling like I had been working quite a lot and realising
3 between the period of time October through to April, for
4 those every fourth day on call or every fifth day on-call,
5 on average, I was staying in the hospital until midnight
6 but often until 2 o'clock in the morning, and then back
7 again at 7.30 for a list. And I think I was at the stage
8 of my career that I probably didn't realise how
9 unreasonable that was. I had young kids, and so it was
10 challenging. It was challenging for my wife. But as time
11 has gone on and I've had the opportunity to chat to
12 colleagues in Canberra, I've realise just how different
13 things look. And so in Canberra, for example, for someone
14 at my level, the on-call burden would normally be something
15 like one shift every three to four weeks and, in that
16 context, they would normally have two registrars, a senior
17 and a junior registrar, that were the primary person in the
18 hospital, and so sometimes you wouldn't even need to have
19 to come into the hospital.

20
21 The other, I guess, things when you look at the job
22 more broadly, when you are comparing somewhere like Bega
23 to - so South East Regional Hospital to Canberra, just the
24 work. And so, if you are working in Canberra, particularly
25 if you are doing those on-call shifts, you would often end
26 up doing some quite interesting clinical work. And in
27 Bega, we actually still get some very interesting things
28 that happened there, but the frequency of those is just
29 much less common. And so from a perspective of thinking
30 about my clinical skills, there is always that thought, "If
31 I stay in the country, with what the work looks like, am
32 I going to be able to retain some of the training skills
33 that I developed, or is that gradually going to just drift
34 away over time?"

35
36 MR MUSTON: You were telling us about some of those what
37 might be described as arduous experiences in the
38 early days. You also told us in your statement about your
39 personal decision to work as a VMO rather than a staff
40 specialist. Does the ability to manage in your own life
41 some of those potentially arduous working conditions
42 feature in your decision to be a VMO rather than a staff
43 specialist?

44
45 DR OATES: So this was an interesting thing starting the
46 job. I had no idea about the contracts, and I was just
47 given a VMO contract. So that was what happened for the

1 whole department at the time that I went there. The
2 decision for VMO contracts was made by the then-director on
3 the basis that if we had longer hours on-call, we would get
4 paid for them, and in the staff specialist award, there is
5 an allowance for on-call, but it is an allowance for
6 on-call that, from the perspective of us in the country,
7 was made with reference to what work looks like in the
8 city.

9
10 MR MUSTON: So that, again, so we understand that, we have
11 some evidence about the on-call allowance which requires,
12 effectively, for you to have been working on-call or
13 working additional hours which are in excess of
14 "reasonable", which, do I take it, what you tell us is in a
15 city context, what one might need to work and the extent to
16 which one might see that as reasonable as opposed to - or
17 business as usual as opposed to not business as usual might
18 be different to the arduous experiences you've just told us
19 about from your earlier days?

20
21 DR OATES: I think, yeah, that - how do you interpret the
22 word "reasonable"? I mean, I think there will be lots of
23 different perspectives on that, and I think any different
24 hospital you will go to, it will be different depending on
25 some of those factors that I have spoken about. But, like,
26 it's not a fundamental approach to an employment contract
27 that works well in the country. It just doesn't work. It
28 doesn't take into account even what it might look like up
29 the road at Moruya, and it doesn't take into account things
30 like do you have a junior doctor that is going to help
31 offset some of what the work looks like? And across each
32 different discipline again, it looks very, very different.

33
34 THE COMMISSIONER: A 2am finish and a 7.30 start couldn't
35 be anywhere considered reasonable anywhere, could it?

36
37 DR OATES: No. No. And I think there is a lot of
38 evidence around that, and just being able to provide safe
39 patient care. But at the same time if I, in the context of
40 our workforce, if I say, "No, I'm not going to come at
41 7.30," that means there might be five people that have
42 planned elective surgery that then don't get the operation.

43
44 THE COMMISSIONER: Sure.

45
46 DR OATES: And so there is a lot of pressure to continue.
47 I had actually just moved from doing a fellowship in an

1 African country, and so it actually seemed better than
2 where I had come from. So I think that was partly why my
3 perspective was probably a little bit different.

4
5 THE COMMISSIONER: That is one way of looking at it,
6 I suppose.

7
8 MR MUSTON: I think I distracted you with our foray into
9 the award structure. In terms of challenges in the
10 workforce, you have told us that each department will be
11 different, but I think you say the general themes are
12 similar. What do you need to do in your department, do you
13 think you, to get it to the point where it has reached that
14 critical mass --

15
16 DR OATES: Yes.

17
18 MR MUSTON: -- that makes it --

19
20 DR OATES: So I guess I'm thinking about this more in the
21 context of we are likely to lose some of our staff, and we
22 have been trying to recruit unsuccessfully for a couple of
23 years. I think to attract anaesthetic specialist staff,
24 one of the things that would make a big difference is just
25 around the range of work we do in the hospital. It would
26 be - for example, there's been discussion about ENT
27 services, if there is movement towards re-establishing
28 those services and providing a range of different things
29 that are available in that service. I think there are a
30 number of other disciplines; I can talk about specific
31 things that would be helpful. There are a number of
32 different things where there is quite a lot of community
33 need, and no real opportunity that we can see to be able to
34 expand the things that we offer the community, despite what
35 we know about our district paying for those services to be
36 performed by Canberra, for example.

37
38 THE COMMISSIONER: Is this what you have touched upon in
39 paragraph 34 of your statement?

40
41 DR OATES: Yes. Yeah, and I think it's getting to the
42 idea of the activity-based funding, and - and again, this
43 is our perception. I don't know if this is the reality,
44 but the perception we are given is that within that model
45 of activity-based funding, because there are a number of
46 different services in a hospital that are never able to be
47 provided with the same degree of "efficiency" as a larger

1 metropolitan centre, and the implications of that for the
2 budget of the district as a whole, and how New South Wales
3 sees that, when we talk about, "Can we establish something
4 else that's really needed?", and there are things at the
5 moment like trans-oesophageal echocardiography that I could
6 talk about, but where there are these things that we would
7 need, and potentially quite straightforward to start
8 implementing, the common thing we have heard is that we're
9 not functioning at the level of efficiency that we should
10 be, and we're not considering any new services until the
11 hospital improves in relation to the expectations from
12 NSW Health.

13

14 THE COMMISSIONER: Just explain by what you mean by not
15 operating at the level of efficiency you should be?

16

17 DR OATES: The example I gave was around the obstetrics
18 service. I think there are a few different ways you could
19 categorise it, but with the obstetrics service, at our
20 hospital we deliver between 260 to about 290 babies a year.
21 And despite that being actually quite a low
22 volume obstetric service, by virtue of our geography, it
23 absolutely is required. And in order to have the service
24 in place, you have to have a 24-hour roster with an
25 obstetrician on call, you need to have a midwife team, you
26 need to have the availability of the paediatrician. There
27 are all these things required for the service.

28

29 THE COMMISSIONER: So the cost of providing the service
30 and the service has to be there, and it is just not
31 captured in the --

32

33 DR OATES: Yes. And, for example, if you were delivering
34 350 or 400 babies a year, there probably wouldn't be a
35 major change required in staffing level in order to have a
36 significant increase in the number of patients that we're
37 looking after. And so, in the AVF funding model, whenever
38 you look at a service like obstetrics, it is never going to
39 look like it is performing well because of the number of
40 patients coming in and accessing that service.

41

42 MR MUSTON: Unless you are, say, in an area that has a
43 large volume of babies being born?

44

45 DR OATES: Yep, obviously. And there's that kind of
46 concept about economies, it is really an economies-of-scale
47 argument, is replicated in some way in a number of

1 different parts of the hospital, including in the operating
2 theatres, where we have services that we have to provide,
3 for example, emergency surgery, which are always going to
4 look more expensive by virtue of where we are and the
5 number of people coming through.
6

7 THE COMMISSIONER: Because this may not be a flaw of the
8 funding model, it might simply be that is how the funding
9 model works, and it might be a flaw in how you are actually
10 funded beyond that?
11

12 DR OATES: Yep.
13

14 MR MUSTON: Just coming back to a comment you made about -
15 I think you gave an example of a trans-oesophageal - a long
16 word that starts with E that I will mispronounce --
17

18 DR OATES: Echocardiogram. Ultrasound of your heart.
19

20 MR MUSTON: If those sort of needs, community needs,
21 weren't being met, do I gather from what you've told us
22 that that would also potentially have a knock-on effect in
23 terms of workforce because --
24

25 DR OATES: Absolutely
26

27 MR MUSTON: -- the performance of those "interesting", for
28 want of a better word, procedures that put variety in the
29 procedures that an anaesthetist within your hospital would
30 be providing would make it potentially a more desirable
31 position for an anaesthetist to come and work?
32

33 DR OATES: There is a whole series of knock-on effects.
34 So, directly for the patient - and, for example, last week
35 we had two patients that were inpatients waiting for
36 transfer for this procedure. And so for the patients it is
37 much better for them if we can do it in-hospital. And
38 again, we've got the cardiologists that can, we've got the
39 equipment, we've got the operating theatre. It is all
40 about the decision to provide that service. And then there
41 are other things. So those patients with that problem that
42 they have, it makes the work of the physicians more
43 interesting, because they have the patient with that
44 problem that they are looking after in the medical ward.
45 It also has a flow-on effect to the intensive care. So
46 some of these patients might end up in intensive care. And
47 it just means that the entire care of the patient, we have

1 a greater capacity to provide the whole of the care of that
2 patient in a rural environment.

3
4 MR MUSTON: It sort of comes down perhaps to a discussion
5 about what the public health system should or does look
6 like. Do you have a sense that that discussion - or let me
7 take it back a step. Obviously, there comes a point where
8 there are procedures which it has to be accepted the public
9 health system can't be offering at every facility.

10
11 DR OATES: Yeah

12
13 MR MUSTON: For example, heart transplants at Bega, as
14 exciting as it no doubt would be, is not a reality. But
15 somewhere between your heart transplants and your more
16 minor procedures lies a hypothetical line that, through
17 process of discussion, both the community clinicians and
18 those who fund the health system need to identify as being
19 what, in a place like Bega, the public health system should
20 look like. Does that discussion happen? And, if so, is it
21 a discussion that clinicians or the community, you feel,
22 are involved in?

23
24 DR OATES: I think, as has been mentioned already, those
25 of us that live and work in the hospital that provides
26 services to the community want that service to be what we
27 would expect for people that we know that are going to use
28 it. And so, any discussion about should we be doing heart
29 transplant in Bega is with that context in mind. We don't
30 want the hospital to be doing things that it is not going
31 to do well. So it really fits in with the hospital
32 actually just doing things within its role delineation, and
33 that's, I think, fairly well set out by NSW Health. But it
34 is about using that as a - not necessarily a "you can do
35 this", but the hospital should be aiming to provide those
36 services to the community and looking at the need and
37 actually really trying to meet the need of community,
38 rather than saying, "We only have three anaesthetists here
39 and we're not going to try and do any more than we are
40 currently doing."

41
42 MR MUSTON: From the sounds of things, that's also likely
43 to be a dynamic process in that the needs of the community
44 today might actually be a little bit different, but
45 materially so, to the needs of the community in two years'
46 time or four years' time?

1 DR OATES: To a certain extent. I think some of these
2 things change fairly slowly, and there has been
3 conversation around the ageing community on the south
4 coast, and I think some of the things we are seeing in
5 different parts of the hospital are reflective of the
6 ageing community as well as the increase in population.
7 Things change as well in terms of there was population
8 forecast in 2019, pre-COVID, and then when COVID came
9 along, a whole series of things changed really
10 substantially for the community at large and the population
11 predictions have now also changed quite significantly.
12

13 MR MUSTON: Do you feel that the planning process, to the
14 extent that you are familiar with it or involved in it,
15 around what sort of services are to be delivered at what
16 hospitals, what should our number and location of hospitals
17 be, those sorts of decision-making process, have they taken
18 into account that change?
19

20 DR OATES: I don't think so, but I'm not part of the
21 planning process and so it may well be happening and I'm
22 not aware of it.
23

24 THE COMMISSIONER: I know we haven't given Dr Clarke any
25 time yet, but is that a convenient time ?
26

27 MR MUSTON: It is. I think some of these clinicians might
28 need to be away at some point early in the afternoon.
29

30 THE COMMISSIONER: I am flexible.
31

32 DR STAPLETON: I need to be out at 2.30. That's my only
33 hard one.
34

35 THE COMMISSIONER: We can either take a shorter lunch
36 break if that suits, or we can keep going for a while. You
37 tell me what you think.
38

39 MR MUSTON: I thought maybe if we push through to 1.30.
40 The next witnesses are coming at 2.30.
41

42 THE COMMISSIONER: That's fine.
43

44 MR MUSTON: So if we push through to 1.30, and perhaps
45 worst case, if the stenographers will tolerate me for that
46 period of time, 1.45 --
47

1 THE COMMISSIONER: If they're happy, we can keep going.

2

3 MR MUSTON: -- and then we'll keep going to finish with
4 these guys so they can get back to either their days off or
5 more likely the important work that they do.

6

7 Dr Clarke, you have heard all of what everyone else
8 has said. Could we hear from you on those topics from a
9 Cooma perspective.

10

11 DR CLARKE: Yeah, from a Cooma perspective. I will just
12 clarify my fellowship. I am a fellow of the Royal college
13 of general practitioners with rural, generalist training in
14 emergency medicine, so I am what my colleague speaks of
15 that we need to grow more of. Currently, the medical or
16 the workforce model in Cooma is entirely VMO-based. So
17 everyone is on a zero-hour contract and paid for a service
18 if they attend or don't attend, or if they're on call.

19

20 MR MUSTON: Just pausing there, is that an arrangement
21 which, at least amongst the cohort of GP VMOs in Cooma,
22 people are broadly happy with? That is to say, the
23 zero-hour arrangement?

24

25 DR CLARKE: I think people have been happy with it to
26 date, but I think as we invest in new trainees and
27 registrars that are coming through, there is a desire to
28 be - have a more stable workplace environment. The
29 provisions of a VMO contract are no sick leave, no
30 WorkCover insurance, no leave loading, no penalties. It is
31 a flat rate fee. If you don't work, you don't get paid.

32

33 MR MUSTON: Like barristers.

34

35 DR CLARKE: I'm very sorry about that. I work in
36 emergency; I don't think I can fix that. So as the
37 workforce changes and registrars are maturing to, you know,
38 finalising their fellowships in rural generalism, I am
39 being asked the question, "Can I have a staff specialist
40 position?" And currently under the award, the fellowships
41 in general practice and Australian College of Rural and
42 Remote Medicine are excluded. I am sure you are aware of
43 that. So it makes it quite a difficult conversation to
44 have. So, getting back to that raise, train and sustain
45 model that, you know, we all like to build workforces on,
46 I can raise them as a registrar. I don't have any time for
47 training because there is no provision to pay VMOs for

1 their time for training courses. It is either you are
2 clinical or you are off the floor, unless you have a
3 specific delegation from an executive.
4

5 THE COMMISSIONER: So it's not part of the contract?
6

7 DR CLARKE: It's not part of the contract. So, for
8 example, in Cooma at the moment, there is one VMO, Dr Steve
9 Murdoch, who has an arrangement where he has up to five
10 days a week in order to run the hospital from an
11 administrative, clinical and governance point of view. And
12 that's not a lot of time when you are talking about running
13 a rural hospital with - a level 3 rural hospital with a
14 medical board, an obstetric department, anaesthetic
15 department, a day surgery procedure capability and an
16 emergency department that, you know, punches 12,000-plus
17 people through in the last financial year, with a heavy
18 trauma load. So I think Cooma has been underdone for a
19 number of years, and it's not until the true accounting and
20 reconciliation of what we have actually done has hit the
21 headlines, has the numbers increased. For example, and
22 I can only speak anecdotally from other clinicians there,
23 two years ago, you know, the roster looked like two GPs.
24 One came in in the morning and one came in of a night, and
25 they did a 12-hour shift and they were still pushing
26 through those numbers
27

28 MR MUSTON: And would it be fair to assume that they were
29 also seeing patients in rooms at some point?
30

31 DR CLARKE: They would be seeing their patients in the
32 rooms the next day or the day of, depending what their
33 roster was. Now, I think in terms of our acuity as more
34 people have found the snow and the mountain biking, our
35 numbers have increased as well, as well as the treechangers
36 coming from the capital cities that like the cooler
37 weather. Not so much the sun, but the cooler weather. So
38 I see Cooma as morphing quickly without any kind of lead or
39 governance program or plan to move it forward, and I think
40 we're now suffering from that. I think that those
41 conversations and that planning needed to be done probably
42 10 years ago, as the numbers started to increase, and
43 that's now simply caught us in a hole where the majority of
44 my --
45

46 THE COMMISSIONER: The numbers of presentations started to
47 increase?

1
2 DR CLARKE: Yeah, the number of presentations started to
3 increase. And as now my retiring VMO pool of
4 sub-specialists are, you know, reducing in their time
5 they're available as they are hitting those sort of
6 twilight years of their careers, I don't have an immediate
7 plan to fix it.
8

9 In terms of Cooma, if I was to talk about, you know, a
10 particular day for me, I might start my shift at 10 o'clock
11 and do the 10 till 8 shift. In that time, there will be an
12 obstetric emergency so the on-call anaesthetist who might
13 also be working on the floor in ED at that time is called
14 to theatre. I am called to assist and scrub, to help the
15 GP obstetrician do an emergency caesarean, at which time,
16 you know, we deliver a flat baby, not breathing, no
17 discernible heartbeat. And then we are talking about, you
18 know, complex skills like cannulating umbilical cords in
19 newborn babies while I am on the phone to a neonatologist.
20 So in terms of what your day can go from, it can go from a
21 bruise on someone's knee and a scrape all the way through
22 to quite large and complex resuscitations. All the
23 meantime, I am leaving some poor morning doctor, who is
24 still running the emergency department with 40 to 50
25 presentations in front of them.
26

27 So I guess it is rural generalist heartland where
28 that's not every day, but that's the extreme that which we
29 need to prepare and train for. I don't have the staff,
30 I don't have the training budget, and I need more
31 registrars in rural - in our localities to train up to take
32 over the next leaf from those who are about to retire.
33

34 THE COMMISSIONER: The extreme isn't every day, but what
35 I understood from the round table discussion we had, that
36 serious trauma is not uncommon.
37

38 DR CLARKE: I think that's part of the joy of where I work
39 is actually I got to take an X-ray and see a fracture, as
40 opposed to take an X-ray and not see a fracture. So it is
41 becoming more common than not. We are dealing with severe
42 spinal fractures. C1 vertebral fractures with vertebral
43 artery dissections. We've had cases where --
44

45 THE COMMISSIONER: That sounds serious to me, as a
46 non-clinician.
47

1 DR STAPLETON: Very bad. Very bad.

2
3 DR CLARKE: I think we told the gentleman, "Please don't
4 sneeze and please don't move", while we, you know, on the
5 phone organising his recovery. And that's, you know, a
6 specialist recovery team, and that's long conversations
7 with retrieval coordinators to work out the appropriate
8 means to transport him, the appropriate staffing to
9 transport him and the appropriate location for him to go
10 to. Now, I was involved in that case, and I think after
11 about the fifth phone call I'd made to various
12 neurosurgical teams across the State, and all of them
13 going, "I don't know how to help you," I eventually picked
14 up the phone to the air and medical retrieval and said,
15 "This guy has got to go, can you help me."
16

17 So I guess that's - we don't have a surgical
18 capability, so if there is serious trauma that comes in, it
19 has to go, and it has to go in a timely manner. We're
20 fortunate with our support from Canberra that we can move
21 most patients quickly. Often there is some negotiating
22 between various teams as to who about take the patient and
23 invariably my Hail Mary is to talk the emergency consultant
24 and the admitting officer of the day and say, "This person
25 needs to come to you. I am having trouble negotiating a
26 pathway. Can you help?" And I've been fortunate to have
27 that good support.
28

29 I know my registrars have sometimes struggled, and so,
30 hence, I've had phone calls at 10 o'clock at night, "Hey,
31 can you help me with this patient? I'm not quite sure
32 what's going on." And that's an informal relationship that
33 I use to support the junior staff, rather than I'm being
34 on-call for any particular reason.
35

36 MR MUSTON: Just picking up on something you said a little
37 bit earlier about your ability to grow, train and retain -
38 I have forgotten the three words you used before.
39

40 THE COMMISSIONER: Raise, train and sustain.
41

42 DR CLARKE: Raise, train and sustain.
43

44 MR MUSTON: You made the observation about registrars
45 showing interest in staff specialist positions and that not
46 being possible. Do you have a view about whether, at least
47 in your area, a salaried position for a GP with specialist

1 advance training skills or a rural generalist which might
2 be delivering primary care to the community through a
3 clinic-typesetting at one part of their day or one part of
4 their job and then at another point when that woman comes
5 in needing an emergency Caesar, they might need to be the
6 person instead of you on the floor who goes in and scrubs
7 in and assists with the delivery is a model that might
8 actually assist you to: (a) provide good primary care to
9 the community of Cooma; (b), deal with some of the
10 workforce challenges that you've got to deal with the
11 trauma and the other cases that you have coming through
12 your door; and (c), to actually attract some people to
13 accept those jobs?

14
15 DR CLARKE: I think it is where we're going, and I think
16 that in terms of where New South Wales is behind the other
17 states - I do apologise for that statement, but I will
18 clarify that. I was a staff specialist in Tasmania and
19 I was a staff specialist in Victoria before coming to
20 New South Wales, and I was shocked that I couldn't
21 immediately be offered a position, and it has taken some
22 significant negotiating at higher levels than me going
23 forward to sort of even establish one permanent position at
24 the hospital.

25
26 MR MUSTON: In terms of your sense of what you hear from
27 your registrars, a salaried position, even for those who
28 might primarily be delivering primary care, but
29 delivering some services into the hospital as well, is that
30 something you think they, based on your discussions, would
31 see as more desirable?

32
33 DR CLARKE: That's what they're training for. That's what
34 the ACRRM pathway and RACG PRG programs are completely
35 designed for, where we have a group of general
36 practitioners that have taken the time to study in a chosen
37 field, to break out of the monotony that is nine to five,
38 the grind of general practice, and work in rural locations.
39 I mean, my other hat is an ACRRM medical educator working
40 in accreditation and working with registrars and mentoring
41 them. That's where - they sign this program, that's what
42 they want to do, but there is no facility in
43 New South Wales for them to do that. We recently, you
44 know, in the last 12 months, we have lost a fellowed
45 registrar to Queensland, where she was offered a position
46 as a staff specialist in a hospital north of Brisbane with
47 a registrar and her own JMOs. She couldn't be offered the

1 same thing in New South Wales

2

3 MR MUSTON: Dr Oates, putting your training hat on, in
4 terms of the Holy Trinity of growing your own that we have
5 just heard about, do you see any other impediments,
6 systemic impediments, to achieving that in this LHD?

7

8 DR OATES: I think there has been a bit of conversation
9 about the cross-border arrangements, and so there are some
10 issues there.

11

12 MR MUSTON: What do you see those issues from your
13 position as being?

14

15 DR OATES: Look, there are some specific things. So as
16 relates to the PGY1s and 2s - and I guess there's training
17 in different areas, and I also work for the medical school.
18 So I could talk to the medical school, PGY1 and 2 or
19 vocational training programs.

20

21 MR MUSTON: Why don't we step through it in the same way
22 as a medical student would be stepping through it, that is
23 from 18 through to 42, or whenever it is you finish your
24 training.

25

26 DR OATES: Yeah, it takes a while. So medical school, the
27 main thing, I guess, that I see as a - maybe as a potential
28 impediment, is the availability of some training terms in
29 the country. So, again, the very brief background to this,
30 there is growing evidence that the more the number of
31 exposures across trainings, so med school
32 prevocational/vocational training stages, the more likely
33 you are to go back to the country. So in medical school,
34 if you can have a number of different rotations in the
35 country, it helps. And some of those rotations should be
36 available to start.

37

38 MR MUSTON: Why aren't they, do you think?

39

40 DR OATES: Look, part of it is actually around
41 supervision, and supervision gets back to what is it for
42 that discipline that makes a stable and sustainable work
43 arrangement, and they just don't have the stable medical
44 staffing in order to then make an arrangement with the
45 medical school to have a rotation there.

46

47 When you graduate from medical school and go into your

1 internship, there is an issue with us in southern, in that
2 we are New South Wales hospitals but the program is
3 administered through the ACT, and if you are, for example,
4 coming from the uni of Wollongong and looking for a
5 placement with us in southern and you go to the NSW Health
6 website and HETI, you won't find anything on the southern
7 JMO programs. Including under the rural preferential
8 program, which administers for students that are interested
9 in working around the country around the state, there is no
10 information on our hospital, for example, which takes
11 year-long both intern and resident positions.

12
13 MR MUSTON: And would it be right for us to assume that if
14 that information was there and someone applied, there would
15 be a job for them in your hospital?

16
17 DR OATES: They would go into the pool of applicants and
18 their application would be considered.

19
20 MR MUSTON: Yes.

21
22 DR OATES: And - yeah.

23
24 MR MUSTON: Do you - well, you may or may not know this,
25 but district-wide, is that pool of applicants sufficient to
26 quench the thirst of the district for junior medical
27 officers in their PGY1 and 2 years?

28
29 DR OATES: We constantly have positions around the
30 district in that both PGY1 and 2 positions that are not
31 filled, because they are rotated from Canberra, and on
32 average across the last couple of years, I'd say probably
33 two to three positions across the whole district are not
34 filled every term.

35
36 MR MUSTON: So we've got first issue challenges around
37 providing clinical placement opportunities for university
38 students within facilities, for reasons you have spoken of?

39
40 DR OATES: Yeah

41
42 MR MUSTON: We then get through to PGY1/2 prevocational
43 training and the arrangement with the ACT --

44
45 DR OATES: Yeah

46
47 MR MUSTON: -- and the absence of an arrangement with

1 New South Wales creates another potential difficulty in
2 terms of: (a), providing rural exposure or local exposure
3 to PGY1/2 to students/graduates; and two, also creates some
4 challenges in terms of populating your workforce with a
5 junior component of it. What about vocational training?
6 Where do we go from there?

7
8 DR OATES: Can I just quickly add two other things to
9 prevocational space, just because I think they are
10 important for this meeting?

11
12 MR MUSTON: Yes.

13
14 DR OATES: The first thing is with the PGY1 and 2
15 rotations, the ACT has got a different rotational timetable
16 to New South Wales, and so they have a four-term year.
17 New South Wales has a five-term year, which makes just the
18 whole series of logistics actually quite challenging. The
19 second issue that we've had in the last few years has been
20 for specific terms, again because of our workforce
21 instability, the accreditation of those terms has been
22 threatened any number of times because we haven't had
23 senior medical staffing to provide the supervision that's
24 required for the prevocational terms.

25
26 MR MUSTON: So that is threatened. When you say,
27 "threatened", it is discussions with the ACT accreditation
28 authority, ACT equivalent of HETI --

29
30 DR OATES: Yes.

31
32 MR MUSTON: -- have indicated that due to instability in
33 workforce, their willingness to accredit some of your
34 facilities as a prevocational training site have been
35 placed in jeopardy?

36
37 DR OATES: It has been nearly withdrawn. And so, across
38 particular disciplines it's been a problem.

39
40 MR MUSTON: Vocational training?

41
42 DR OATES: Vocational training. So vocational training.
43 Again, in our context, vocational training is somewhat
44 constrained by, for example, the volume of practice. And
45 so, "volume of practice" just means the number of a
46 particular type of case that the trainee gets exposed to
47 that is a requirement of their training program. And so,

1 this again gets to the way services are designed, and
2 services being designed around something that's historical,
3 not necessarily something that is targeting the community
4 need. And so volume of practice is an issue, and then once
5 again, supervision and stable senior medical workforce. So
6 no position can be accredited unless you have someone who
7 has committed to be a supervisor for that position and
8 there are processes in place and staff in place to provide
9 the supervision and the teaching required for that
10 position.

11
12 MR MUSTON: Does the fluctuating population contribute to
13 that challenge in the sense that at this particular time of
14 year, in Batemans Bay or Moruya, there might be a little
15 bit of head space to provide, or head room, I should say,
16 to provide some training alongside the work that's coming
17 in, but when you have an enormous influx in summer of a
18 tourist population, your ability to guarantee that that
19 time can be cordoned off to provide training is less
20 secure?

21
22 DR OATES: I think it doesn't matter which clinical
23 setting you work in, there will always be fluctuations. We
24 have our own specific issues in southern, and if you work
25 somewhere else there are specific issues to other places.
26 The key issue that I see is that training isn't something
27 that has historically been prioritised, and it's not taken
28 into account with the way that teams are set up within the
29 hospital. At the moment, I am actually working through
30 some rostering for our own ED with the program that we are
31 designing for next year. And once again, all of the
32 discussions around how we go about rostering these
33 positions is all on service provision. It's not with
34 reference to what's required for training.

35
36 MR MUSTON: And so when you talk about those decisions,
37 we're not talking about the decisions about how many people
38 you necessarily have available, but that anterior step of
39 working out how many positions are funded to be employed to
40 deliver care on any particular day in a hospital is not
41 taken into account, the fact that those people, there need
42 to be sufficient of them, with salaries or income attached
43 to them, for at least a portion of them to be doing some
44 training.

45
46 DR OATES: So the specific question is around the John
47 Flynn senior resident program that we're starting, and so

1 some of those positions are coming in with external
2 funding, and so the question is whether or not those
3 positions that are externally funded could then replace
4 positions that have historically been internally funded.
5 And again, the discussion around that doesn't take into
6 account the fact that these positions, what we're aiming
7 for is actually a training position and a position that
8 will provide a good, both experience and also training
9 setting, that requires time and input from people that are
10 working in the ED. And so, when we look at how we go about
11 rostering, what we would ideally say is, well, when we look
12 at that, we need to say this is not just another body to
13 provide service to the patients coming in the door. They
14 are going to see patients, but we now need to think about
15 how we can enable a roster to have a senior person to be
16 providing some oversight and some training, and so we might
17 not be reducing the expenditure that we used to have on
18 those staff because the goal is now not only to provide the
19 service, but also to provide training for this new
20 position.

21
22 DR STAPLETON: Could I just make a small comment there?

23
24 MR MUSTON: Please do.

25
26 DR STAPLETON: We are focusing a lot on medical training.
27 We are not thinking about nursing and allied health in the
28 system. And a strong belief of mine is in regional
29 settings. Everything needs to be thought about as
30 clinician-based. It is not siloed into professional
31 groups. And we lose opportunities in how we can set up
32 training as a result of doing that. We also don't - look,
33 I'll give you the example of my wife, who now works
34 two days a week, mind you. She's a nurse, ex-ED nurse,
35 ex-triage nurse, I just survive that. But she, when she
36 started in this new unit, had 124 modules of mandatory
37 learning for which no time was provided. The system is
38 just screwy in terms of trying to educate people to work in
39 systems and provide safe quality care, and we're just
40 losing these opportunities. And we wonder why people don't
41 follow procedures and protocols, because they haven't had a
42 chance to look at what the training is. So we create these
43 problems by focusing on just service, service, service, and
44 not looking at how we provide education to provide safety.
45 And it is much worse in the rural setting.

46
47 MR MUSTON: If the transcript could note that there was a

1 lot of nodding that appeared to reflect general agreement
2 from the other three participants in the panel in response
3 to that observation.

4
5 DR STAPLETON: I just have one other comment, if you don't
6 mind.

7
8 MR MUSTON: Please.

9
10 DR STAPLETON: It is going to something Nathan touched on
11 before, which you couldn't pronounce, which was
12 transoesophageal echocardiography.

13
14 MR MUSTON: I got the first two words.

15
16 DR STAPLETON: That brought in just an overall issue around
17 how we think about a service and the things that it needs
18 to hang off it to do what it is actually meant to do. So
19 in the planning model for the new EROH, there is meant to
20 be a four-bed stroke unit, which is meant to provide
21 services for patients that do not require thrombolytic
22 therapy or transfer for endovascular clot retrieval. All
23 of those patients require quite a detailed cardiovascular
24 and neuroimaging work-up, and one of the key issues in it
25 is identifying patients who may have atrial fibrillation,
26 who are at risk of embolic stroke, who may require ongoing
27 anticoagulation therapy. There is no thought around, in
28 the new model of care for the hospital, how the stroke
29 service does that. There is no planning around those
30 investigative services.

31
32 Now, in regional settings, as you rightly point out,
33 we are never going to do heart transplants, we are never
34 going to do endovascular clot retrieval. We are years off
35 doing interventional cardiology. It will happen in 10 to
36 15 years' time, but at this point we need to be experts,
37 given the transfer times to those definitive care, in being
38 able to provide high level, timely, investigative services.
39 And we're not planning those beyond your standard CT or
40 MRI. We're not thinking about those other services that
41 are required.

42
43 Last year, I put up a proposal for a system of
44 interrogating a patient's permanent pacemaker or internal
45 defibrillator. It requires an iPad that interrogates the
46 thing, sends it off to the company, they send you back to
47 the report and tell you what it has been doing. We were

1 knocked back because it was out of budget, not in plan. So
2 we struggle to get these planning things in place to
3 provide the appropriate investigations that our community
4 needs. There is no planning process for cardiology in the
5 new hospital. Now, we have got an ageing population --
6

7 THE COMMISSIONER: Can I just understand exactly what you
8 mean by that. So when you were talking about the strokes
9 and you said there is no thought around the new model of
10 care for the hospital, how the stroke service does the
11 investigations, you were talking about, should I understand
12 that to mean --
13

14 DR STAPLETON: I'll give you an example, okay? Until
15 I worked here, I was working at the hospital formerly known
16 as Calvary in the ACT.
17

18 THE COMMISSIONER: Yeah.
19

20 DR STAPLETON: We had a stroke unit there, we had a
21 cardiology service. And I think it is fair to say that the
22 standard of care internationally for a patient who is
23 admitted for a stroke is that they will have a - they will
24 go through an ECG process, they will have CT scanning, MRI,
25 they will at some point get trans-thoracic
26 echocardiography, and if they are in atrial fibrillation,
27 they will get transesophageal echocardiography to identify
28 clot risk for further embolic stroke. There is nothing
29 thought about that in supporting four stroke beds.
30

31 THE COMMISSIONER: I am not going to attempt to use all
32 the words you just did --
33

34 DR STAPLETON: That's all right.
35

36 THE COMMISSIONER: -- but should I understand it to mean
37 there is no planning to have the clinicians necessary to
38 provide those services? Or should I --
39

40 DR STAPLETON: Both equipment and --
41

42 THE COMMISSIONER: Equipment and people.
43

44 DR STAPLETON: -- the correct clinical staff to do it.
45

46 THE COMMISSIONER: Correct clinical staff. All right.
47 Thank you.

1
2 MR MUSTON: Could I ask you, Dr Piper, a question - I have
3 only got three more topics.

4
5 THE COMMISSIONER: Sorry, can I just ask: that seems to
6 be repeating the mistakes of the previous hospital that
7 opened in 2016. Would I be right about that?

8
9 DR OATES: Yeah.

10
11 THE COMMISSIONER: Again, you are all nodding. We are
12 going to take that as four yeses.

13
14 MR MUSTON: You told us, Dr Piper, about having brought
15 the paediatric group workforce to a point where it is
16 coming along both in terms of its medical workforce, but
17 presumably also its broader clinical workforce. What do
18 you need to do, do you think, to sustain that and train up
19 paediatric nurses or bring more people in for succession if
20 and when needed?

21
22 DR PIPER: I think it is a good point. We do have a
23 college accredited position for advanced trainee in our
24 unit. That is an STP federally funded training position.
25 But at the moment for paediatric training, people do have a
26 rural training requirement. There was discussion earlier
27 this year by the college of physicians about removing that
28 rural training requirement, which we were very upset about
29 for many reasons, not least of which we think the only way
30 to learn - gain rural experience is to gain rural
31 experience. You can't learn it from a module online

32
33 MR MUSTON: Even if you are --

34
35 DR PIPER: But if the college takes that requirement away,
36 I think that position will become very difficult to recruit
37 to. And what I would say is the current trainee we have in
38 that role this year is thriving and is expressing a desire
39 to stay in the area and live and work in the area. So
40 making sure that we've got the good quality training
41 positions, and I think Dr Oates has made the really good
42 point about you actually have to have the capacity to
43 train, which means you have got to have enough senior staff
44 to provide that training. The gap for me right now is
45 I really, really want to be able to train our rural
46 generalists with paediatrics as their special interest or
47 skill, and so I need funding model training positions that

1 allow me to provide that training, which at the moment
2 I don't have enough activity to justify to say to the
3 hospital, "I need another junior doctor. Give me another
4 junior doctor." I don't have enough activity to justify
5 that. I've got activity to train a junior doctor, and if I
6 get another junior doctor, I can train them in clinics, but
7 who is going to fund that position?
8

9 And that is where HETI, we work with them. We are
10 nearly over the line with training accreditation with the
11 college of rural and remote medicine to say we can have a
12 trainee for 12 months to do paediatrics as an advanced
13 skill, but, for example, part of that will be I need to
14 send them away for at least four, six weeks to do neonates
15 in a busier unit where they will get more neonatal
16 experience than I can give them in my unit. I can give
17 them lots of clinic, I can give them first on-call, but
18 I probably cannot give them enough neonatal experience that
19 at the end of 12 months they are going to be able to say,
20 "I am confident with that skill set." So I need a training
21 position which means it can't just be providing a service
22 need, so we need funding models that allow for that.
23

24 And the other thing I would say about that is if there
25 is a rural generalist GP or a fellow GP out there who says,
26 "I want to build and develop my paediatric experience and
27 skills, at the moment there is no funding model that allows
28 me to train them. They could come in and, out of the
29 goodness of their heart, get experience and training
30 unpaid; I don't think anyone is wanting to do that. But
31 I haven't got any funding stream or model where I can pay
32 them to come and work in my clinics to get that experience.
33 So if they had access to a training scheme or scholarship
34 or something that says you can come one day a week for the
35 year to do a paediatric clinic and we'll pay you to do that
36 clinic, then we've got the work for them.
37

38 MR MUSTON: Presumably at least at some point within that
39 year, perhaps not day one, those trainees would actually be
40 delivering meaningful and valuable care to people --
41

42 DR PIPER: Absolutely.
43

44 MR MUSTON: -- who might currently be amongst the
45 four-week waiting list?
46

47 DR PIPER: So we are excited just because with the SRMO,

1 the senior resident rural year that we are starting next
2 year, we will have a trainee who will spend four days a
3 week in our department, one day a week in general practice,
4 and during their four days in our department, they will do
5 a mix of clinic ward work, they will spend a night being
6 first on-call where they are the person who takes the first
7 call, but as the consultant on-call supervising them, I
8 will know they are going to ring me about everything
9 because they are junior and we're training them up. Our
10 current advance trainee does a night a week of first
11 on-call and he has nearly finished his training, very
12 experienced and often manages things independently. But we
13 are excited to have the trainee starting in our department
14 next year.

15
16 MR MUSTON: Just picking up on something you mentioned
17 around needing to send trainees to other facilities to get
18 the case mix --

19
20 DR PIPER: Yeah

21
22 MR MUSTON: -- so the neonates you have referred to, we
23 have heard in our travels that the absence of a tertiary
24 hospital within this local health district is something
25 that poses particular challenges both in terms of patient
26 transfer, the ability to move your trainee into that
27 tertiary hospital as part of their day-to-day work to get
28 that experience, but also the ability to phone a friend to
29 a subspecialist in a tertiary hospital to assist with
30 something that you might be faced with in your practice.
31 Any of you can answer that question, but is the absence of
32 a tertiary hospital an issue?

33
34 DR PIPER: I will talk about from Pete's - Pete's is a bit
35 different, because our tertiary hospitals are the
36 children's hospitals. But to put - if I put paediatric
37 training in perspective, what we would argue is that at the
38 moment paediatric training is too tertiary-centric and
39 there needs to be recognition on the college of physicians'
40 point of view of the value of rural and regional and, you
41 know, metro level four paediatric unit time.

42
43 MR MUSTON: What about the "phone a friend"? Well, that's
44 a poor expression, but you encounter something in your
45 practice which you think, "A subspecialist in this area
46 might be able to guide me in a way that means I don't have
47 to refer that patient"?

1
2 DR PIPER: I'm fortunate in paedics, because my options in
3 that are just limited really. It is the two tertiary, the
4 SCHN children hospitals. But I presume it is quite
5 different for these guide in outland work.
6

7 DR STAPLETON: Yeah, it is. There is a process that the
8 ministry has for - I'll use critical care transfers as an
9 example. There is a critical care transfers policy which
10 is both for adults and there is a separate one for
11 paediatrics, and that's just undergoing review.
12 Historically for us on the south coast, that is a referral
13 to Canberra and, you know, for the south coast and
14 sometimes the guys in Cooma, sometimes the guys in
15 Goulburn, there are challenges because of the
16 cross-jurisdictional issues and associated lack of
17 situational awareness about what we actually have
18 available. So that causes problems from time to time.
19 New South Wales pays a lot of money for that service. It
20 is close to \$100 million a year, I believe. And I would,
21 from personal experience, say that overall it probably
22 under-delivers for the money that we pay. So I think that
23 there is an issue there.
24

25 In recent times, there has been discussions at the
26 ministry level now with the revision of that policy, of
27 looking to - do we start looking to move north and moving
28 to places such as, when it comes online as a level 5
29 hospital, Shoalhaven. Wollongong will go up to level 6 at
30 some point, so that becomes a referral process up the
31 coast. That takes time to develop, and in the meantime, we
32 have got to put up with what we've got.
33

34 MR MUSTON: It's 1.42. Recognising I am testing
35 everyone's friendship in terms of blood sugar and the
36 stenographer's frantic recording of everything we have been
37 saying, but I will risk one more question. Do you,
38 Dr Stapleton, you no doubt have heard the communities
39 concerns around the closure of Bateman's Bay Hospital.
40 Without the need to take you through each of those concerns
41 in seriatim, what is your view, in broad terms, on the
42 proposal that Batemans Bay Hospital emergency department
43 will be closed when the new Moruya Hospital is opened?
44

45 DR STAPLETON: Okay, so I'll go back a step on that.
46

47 MR MUSTON: Yes.

1
2 DR STAPLETON: So, as you are probably aware, Batemans Bay
3 is level 2 at the moment. Moruya is level 3. We are
4 looking to go to level 4. That opens up all sorts of
5 clinical service, levels of care, opportunities for the
6 region. That is a very good thing. The fact that it
7 involves moving towards having an intensive care service in
8 the region is also good, because at the moment any - so,
9 for example, any patient under the current policy that
10 requires non-invasive ventilation longer than eight hours
11 needs to be transferred out. Now, that's unrealistic
12 clinical practice. So we're going to improve clinical
13 practice.

14
15 At the moment for me, specifically around the EDs, at
16 the moment we've got too little-bit-pregnant emergency
17 departments. We need to have a live birth. And that is
18 where I see as having to develop the services and build
19 them up into the future.

20
21 Touching on issues such as vocational training,
22 neither side at the moment meets numbers that make it
23 suitable for vocational training in emergency medicine.
24 Combining the units into one would do that, which is a
25 positive step again for the region. A lot of the --

26
27 THE COMMISSIONER: Can I interrupt you just to an extent,
28 sorry? I'm not sure anyone is going to put a submission to
29 me, or give evidence that a new level four hospital in this
30 general area is not a good thing for all the reasons that
31 you've --

32
33 DR STAPLETON: Yeah.

34
35 THE COMMISSIONER: -- what I think the concern is, and this
36 is what I'd like your opinion --

37
38 DR STAPLETON: Yeah.

39
40 THE COMMISSIONER: -- on is, and these are not my findings,
41 I'm just repeating what concerns have been raised with me,
42 is that it might be great that there is this new level four
43 hospital going in Moruya. Query whether that location
44 should have been picked, but leaving that aside, in terms
45 of Batemans Bay having a permanent population of nearly
46 20,000, Moruya has a permanent population of just over
47 4,000. In terms of the extra numbers here in summer, the

1 community concern as I understand it is that it is a bad
2 thing to lose the Batemans Bay emergency department, and
3 what's proposed as some form of substitute, ie, an urgent
4 care centre or clinic, whatever you call it that's open for
5 a certain number of hours, is no proper substitute. Now,
6 that's, I guess, what I would like to hear you on.

7
8 DR STAPLETON: Well, if I look at the state-wide plans
9 that have happened in other areas and changes in level of
10 hospital and services, any time anything is moved from -
11 has been a level 2 hospital that is ultimately closed down,
12 any emergency department is gone with it. It tends to get
13 converted into something like a community health centre
14 plus or minus an urgent care centre attached to it, but it
15 provides an ongoing service.

16
17 The last one of those that I seem to remember was sort
18 of up the Bellingen way, up near Coffs Harbour. They
19 haven't run into problems with this. That's a major area
20 which is not dissimilar to this in terms of seasonal
21 populations and things like that. There is more general
22 population. And they haven't had a problem.

23
24 A lot of the concern is often around, "Oh, it is so
25 much further to go from Batemans Bay to Moruya." The
26 ambulance service does not see it as an issue.

27
28 THE COMMISSIONER: Busy roads. Right.

29
30 DR STAPLETON: Okay? The Moruya Bridge is often raised as
31 an issue in summer, "We can't get through." Ambulance says
32 it not an issue. So I hand my hat - I hand the response to
33 the experts that have to arrange transport.

34
35 The other thing that is often forgotten in this day
36 and age with paramedic services, and I know a couple of the
37 people who have made comments to the opposite of this --

38
39 THE COMMISSIONER: Yes.

40
41 DR STAPLETON: -- in their experience, ambulances did not
42 function as mobile intense units with paramedics. And as a
43 result of that, in regions like this, people go, "Oh, Bob's
44 got chest pain, I'll throw him in the back of the car and
45 get him to hospital," and he arrests on arrival, instead of
46 calling the ambulance service, which would have given them
47 a much better opportunity of having immediate diagnosis,

1 treatment, and a better outcome. This is part of what
2 needs to be educated in the community moving forward.

3
4 The urgent care centre issue, that's one which I have
5 mixed views on, I'll be frank.

6
7 THE COMMISSIONER: Yes.

8
9 DR STAPLETON: I believe it will provide a good, based
10 system of care in the Batemans Bay area. It is certainly
11 the commitment of the company that's been involved and, to
12 date, for the things that they have been doing and the
13 interaction, they are on site at Batemans Bay Hospital at
14 the moment, and next to the ED. The interaction between
15 the two seems to work well. The plan, as I understand it,
16 is for that service to expand to 16 hours a day, seven days
17 a week, with appropriate staffing, and there is a
18 commitment from the Ambulance Service to support them in
19 terms of urgency of call, should they have a sick patient
20 to collect, help to support them and move them to Moruya.

21
22 The figure I heard at one of the community meetings
23 where I think I was almost the son of Satan, from members
24 of the community, was, "It takes us" - you know, "We've
25 timed it. It takes us 30 minutes to get to Moruya
26 Hospital." The ambulance sort of laughs at that and go,
27 "Lights and sirens, it's 12." There's a lot of funny
28 information floating around.

29
30 MR MUSTON: Can I ask you a question as a specialist in
31 emergency medicine, based on your understanding of the
32 services that are often at the urgent care clinic centre
33 service? If our hypothetical elderly man was barrelled
34 into the back of the car and driven at speed to an urgent
35 care centre and arrested as they were dragged out of the
36 car, obviously, it would depend on a whole constellation of
37 factors, but the care that could be delivered by people at
38 an urgent care centre presumably would enable something to
39 be done?

40
41 DR STAPLETON: Oh, definitely, and all of the staff, to my
42 knowledge, are advanced cardiac life support certified.
43 They have a defibrillator on site. They have a
44 resuscitation trolley with appropriate resuscitation drugs,
45 so they can start delivery of care. There is no - I don't
46 believe there is any question about that.

1 Moving forward in terms of it, one, we have made -
2 I have made a commitment to them, that we will help
3 continue to support training and education of their staff
4 for those scenarios and run simulations with them to
5 support that into the future. But the big key for the
6 future when you do these sort of big regional changes is
7 educating the community about getting the right help to you
8 in the right time, which is triple-0, call an ambulance.
9

10 MR MUSTON: In the ideal world does that process of
11 education coincide with a process of consultation, which
12 occurs before the decision - a decision has actually been
13 made to make the change?
14

15 DR STAPLETON: Look, I can't comment on that one in terms
16 of how that happened here. In the ideal world, that should
17 be part of the process. And, look, I - in terms of the
18 consultation processes, from my personal perspective when
19 I arrived in here doing part-time support of the
20 department, I had the plans for the new ED thrust in front
21 of me, saying, "You need to sign this off." And
22 I basically took one look at it and went, "No. It is a
23 wonderful architect design, but it is totally
24 non-functional." So we spent six months arguing, going
25 backwards and forwards. We finally got something which is
26 sort of okay. There is no growth factor in it, so there
27 are going to be issues there in five years' time, but
28 that's what happens in health infrastructure planning.
29

30 THE COMMISSIONER: Sorry, I shouldn't laugh. It is not
31 the first I heard of it.
32

33 DR STAPLETON: Oh, no, I laugh at it all the time
34

35 MR MUSTON: I won't say I have no further questions for
36 these witnesses, I have lots of questions I would like to
37 ask them, but I think I have indulged that desire for long
38 enough.
39

40 THE COMMISSIONER: Can I ask this. I don't want any of
41 you to leave here thinking you haven't had the opportunity
42 to at least raise something you think is very critical.
43 Having said that, please bear in mind that the inquiry
44 doesn't end today, and if something occurred to you next
45 week, you can always make a phone call. Is there something
46 further that any of you would like to raise that you think
47 is really important? I'll start on my left.

1
2 DR PIPER: No, other than to reinforce the comments about
3 the salaried options in hospital for rural generalists and
4 they need to be recognised for the specialists that they
5 are, which means that they should be able to be employed as
6 staff specialists.

7
8 MR MUSTON: The transcript can record that everyone was
9 nodding at that.

10
11 THE COMMISSIONER: We are going to assume complete
12 agreement unless someone puts their hand up. Dr Stapleton?

13
14 DR STAPLETON: In terms of the notes I made, that was the
15 last one I made was around contracts. I sat on ASMOF
16 council as a junior consultant, it would have been 25 years
17 ago. It was very clear that the whole award negotiation
18 process came out of Royal Princess Alfred anaesthetic
19 department and had no vision beyond. And, I will be frank,
20 until the last 12 months, maybe, it hasn't changed.

21
22 MR MUSTON: I won't be cheeky enough to ask whether that
23 was Royal Prince Alfred or the fact that they were
24 anaesthetists.

25
26 DR STAPLETON: I think you could probably add the two
27 together.

28
29 THE COMMISSIONER: Anyone else?

30
31 DR OATES: Just to add with the RG rural generalists
32 thought, and again I'm not a GP, but I think the viability
33 of general practice in the country is really difficult, and
34 I think if there was possibly --

35
36 THE COMMISSIONER: It's difficult and crucial, correct?

37
38 DR OATES: So I think if there was a possibility for those
39 salaried rural generalists to be able to function in
40 primary care as well as in their advance skills training
41 position within the hospital, that would be the ideal
42 situation

43
44 MR MUSTON: So particularly, for example, in an area where
45 there might not be any or sufficient primary care cover
46 through a market-based GP service, a rural generalist on a
47 salaried model delivering primary care through rooms,

1 perhaps co-located in the hospital, but giving that good
2 continuity of care to people of that community while at the
3 same time providing input into the hospital of the type
4 that historically a GP VMO from the town might have
5 provided --

6
7 DR OATES: Yeah, that's exactly what I had in mind

8
9 MR MUSTON: And having that on a salaried model, it is
10 probably useful to turn to the last in the panel,
11 Dr Clarke. It may be something that you --

12
13 DR CLARKE: I think as the RG that sits on this panel,
14 thank you very much to my specialist colleagues. I think
15 in the rural setting, the importance of training can't be
16 understated, and I really thank Dr Stapleton for mentioning
17 the fact that it includes everyone. In an emergency
18 situation in the rural context, these are teams you might
19 not work with all the time. There might be a VMO that
20 comes in once or twice that month and you get a severe
21 emergency there. If he hasn't at least seen it once, then,
22 you know, there's a risk to the patient and a risk to the
23 other staff that we might not get it right and that patient
24 might have a bad outcome, and I don't think - I think
25 that's what we want to avoid.

26
27 With regard to the urgent care centres, I have worked
28 in one and have seen them implemented in Victoria and
29 Tasmania. I caution their use as political throwaway to
30 fixing emergency department waiting times. You have to
31 think about, especially in the rural context, there is a
32 limited medical workforce. If you throw an urgent care
33 centre in there, you have a duplication of effort that
34 deteriorates and detracts from, you know, the primary
35 healthcare facility. So that's a real risk in somewhere
36 like Cooma where it is an MMN5 and the pool is only so big.

37
38 THE COMMISSIONER: That requires really careful planning
39 about whether you have one.

40
41 DR CLARKE: You can't just throw it down the street and
42 say that will take care of your 50-plus patients. It
43 doesn't work.

44
45 MR MUSTON: Unpacking that, do we take from that, limited
46 medical workforce, setting up an urgent care centre to deal
47 with emergency department waiting times by putting them

1 into an emergency department that has got a different name,
2 if they're lower acuity, does not necessarily provide them
3 with the primary care, good continuous primary care of the
4 type they need?

5
6 DR CLARKE: No

7
8 MR MUSTON: And dilutes the existing workforce that might
9 otherwise be providing that care?

10
11 DR CLARKE: Dilutes my workforce. And I could - when you
12 are dealing with a limited pool of numbers, I could better
13 use that resource in the department than have the work
14 duplicated by somebody still triaging the patient. You
15 know, an administrative person still seeing the patient, a
16 nurse still triaging the patient, a physician or a GP still
17 seeing them, you know? "Oh, look they've got chest pain.
18 Oh, you have to go next door now." You know, I'm delaying
19 their care and I'm not delivering a good outcome to the
20 patient.

21
22 DR STAPLETON: I think the experience we have seen so far,
23 and I don't have good data because currently the data
24 sharing between the urgent care centre and the ED is not
25 ideal, but what I think we are seeing is the urgent care
26 centre is providing access to acute primary care that is
27 not available in the region more than taking up the load
28 off the emergency department, and I think that's been the
29 case in other areas as well. I think that, and I fully
30 agree with Andrew, it's often seen as the quick fix to ED
31 waiting times. I have mixed views about what I think about
32 the validity and utility of ED waiting times. Provided we
33 see the sick patients, we will always see everybody else at
34 some point, and that's the way we need to do business.

35
36 Unfortunately, the waiting time model was developed
37 back in the '90s as a way to prove resource lack in EDs,
38 and it then flipped and became a bureaucratic tool to sort
39 of beat EDs over the head with and beat LHDs over the head
40 with. So I think that the utility of it in terms of how we
41 actually practice in emergency medicine these days is now
42 limited. And if we want to look at KPIs and things like
43 that, the bigger one that is much more important is around
44 patient flow out of the department and how we get that
45 right. Because, you know, if you don't have the bed ready
46 to see the next sick patient, that's when your risk starts
47 escalating. But the urgent care centre here, from my

1 perspective, has provided that additional general practice
2 support. Because to my knowledge every general practice in
3 Eurobodalla has currently closed their books, so that is of
4 value.

5
6 MR MUSTON: Coming back to that question I put to
7 Dr Clarke a moment ago, whilst providing - picking up the
8 overflow from what is an insufficient market of general
9 practitioners within the area, it's not delivering to the
10 patients who form that overflow what one might regard as
11 good GP continuous care; rather, it is patching them up and
12 dealing episodically with something that might have reached
13 a bubble-over point and not dealing with, say, a chronic
14 illness and the like in the way a good primary care network
15 should deliver it. I have no further questions.

16
17 THE COMMISSIONER: Mr Chiu, do you have any question?

18
19 MR CHIU: Thank you. I just have one further question
20 that I have to ask. Please - first of all, thank you all
21 for coming and for your time, and what you have raised with
22 us is really important. We do take it seriously, but
23 I have to look after my mental health and I've got limited
24 responsibility for the morale of the staff. So Dr Oates,
25 you are under oath. Out of 100, how many marks would you
26 give Mr Muston for his intubations in your simulation room?

27
28 DR OATES: So intubation is really a binary, so either it
29 is successful or it's not. And so, it was 2 of 2.

30
31 THE COMMISSIONER: Excellent. I won't ask you what marks
32 you would give the Premier, but I am going to assume less
33 than Mr Muston.

34
35 DR OATES: 0 of 1.

36
37 **<THE WITNESSES WERE RELEASED**

38
39 THE COMMISSIONER: Thank you all very much. We are very
40 grateful. And you are at last excused.

41
42 MR MUSTON: Thank you to the stenographers who are remote.

43
44 THE COMMISSIONER: Is it viable to have an hour or not?

45
46 MR MUSTON: I think it is. If we collectively and the
47 stenos are happy to sit, possibly, until 5.30, I think an

1 hour gives them an opportunity to have a proper break after
2 a long day.

3
4 THE COMMISSIONER: Yes. Let's resume until 3 o'clock
5 then. We adjourn till then.

6
7 **LUNCHEON ADJOURNMENT**

8
9 THE COMMISSIONER: Yes, Mr Muston.

10
11 MR MUSTON: The next two witness, who we are calling
12 together, Drs Serena Ayers and Joann Cawthorne.

13
14 THE COMMISSIONER: Dr Ayers, would you like to give your
15 evidence by way of oath or affirmation?

16
17 DR AYERS: Affirmation.

18
19 **<SERENA AYERS, AFFIRMED** [3.05 pm]

20
21 THE COMMISSIONER: Ms Cawthorne, would you like to give an
22 oath or affirmation?

23
24 MS CAWTHORNE: Affirmation.

25
26 **<JOANN CAWTHORNE, AFFIRMED** [3.05 pm]

27
28 MR MUSTON: I will start with you, Ms Cawthorne. Can you
29 state your full name for record, please?

30
31 MS CAWTHORNE: Joann Robin Cawthorne.

32
33 MR MUSTON: What is your role within the local health
34 district?

35
36 MS CAWTHORNE: I am deputy director nursing midwifery at
37 Cooma Health Service.

38
39 MR MUSTON: Based at Cooma Health Service. Thank you. I
40 think, Commissioner, Ms Cawthorne does not have a
41 statement. As you are aware, we picked her up en route as
42 we passed through Cooma.

43
44 Dr Ayers, could you just state your full name for the
45 record, please.

46
47 DR AYERS: Serena Kian Ayers.

1
2 MR MUSTON: And your role within the local health
3 distract?
4
5 DR AYERS: I am the inland network director of medical
6 services.
7
8 MR MUSTON: How long have you held that role?
9
10 DR AYERS: Six months now.
11
12 MR MUSTON: And you have prepared a statement to assist
13 with its work, dated 8 August 2024?
14
15 DR AYERS: Yes, I have.
16
17 MR MUSTON: Do you have a copy of that with you?
18
19 DR AYERS: Yes, I have.
20
21 MR MUSTON: Have you had a chance to review it before
22 giving your evidence today?
23
24 DR AYERS: Yes, I have.
25
26 MR MUSTON: Are you satisfied that its contents are, to
27 the best of your knowledge, true and correct?
28
29 DR AYERS: Yes, I have.
30
31 MR MUSTON: That will be tendered in due course,
32 Commissioner. I say to the two of you in relation to the
33 process today, whilst I'll be asking you some questions and
34 perhaps directing questions at one or other of you along
35 the way, please don't think that if I haven't directed a
36 question at either one of you, that you are not free to
37 jump in and answer. And in fact, if you think in order to
38 best flesh out some of the issues which you guys have a
39 lived experience of and ability to help us with, if asking
40 one another questions throughout this process is something
41 that you think would be useful to tease out an idea that
42 I am not managing to tease out, then please feel free to do
43 it.
44
45 Can I start by just looking at some of the challenges
46 that we have heard quite a bit about throughout our travels
47 and come to understand how those challenges manifest, at

1 least in your respective roles. The first and perhaps
2 largest amongst them is the workforce challenges that
3 present in the context of the delivery of public health.
4 Perhaps Ms Cawthorne first. As from a Cooma Hospital
5 perspective, what are the real workforce challenges that
6 you experience?

7
8 MS CAWTHORNE: So, essentially, utilisation of agency. We
9 are utilising agency nursing in order to prop up deficits
10 in our registered nursing, our enrolled nursing. We are
11 also doing that now in regards to medical, which I will let
12 Serena talk to later, and also we are now branching into
13 the loss of our GP VMOs, we are now getting locum
14 anaesthetist in as well. So we are using premium labour.

15
16 The biggest issue I am finding is specifically in
17 regards to the midwifery side of it, and the competition
18 that we have to get the very sparse, very thorough and few
19 midwives attracted to rural. There is so very few of them
20 that even within the agencies now we are utilising premium
21 surge agency staff to prop up the deficits in our maternity
22 department, which is costing us far more. And that's not
23 just in wages, it is in accommodations. It's becoming - it
24 is very competitive, to the point that I actually have
25 agency nurses that are changing from different agencies to
26 other agencies where they can get further - further
27 funding. And they are calling the shots. They're taking
28 on - they're calling on how they want their rosters. They
29 are calling - so they are actually now doing a disservice
30 to the locum staff that are there, saying that "I will only
31 come for this period of time if you provide me with X, Y
32 and Z." So, premium agency use is really killing Cooma.

33
34 The swings in our staffing, so you will look at
35 blanket numbers and you will say that the in-patient unit
36 is functioning below the 100 per cent capacity. However,
37 it's the daily swings that you can't surge for. In the
38 past month, where we are having seven discharges for our
39 14 beds, but we have having eight admissions at 10 o'clock
40 at night. I can't staff for that. I can have my regular
41 FTE that's required for our inpatient unit, but I can't get
42 casuals - two weeks ago, I had 168 hours of casual hours
43 used, also buffered with overtime. So I don't have the
44 flexibility in staffing in rural.

45
46 So agency staffing is most definitely a big concern
47 for us, and that is because of a deficit in our own

1 nursing, but also the swings that happen with challenge.
2 I don't have a buffer to be able to flex, to surge. So,
3 you know, the larger hospitals, metros, they have the
4 capacity to draw from one ward to buffer another ward if
5 they're in deficit, in part of a short-term escalation.
6 I don't have that buffer. So that is certainly impacting
7 on our ability to staff facilities in times of surge and
8 does impact our capacity to recruit and retain. Do you
9 want to talk to the medical side?

10
11 MR MUSTON: I might come to the medical in a minute, but
12 in terms of challenges that that presents to you in terms
13 of recruiting and retaining, what is it about the stretched
14 workforce which presents a recruitment retention challenge?

15
16 DR CLARKE: So you do have the agency staff that come
17 through. They do take precedence. They take all of the
18 resources. It does create a divide between teams. Do
19 I dare go into what that actually does from an operational
20 and cultural perspective? It's very, very --

21
22 MR MUSTON: This is the place.

23
24 MS CAWTHORNE: Yes. So from a cultural perspective, it
25 depends on who you get. So if I am choosing an agency
26 staff member, I am choosing them on a CV. I don't get to
27 interview them. I don't know their personalities. They
28 are coming in and they are here for a four-week period. It
29 creates complete turmoil, or they could be amazing.
30 I don't know until they get there. And when you are using
31 a significant proportion of them for a particular unit to
32 manage culture, and I take my hat off to our chief
33 executive who has put a lot of work into running out a
34 cultural program for us to develop this for us, and for
35 those of us on the ground it works fantastic, but I can't
36 manage these swings of the staff that are coming through,
37 that when they are a vast proportion within a unit, and
38 shall I use our maternity unit for instance, I can't
39 control the culture. That creates a divide in the team,
40 and then I lose more staff. That is essentially the crux
41 of what happens there.

42
43 Then I - dare I delve into our funding? Our funding
44 model is based on documentation. I don't have control over
45 their documentation. I don't have - I have very limited
46 control over what mandatory trainings they come with. So
47 I inherit that. When I go into accreditation and they are

1 looking at my mandatory training compliance, they say
2 I have a very small workforce in regards to the rest of the
3 district, you look at that, but you look at the percentage
4 of those that are non-compliant with mandatory training.
5 They are all agency. They are people I can't control. But
6 they are people I desperately need to fill the deficits.
7 It is a revolving door. It is very, very challenging

8
9 MR MUSTON: So coming back to the funding issue, just to
10 understand something you told us a moment ago, is one of
11 the challenges that you've experienced with a heavy
12 reliance on agency staff the fact that that from a coding
13 perspective they don't necessarily produce documentation
14 which is optimal, you have limited control over what they
15 produce because they come and go?

16
17 MS CAWTHORNE: It is hard to train. So they are also not
18 invested in that side of it. They are there from a
19 clinical perspective. And this goes for medical and for
20 nursing. And when you have got an activity-based funding
21 site that is reliant on your clinical coding, your
22 diagnoses, this is our bread and butter. And, you know,
23 I said it once and I'll get into trouble, but I'm going to
24 say it again: you've got computers. Our computers are our
25 cash registers, and that is essentially what is generating
26 our revenue for us. And when I've got doctors and nurses
27 that are here from a clinical perspective, I've got
28 educators on site, I've got nurse unit managers, and they
29 are - they are ensuring that we are doing orientation for
30 these staff into the day-to-day running of the facilities,
31 but how on a short-term contract, whether it be a week for
32 a doctor or a month for an agency nurse, how can I teach
33 them what I need them to do for our site to help generate
34 our revenue in that space? It's very, very challenging,
35 speaking for clinical.

36
37 MR MUSTON: Is it oversimplification to say the
38 consequence of that is the agency staff are more costly,
39 whether they be medical or nursing --

40
41 MS CAWTHORNE: Yes.

42
43 MR MUSTON: -- but because of the inability to get them
44 properly engaged in the coding practices which generate the
45 highest level of activity, or when I say "highest level",
46 accurately capture the maximum activity that can be
47 captured through the delivery of service, that you are in

1 fact receiving less money from a funding perspective for
2 the care being delivered by this more expensive asset?

3
4 MS CAWTHORNE: Yep. Particularly when it is more
5 medically driven. Yep.

6
7 MR MUSTON: Before I come to the medical side of it, it
8 might be useful for the Commissioner to get an
9 understanding of why it is important for a relatively small
10 hospital like Cooma to maintain a maternity service.

11
12 MS CAWTHORNE: Our geography is our biggest concern.

13
14 MR MUSTON: Yes.

15
16 MS CAWTHORNE: So we do have, essentially, a low activity.
17 So we are looking - you know, you are looking at between
18 140, 150 births a year. We still have our outpatients, so
19 I don't want to get caught up in just what the births are,
20 because we have got to provide internatal and postnatal
21 care across a geography. It is not unusual for us to have
22 people travel an hour and a half to our facility to have
23 their cares. If they have got to go on to the ACT, on to
24 Queanbeyan, on to Bega, that's another hour down the road.
25 So our geography in itself and, you know, we are a low
26 level - we are a level 3 facility providing low level care,
27 but it's not unusual for us to have to deliver twins. It
28 is not unusual for us to have birthing abnormalities that
29 require transfer out.

30
31 So we are at a staging, I suppose, is what we need.
32 It also requires a skill set and, you know, we still need
33 to deliver a service because of that geography. So we -
34 southern area covers an area of 44,500, I think it was,
35 that I've read in our strategic plan. It's a huge - 44,500
36 hectares with 219,000 people is what we've got in our
37 strategic plan. It's not a lot of people, I suppose, over
38 a big geography. We have to be able to be available to
39 provide that level of service. That's - yeah. We cover
40 from - Cooma's maternity service will cover us down to the
41 Victorian border. We are covering across to the back of
42 Jindabyne. We have a very sparse area to cover.

43
44 MR MUSTON: The relatively low level of deliveries at that
45 facility doesn't, presumably, mean that it doesn't need to
46 be staffed and ready to deliver those twins that might walk
47 in the door at any moment?

1
2 MS CAWTHORNE: And herein lies the challenges in staffing
3 that unit, is because you are expecting clinicians to come
4 to Cooma, it makes it very hard to attract. So, you know,
5 the current model that we have in place, and our chief
6 executive in the district, has a commitment to providing a
7 midwifery group practice. So we are looking at how we can
8 provide a gold standard in care and how we can attract and
9 retain staff that want to come and work in a midwifery-led
10 model.

11
12 But with that, it comes with risks. So we need to be
13 able to maintain a skill set for our staff to be able to
14 work in that unit. We need to be able to keep them skilled
15 but enticed in staying there for those days where they
16 might have stretches that no-one is in the unit but there
17 are still outpatient cares that still need to be required.
18 So it comes with its own challenges, but it is a necessity.
19 I think we can absolutely achieve that by going to our
20 midwifery group practice. There is a long way to go in
21 regards to getting that, but I think we can do it and we
22 can do it efficiently and we can do it safely, but it is a
23 bit of a challenge for us at the moment. Yep.

24
25 MR MUSTON: Coming to the medical workforce, Dr Ayers,
26 what, if anything, would you like to add to that, to the
27 answers that have been given in relation to the workforce
28 challenges that are faced, or more acutely faced, in that
29 medical space?

30
31 DR AYERS: So, the medical workforce challenges are highly
32 complex. We sit across two borders. So we have our border
33 with ACT and we have our border with Victoria, as Jo has
34 already mentioned, so there is complexity around managing
35 movement of workforce, as you can appreciate, and movement
36 of patients as well across those borders. It's always a
37 challenge in a rural area. We are less populous than in
38 the metropolitan areas. It's going to be a thinner market;
39 that's just the truth. It means that it's harder to
40 attract a workforce that isn't already there and I'll
41 expand on that.

42
43 What I mean by that is if you have people who have
44 grown up in the area, who have links, family, they're much
45 more likely to want to be in a rural place and continue to
46 deliver care, or some kind of contribution to a rural place
47 because they understand, their families live there; their

1 friends are there.

2

3

4 Getting a workforce that comes from a metropolitan
5 area is much, much harder. They may have never lived in a
6 rural area before so, in many ways, we have to inspire them
7 and make them interested in wanting to come to a rural area
8 from when they're young in their career, and when they're
9 still looking for their final destination, I guess, and are
10 still full of excitement about the road ahead and that's
11 why we need to think and design a workforce pipeline really
12 quite intentionally. What we can't do is expect people to
13 come, if you like, ready-formed and want to come to a rural
14 area unless you're going to really incentivise that, but
15 I honestly think that, in my opinion, it's too late by
16 then. You want to attract them at the beginning of their
17 careers. You want to talk to them and make them excited
18 about coming to rural to work, and there's a lot of work
19 that we need to do in that space

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MR MUSTON: I gather from that that at least in the
medical workforce, the sort of inducements and incentives
that might be offered to later career or, you know, early,
mid, late career doctors to come and work in rural if they
have not had that earlier exposure are really not enough to
shift the dial?

DR AYERS: No. Because by the time they have spent, let's
say, four, five, six, up to 10 years, training in a
metropolitan site, they've got friends, they've got family,
they've got mortgages in the city, why would they want to
uproot, and that's the reality of it. All of you in this
room, would you want to do that if your whole life is in
the city? And all the doctors I talk to, and the
healthcare staff that I talk to, and it's the same for
nursing, it's the same for allied, by that time, when
they've got kids in schools, when they have got a house,
when they've got families in the city, it's too late. It's
too late.

And then you factor in the fact that for both our
disciplines, it's now much more common for it to be a
graduate degree rather than an undergraduate degree, as it
was 20-30 years ago, let's say. They are going to start
off later in their life when they qualify. So they may
already be in their 30s, may already have a spouse; may
already have children. Attracting them out of the city is
much harder.

1
2 MR MUSTON: Part of that attracting people out of the city
3 involves, as a first step, attracting them into the public
4 system in the first place.

5
6 DR AYERS: Yes.

7
8 MR MUSTON: Do you, Dr Ayers, have a view about whether
9 the existing award arrangements and VMO arrangements are
10 fit-for-purpose in terms of attracting our best and
11 brightest to come and work in the public health system?
12

13 DR AYERS: I will be honest --

14
15 MR MUSTON: Please do.

16
17 DR AYERS: -- and in my opinion, they are absolutely not
18 fit for purpose. They are very outdated and it's, again,
19 thinking about healthcare as it was 20, 30 years ago, but
20 times have changed, and the workforce is different; their
21 needs are different. The things that incentivise our
22 workforce are different, and we're also incentivising the
23 wrong things.
24

25 MR MUSTON: In what sense?

26
27 DR AYERS: So, for example, the locum and agency
28 workforce, they're being paid sometimes two times what our
29 regular staff are being paid, sometimes two and a half
30 times, it just depends, but they're being paid that much in
31 order to drop everything and come to you at short notice
32 and over a short term as we mentioned. They're a temporary
33 workforce. They're not coming to you permanently. They
34 don't have an intention to come permanently. They may not
35 be invested, as Jo has just described, because they are,
36 honestly, there because it's bigger money than in their
37 regular job, if I'm honest, and absolutely I recognise that
38 people are needing to find ways to maintain families, their
39 mortgages, et cetera, you know, I understand that, and so
40 they're going to want to do things that are financially
41 beneficial, but you're incentivising short-termism. Where
42 are the incentives for coming to rural long term? Where
43 are the incentives like you see, for example, in private
44 organisations, in commercial organisations, that reward
45 longevity. Instead of incentivising the first two years in
46 rural, for example, why don't we incentivise people for
47 staying five years, 10 years, 15 years in rural? We need

1 to think outside the box. We need to look at the way that
2 perhaps our commercial competitors, shall we say, do
3 things. Can we learn things from that? We need to realign
4 contracts and incentives so that it really does produce
5 more workforce equity.

6
7 MR MUSTON: When you refer to that realignment and, sort
8 of, drawing parallels between the public system and your
9 competitors, are you referring to a need to match income
10 levels available in the private system, or are you more
11 interested in looking at conditions that actually mean the
12 working conditions within the public system better match
13 what is available from the working conditions point of view
14 in the private sector?

15
16 DR AYERS: So it's really interesting. Again, it's very
17 complex but there are multiple markets that we're competing
18 with. So we are competing with other LHDs and the rates
19 that they are able to push up to.

20
21 MS CAWTHORNE: Across border.

22
23 DR AYERS: Absolutely, across the border. Our ACT
24 colleagues get paid more than New South Wales and that's
25 before I even talk about WA or Queensland.

26
27 I gave an example earlier in the week that I get
28 weekly emails, sometimes daily, asking me as a FACSM if I
29 would like to work in WA for \$4,500 a day or \$5,000 a day
30 at escalated rates. How can we compete with that? That is
31 even before you talk about the private. So this is public.
32 And the ability of different health organisations,
33 different states and territories to increase rates at
34 different caps, shall we say, and different levels. So
35 there are multiple markets, multiple competitors, and even
36 within this same health district, you can get the curious
37 situation where perhaps one site is now very desperate,
38 let's say, for a nightshift doctor and they have increased
39 their rates, and we have found instances of locum doctors
40 and, I am sure, agency nurses who have cancelled at the
41 last minute to take a shift that has been advertised at a
42 higher rate, and it can be horrifyingly within your own
43 health district, but you don't find out until it's too
44 late. So there are lots of things that can happen and
45 that's obviously, thankfully now, that's rarer, but
46 certainly can happen across LHD borders. So they can, at
47 the very last minute, cancel a shift with you because your

1 neighbouring LHD may be advertising a similar role but at
2 much higher money, so they suddenly tell you, "Oh, I'm
3 sorry, I can't make it", but the reason is because they
4 have taken the similar thing elsewhere but for higher
5 money.

6
7 MR MUSTON: Ms Cawthorne, has that been your experience in
8 the nursing temporary workforce?

9
10 MS CAWTHORNE: Absolutely. And, as I say, there is no
11 buffer. There is no buffer for us. If that agency nurse
12 doesn't turn up on that Monday, we already are struggling
13 with the swings and then we don't - we have a roster
14 deficit of a critical position that we thought we had
15 covered and they have taken an offer somewhere else and we
16 have been gazumped. So the rural incentive was great, but
17 we need to stop throwing pockets of money and doing it -
18 you know, you're playing LHDs off against LHDs. You are
19 playing agencies off against agencies. Let's look after
20 the people we've got. And, as I said, cross-border is
21 killing us. It is very, very challenging. There are
22 midwives travelling into the ACT, and it is cheaper for
23 them - they are still making more money even with the
24 travel. So how do we make that better? It's not always
25 about money. I think we need to start looking at, sort of,
26 an advanced credentialing for nurses. We need to be
27 recognising what we do as a skill set in rural as being a
28 specialty.

29
30 I have sort of flown a flag for years saying we need
31 to - talk about rural generalists for medical. Let's talk
32 about rural generalists for nursing. We have a skill set.
33 We are required to provide a level of care. We have
34 chronic and complex. We have got our palliative care. We
35 have got to be specialists in everything and masters of
36 everything. At the end of the day, everything has got a
37 policy and you might have - you know, if you work in metro,
38 you work in a surgical ward. I mean, all of these people
39 that have these amazing skills in a single skill - our ED
40 staff, you know, we have got a small site that's rural but
41 we've got this major trauma that is coming in through our
42 facility, they have got to be a specialist in trauma and
43 then, next minute, they have to be a specialist in
44 palliative care, and then we have to be a specialist in
45 wound care and chronic and complex. So we have a skill set
46 to offer. We have something really exciting to offer.

47

1 In the day and age of where everybody gets a medal for
2 showing up to a race, we need to stop that. You know, we
3 are a society where everybody is rewarded just showing up.
4 It's not good enough.

5
6 Yes, there is registered nurses. Emergency, for
7 instance. Emergency is sexy, it sells. Everybody wants to
8 come to an emergency department. They use rural as a
9 stepping stone to get into something because they don't
10 have a skill set to go to metro. We're desperate, we take
11 them, we skill them up, they get two years with us. They
12 take our education and they run to metro.

13
14 When I started nursing, you couldn't get a job in ED
15 if you didn't have a minimum six years' experience. You
16 couldn't even work to triage. Now I will put you in triage
17 if you have a pulse. That is where rural is at at the
18 moment, and we have got to really start trying to attract
19 people back to rural, start professionally recognising them
20 for the skills that they need, and we need to support that
21 with really extensive education programs. It needs to be
22 professionally recognised and it needs to be financially
23 subsidised. So, you know, again, if you come to rural and
24 you have this skill set, then do it - pay them accordingly
25 for that skill set. It doesn't mean that every registered
26 nurse needs to have the same pay rate and, you know, I am
27 not going into the pays, of how it should be, but it needs
28 to be incentivised through education. It needs to be
29 incentivised through professional recognition, and through
30 remuneration. That's how I feel we attract them.

31
32 When I started back in 2007 in rural, I came to Cooma.
33 I thought I knew a lot. I had gone through the ACT program
34 of working through the emergency department, doing my
35 12 months training in emergency. I was frightened when
36 I got to Cooma because, "Oh, we need to call the med team."
37 Call the med team: I am the med team, with my GP that was
38 at the surgery seeing patients. I needed a pack. I don't
39 have a pack. I've got to get a syringe and a clip and I've
40 got to put it together. I have to have a skill set to know
41 what the background is for me to be able to build that pack
42 that doesn't exist. So I took myself back to Canberra.
43 I got myself the skill set to really know what I was doing
44 to come back to rural. But when I came back to rural,
45 I wasn't just in ED. I was on the ward. I had to cover -
46 I was working in theatre, in recovery. I would be
47 resuscitating a baby in maternity. We have a skill set.

1 We have something very exciting to offer, but we need to
2 support that and you can't do that by throwing novice
3 nurses, and just having staff turn up to rural. So if I
4 liken it to a bare paddock that you put a whole heap of
5 seedlings in, but you don't have the established trees to
6 protect them, I need to have skilled people to grow them
7 and to protect them. Growing your own, I'm all for it.
8 I've done very well in Cooma, but I have to protect them,
9 and I can't when I have got a 50 per cent workforce that is
10 novice in a rotating door. So, people don't stay because
11 they're not supported. It's dangerous.

12
13 MR MUSTON: In terms of grow your own aspect of the
14 workforce, in the nursing and midwifery space, you said you
15 have had success with it. What have you been doing at
16 Cooma in that respect?

17
18 MS CAWTHORNE: So, from Cooma's perspective, we have got
19 all of our education - all of your educators on site.
20 They are all doing "Train the Training" so then we can
21 actually do onsite education. We have got our CMCs within
22 the district, but they are thin on the ground and they are
23 trying their best to cover what they can.

24
25 We have been very fortunate that the district has
26 supported us to send our staff out for training. However,
27 that comes at a cost, a cost that we are not budgeted for
28 and, essentially, we're relying on SP&T accounts and
29 donations that actually prop up our education. There is no
30 pocket of money sitting there for it, and if you're, per
31 the award, you have certain days and you have built into
32 your FTE very few days for education and training, and the
33 rest of it comes down to the site's discretion as to
34 whether you release your staff for that. We are invested
35 in doing that. It comes at a cost. It's not budgeted.

36
37 So from a site level, we have all of our educators
38 training, to the point that I actually have all of our
39 educators sharing the space where they share their
40 education across a site. I have even got an educator and
41 community nurse that goes out to the aged care facilities,
42 outside of our remit, to train them to try and keep people
43 out of our hospital. So, we have a very robust training.

44
45 I had a new grad say to me the other day, "I feel so
46 supported here in Cooma, but" - and her colleagues within
47 the Sydney metro have actually pulled out of nursing

1 because they haven't felt supported. So, we are providing
2 a support, but we are doing it at a cost, and a cost that
3 we are not funded for.
4

5 MR MUSTON: Before we come to growing your own medical
6 workforce, I gather a lot of that training work that you
7 are talking about is training which is being delivered to
8 brand new graduates who have come out of nursing programs
9 into Cooma?

10
11 MS CAWTHORNE: Yep.
12

13 MR MUSTON: Before they get into those nursing programs,
14 is there any work done by you, or by the local health
15 district, in an attempt to sort of tap the resource that is
16 the kids of Cooma --

17
18 MS CAWTHORNE: Yep.
19

20 MR MUSTON: -- some of whom might, one day, become a
21 great member of the workforce at Cooma Hospital.
22

23 MS CAWTHORNE: So, it is fortunate I have a generalist
24 educator to site who has worked very, very tirelessly over
25 the last 12 months. She is new to the role. She is a
26 person we attracted out of Sydney, which is lucky, and we
27 have been developing her skills. She has gone through from
28 being a registered nurse on the ward to being a nurse
29 educator, to now being a part-time NUM of our ward. So
30 growing her has also inspired her to grow others. She has
31 tapped into the local schools. We have got a single
32 process of where we can actually - we are reaching out to
33 the careers advisers at the school with attending the
34 careers education days and we have, probably, the largest
35 number of year 10 work experience students coming through
36 Cooma in this last 12 months. With that, we offer them the
37 opportunity to do community nursing, to go into oncology.
38 They are also been spreading out into our allied health
39 space because I - you know, not to forget them because they
40 are under the same suffering that we are. It is not just
41 medical and nursing, just to make it clear, it's - we need
42 to entice them. So if we give them a little bit of
43 everything, then they can make a choice, and Cooma is
44 fortunate that we have such a strong management team that
45 we embrace that and these people have come in. They are
46 part of our team for a week and they go out then - I think
47 our last one was pretty keen to come back as a physio for

1 Cooma, so these are our own locals that want to come back
2 to us. So, it is very, very good, but I also don't want to
3 limit their careers by saying "Come to Cooma just because
4 we need you". I actually want you to have that career
5 trajectory when you are here as well and experience. Very,
6 very hard to do that in rural. So, if I use our social
7 work positions in Cooma as an example, they are level 1-2s.
8 They come here. They work in rural. They have a
9 specialty skill set that far exceeds what their grading is
10 and they're expected to perform. They come, they get their
11 ticket, then they leave because they can't go any further.
12 So, we need to look at how we actually celebrate that, how
13 we educate them, how we support them and how we keep them.
14

15 MR MUSTON: Just in relation to that career progression
16 and the importance of it from a retention perspective,
17 I recall you telling us, when we were visiting Cooma, that
18 there is an issue in relation to providing career
19 progression to staff who come under the rural incentive
20 schemes. Is that memory correct? That is to say,
21 promoting someone within the hospital who has commenced
22 under a rural incentive scheme and then been employed in a
23 different or higher position within the organisation, say,
24 a nurse who becomes a nurse educator, is that not --
25

26 MS CAWTHORNE: I'm not sure. I'm not sure whether I was
27 going with that one.
28

29 MR MUSTON: It must have been someone else who was telling
30 us about that.
31

32 MS CAWTHORNE: Yeah.
33

34 MR MUSTON: We'll work it out.
35

36 MS CAWTHORNE: No. Sorry.
37

38 MR MUSTON: That's okay. In terms of the medical
39 workforce, sort of, the growing your own medical workforce,
40 obviously is a slightly different prospect because it takes
41 a lot of years to become a doctor.
42

43 DR AYERS: It does.
44

45 MR MUSTON: And one tends to have to leave one's town to
46 do it.
47

1 DR AYERS: Yes and no.

2

3 MR MUSTON: No?

4

5 DR AYERS: So it is really interesting, isn't it. So
6 there have been universities who have recognised the need
7 to grow a rural health workforce and they are working hard
8 to produce these rural clinical schools.

9

10 I guess one of the things I would love to see southern
11 be able to do is to grow beyond and, if you like, expand
12 beyond just a relationship with the ACT. So, my
13 understanding is that historically, we developed a
14 relationship with the ACT because there was a need for
15 Canberra to have an area, a region, where it sent its
16 medical students and where those medical students would be
17 grown up, if you like. So, we have these historical
18 relationships with the ACT, but I think the time has come
19 for southern to be more sophisticated in its relationships.

20

21 ACT Health is a metropolitan health service. They
22 want to grow city doctors, and I understand that. Southern
23 New South Wales is a rural health service. We want to grow
24 rural clinicians. So you can see that we may not have
25 strategic alignment, you know, we're different.

26

27 Only yesterday I was involved in the rural generalist
28 interviews with HETI and we interviewed five candidates and
29 it was really interesting what they said. They are heading
30 for a career where they are solely rural practitioners.
31 They don't want to go to the city. They want to stay in
32 rural. So many of them spoke of how they have grown up in
33 a rural setting. Their family is in a rural setting and
34 they have done all their medical school placements in a
35 rural setting. And so a number of them were tripped up on
36 a question that asked them to compare a metropolitan
37 workforce with a rural one. A number of them had to say,
38 "I don't actually know because I haven't worked in a
39 metropolitan setting", and that is exactly the problem.

40

41 So, if we are aligned with ACT Health and we're
42 reliant on them for our medical students and for our first
43 and second year doctors, well, in order to be placed in
44 southern, which is a rural health service, you actually,
45 ironically, are having to go and approach a metropolitan
46 health service for a job. But if you are wanting, truly,
47 to grow up as a rural generalist, to be a specialist in a

1 rural setting, you want to work in a rural setting. So you
2 want to be able to apply to a rural setting, but it seems
3 odd that the only way that you can be placed at southern as
4 a first or second year doctor or, currently, as a medical
5 student, is to apply to the ACT. It doesn't seem to make
6 sense and we are largely - I'll use the word "invisible" to
7 applicants at the first and second year level
8 post-graduation for jobs. And, as I have said, if you wait
9 until they are later in their career and expect them to
10 come back, you are going to have to really use quite
11 powerful instruments, shall we say, to incentivise them to
12 come back into rural. We can't do that.

13
14 We have to be training medical students who are
15 passionate about rural and then converting them to our
16 first and second year doctors, and embedding that passion,
17 that rural expertise which, as Jo was pointing out, the
18 same goes for nursing, it is different from the
19 metropolitan expertise.

20
21 There is this myth, and it is unfortunate, that
22 somehow you need to go to the metropolitan services to
23 skill up to become an expert. I would say that that is
24 purely a myth. Rural clinicians have a different skill set
25 but they're just as expert. It is not to take away
26 anything from our metropolitan colleagues because I have
27 spent a lot of time in metropolitan centres and leading
28 metropolitan services, but it's a different skill set.

29
30 In the rural setting, we are all wearing multiple
31 hats, as Jo described. The medical workforce is exactly
32 the same. We are wearing multiple hats and, on the same
33 day, you may have multiple functions within the hospital
34 and that's why the loss of just one team member can make
35 such a difference. If you are in a big metropolitan team
36 and you have 25, 30, 40 team members, the loss of one
37 person is proportionally not as devastating. If you are in
38 a team of four, the loss of one team member is devastating.
39 It's 25 per cent of your team.

40
41 MR MUSTON: Devastating in that --

42
43 THE COMMISSIONER: Can I just ask: when you say "wearing
44 multiple hats", what do you want me to understand by a
45 different skill set for a rural clinician to a metropolitan
46 clinician? I am imagining part of it is having to wear
47 multiple hats, but can you help me with a little bit more

1 precision as to what you mean.

2

3 DR AYERS: Yeah.

4

5 THE COMMISSIONER: Because, in my mind, I am thinking,
6 well, a metropolitan clinician is treating a human being
7 and a rural clinician is treating a human being, I get the
8 circumstances are different --

9

10 DR AYERS: Yes.

11

12 THE COMMISSIONER: -- but you tell me what you mean by
13 that, a different skill set.

14

15 DR AYERS: Yes. So let me give you an example from the
16 emergency department, for example. In a metropolitan
17 emergency department - and I have worked at a big - many
18 big metropolitan emergency departments, you have multiple
19 teams that come down and assist you. So say, for example,
20 we receive a trauma patient. You will have the trauma team
21 come down to assist the emergency department team to manage
22 that patient. It is a team approach. So you will have
23 surgeons there, you will have anaesthetists there, you will
24 have intensivists there, you will have the ED team, and not
25 just doctors but nursing. Nursing specialists from
26 different teams who come in and help. So it's a team
27 approach.

28

29 In a rural setting, you are all those people and you
30 are having to, if you like, manage that patient with not
31 just less numbers, but fewer sub-specialty teams who can
32 come down. So in your rural hospital, you may have general
33 medicine, general surgery. You may or may not have
34 orthopaedics, for example, or you may not even have
35 resident surgeons. They may just be doing day surgery and
36 flying in and out, so you only have the rural generalists
37 who may have trained across multiple specialties in their
38 training. So, our rural generalist may have done training
39 in general medicine, in surgery, in anaesthetics, in
40 obstetrics, in ED, as well as general practice. So, you
41 see, they're multiskilled in one person.

42

43 THE COMMISSIONER: Yes.

44

45 DR AYERS: Whereas in a metropolitan setting, what tends
46 to happen is everybody sub-specialises. So you'll become
47 expert but in a narrow field and, therefore, you lose that

1 ability to be a generalist. So that's really the
2 difference.

3
4 It is evolving a highly developed specialist
5 workforce, that is narrow but deep in their knowledge,
6 versus having a broad generalism where you are able to put
7 your hand to many different things and that's acquired
8 through many, many years of training in different fields of
9 medicine and in nursing.

10
11 THE COMMISSIONER: Sure. Thank you.

12
13 MS CAWTHORNE: May I just add something?

14
15 THE COMMISSIONER: Yes, please do.

16
17 MS CAWTHORNE: So just in regards to that as well, so,
18 with nursing, it is not just that skill set that they have
19 from a clinical perspective as well. As we mentioned
20 before, you have got a clinical broader skill set. But in
21 rural - and we look at nursing numbers of what you actually
22 need for the activity coming through your department, but
23 what you don't understand is that we have got - we have got
24 our KPIs that we need to meet, but we also need to be aware
25 that that same nurse that is on that nightshift is also in
26 charge of hospital, trying to cover sick leave. That nurse
27 is also trying to coordinate a theatre team to come in for
28 the emergency caesarean that has coming on, whilst holding
29 a clinical load. They could also be the security that's on
30 shift for that night because the HASS has called in sick
31 and we were unable to replace it, or ambulance is wanting
32 them. The MOU has indicated that you have to provide
33 somebody to do a mental health transport with them, so
34 I have to find my nurse to go with them as well because
35 that's their job as well. They are also trying to be the
36 cleaner, because we don't have cleaners after hours. They
37 are also trying to be admin, to make sure that we capture
38 all the demographics and all the data and the information
39 that needs to be entered into the system correctly in order
40 for us to be paid. So, there is a lot of staff that is
41 also not captured within the role of the rural nurse.

42
43 And Cooma's numbers, you know, when we are seeing over
44 12,000 a year through our ED department, it may not be a
45 lot in the big scheme of things. You look at the FTE for
46 what you require for that, but what else are they doing,
47 and that is what is breaking our nurses.

1
2 If you are a skilled clinician, that's okay, because
3 you can cope with your own clinical skill set, but if you
4 are learning to be an advanced clinician, as well as being
5 in charge of hospital and trying to learn the operational
6 needs, trying to make sure that you are managing your
7 nursing hours for patient day and cancelling if you don't
8 have enough patients on the ward for the staff, or you need
9 to find another staff member, trying to teach novice staff
10 how to do that, whilst they are trying to learn to be a
11 clinician, they just leave. Why would they want to stay in
12 rural? That is what I find challenging.
13

14 MR MUSTON: Assuming the jobs can be filled, is part of
15 the issue that certain ratios or assumptions about the
16 number of nurses on a shift in a particular facility, with
17 a particular number of patients, maybe are not apt to
18 capture the real workload that is being done by that group
19 of nurses in a facility, like yours, as distinct from a
20 larger metro or regional facility?
21

22 MS CAWTHORNE: And I think in a site the size of Cooma,
23 and the fluctuations that we have, we are looking at
24 averages. You look at the averages and you say, yes, you
25 are sitting below your target, or whatever that may be from
26 the numbers of patients, but the swings that you have got,
27 it is very hard to manage. I know we can get down to six
28 patients a day. I've worked in private enterprise.
29 I don't want to waste money, but how do I plan for that?
30 And you can look at our projected, and we can see that we
31 have got our projected three admissions expected, but I can
32 tell you for the last three weeks, our predicted have been
33 blown out of the water and I can't staff for those swings.
34 So I can have 12 patients in the morning and have three
35 staff on. I come back the following morning and I am
36 sitting on 20, with two staff, three staff rostered.
37 I have rostered for profile, I have three on. I can't
38 factor that. And that creates distress within nursing.
39 I am certainly one not to fall into the dramas of
40 individual behaviours, but I can't staff to that and it's
41 very, very challenging. I don't know what the answer is.
42 That is very, very challenging to work out how we manage
43 those swings in rural, but we need to know that it happens
44 and it happens frequently, and it does.
45

46 The same with the emergency department, but it is the
47 other competing demands. You will look at blanket numbers

1 for the emergency department and there are some days where
2 I will come in and say, you know, we had 30 presentations
3 through ED, for instance, just to give an example.
4 However, the acuity on that particular day was extremely
5 high. What it doesn't factor is my category 4, my low
6 acuity presentation. Elderly gentleman from the nursing
7 home, still sitting there from 16 hours beforehand. He is
8 still a person requiring attention. He may well have
9 dementia. He is requiring one-to-one care because he could
10 be behavioural, you know, but that was one occasion that
11 that person is in the department. One occasion of service
12 that they're there, but they are still there because
13 I haven't called pathology in overnight for them, I haven't
14 called radiology in overnight for them. I couldn't get
15 transport home for them. I don't have a taxi service in
16 Cooma after 11 o'clock at night. So, those 30
17 presentations could be hangovers from the night before.
18 They could be hangovers because of other competing factors
19 that I don't have a control over.
20

21 You know, if I look at my numbers of what we have
22 actually got - and it is a perceived busyness to the
23 department is what we have. I have a look at our triage
24 category numbers and we see a vast proportion of those
25 presentations that come through our ED are triage 3s and
26 above. So we are seeing high acuity. It is certainly
27 captured within our data that we are seeing acuity that is
28 punching above our weight, but it is not just the acuity of
29 the presentations. It is not a single number. It comes
30 down to the skill of the doctors and the nursing that is
31 looking after them, and the resources available for them.
32

33 So my category 1 presentations, on average, their
34 length of stay is sitting close to five hours. That's an
35 average. So they could be in the department waiting for
36 transfers out, and we have got a one-to-one doctor,
37 one-to-one nursing on that consumer that is waiting for
38 that transfer out. So it is just - we have got to stop
39 looking at individual numbers and look at what else is
40 affecting their stay.
41

42 Our category 2s, on average length of stay, they are
43 sitting in the department around four and a half hours.
44 Again, we see a high proportion of category 2s coming
45 through our department. They are filling up a bed.
46 They're still there. Yes, they are one occasion of
47 service; they are one little pocket of money.

1
2 Trauma patient. I could have a \$1,500 nWow for this
3 one occasion. They are still sitting there.
4

5 I heard my colleague Dr Clarke talking to a consumer,
6 "Hey, we had a C1 fracture that was in our department for
7 over 24 hours because we couldn't get them out". They are
8 taking up a resource. They're backing up the departments,
9 and they still require the care, but they are just one
10 number, and we don't capture that.
11

12 DR AYERS: Some of that complexity is because it is not
13 just inside the hospital, but outside the hospital, in
14 rural, the whole infrastructure is thinner.
15

16 In the multiple hats example, for example - and going
17 back to Jo's trauma patient, it might be one of our doctors
18 who is jumping in the back of the ambulance to transfer
19 them. That would almost never happen in metropolitan. So
20 then, all of a sudden, you have lost your doctor in the
21 back of the ambulance to make sure that that patient gets
22 best care during the transfer and the transfer time from
23 Cooma would be --
24

25 MS CAWTHORNE: It's about an hour and a half by --
26

27 DR AYERS: -- an hour and a half. So that's an hour and a
28 half there, and that's not counting them getting back. So,
29 you see - and that may be one of however many doctors, two
30 doctors.
31

32 MS CAWTHORNE: It could be one.
33

34 DR AYERS: Yes.
35

36 MS CAWTHORNE: So after 8 o'clock at night, you have one
37 doctor on, but that's no different to them going into
38 theatre, to do a theatre case and it takes them out.
39

40 I have had occasions where I have actually been in the
41 department without the doctor, and it happens, you know,
42 semi-regularly, but it happens enough for it to be a risk
43 to us, that when your doctor is in doing something else,
44 you don't have coverage.
45

46 Dr Clarke talked to the caesarean sections where you
47 have your ED doctors doing your baby resuscitation, your

1 anaesthetist is in there, all your on-calls have gone. It
2 doesn't happen often but, when it does, it has a
3 significant impact. The department backs up and you can't
4 move. So it's a flow problem.

5
6 DR AYERS: It shows you the necessity to really grow
7 adequate numbers to work in the rural space. Rural
8 healthcare practitioners are really passionate people. If
9 there is one thing that we have all learnt from working
10 rurally, it's we continue to work in rural because we love
11 it and we are with colleagues who feel exactly the same way
12 as we do, and that's wonderful. But we do need to have the
13 right numbers to treat our patients, our community, in the
14 right way.

15
16 MS CAWTHORNE: So with the right --

17
18 DR AYERS: So, adequate numbers with the right skill set.

19
20 MR MUSTON: If there was a single significant change that
21 you could make to the system that you think would better
22 attract or lead to attraction and retention of medical and
23 clinical workforce into rural spaces, like Cooma, what
24 would that be, and you can both come up with a different
25 one if you want to.

26
27 MS CAWTHORNE: I know from a nursing perspective, so it
28 is what I touched on before, it is about having an advanced
29 clinical skill set. It is about being professionally
30 considered in that space. It needs to be acknowledged. It
31 needs to be - we need to provide a training program that
32 actually encaptures all of that. So I can have my
33 educators on-site do our training for our mandatory
34 compliance, but I need to have trauma nursing skill set for
35 our emergency department because that is a major, major
36 part of what we actually feed through our ED. I need to
37 have - you know, we need to tap into our universities and
38 acknowledge the skill set that the rural nurses need and
39 actually have a compiled training program, not just for
40 little educators on-site. And I don't - that's no
41 disrespect to our educators. We need to have a university
42 program, a bit like rural generalists, and acknowledge that
43 and financially reward that, so then we are actually
44 keeping our people. We need to stop rewarding the people
45 that come part-time, and we need to start rewarding those
46 that come, grow their skills, and stay and invest into it
47 because that is what is going to support our sites.

1
2 I think education and a professional acknowledgement
3 of what that skill set is is definitely what we need from a
4 nursing and also from an allied health perspective. This
5 is not just - as I touched on before, this is not just
6 about nursing. This is about my colleagues that I work
7 with on a daily basis, from a physio, from an allied health
8 perspective, it absolutely has to happen.
9

10 Certainly I know from a doctor's perspective, and just
11 to quickly touch on in regards to our medical workforce,
12 I can have a registrar in the ED but it will impact on my
13 flow through that department if I have got a registrar in
14 there on their own, they - I did also hear Andrew talking,
15 and I completely agree in the sense, they might ring
16 Canberra and say, "I have got this patient." Canberra
17 don't know what we don't have and that's half the problem.
18 So they say, "Can you just do this test. Do this test. Do
19 this test", and this is why category 1s sit in our
20 department for five hours because they don't know what we
21 can't manage. So as a role delineation 3, our job is to
22 receive, diagnose, package, and send. I don't have an ICU.
23 I can't do surgery on them. I need - I don't have
24 cardiology. I need to get them out. It makes no
25 difference if I am going to stay and do a series of
26 investigations because then it just pushes them into a
27 nighttime where I don't have an ambulance, I have them
28 on-call. So, we have an ambulance service that is on-call
29 on a nightshift, I am sending them down the road at a risk
30 to the drivers, at a risk to the patient after-hours,
31 taking out a service for ambulance during the day when
32 I should have sent them out in the first place. So you
33 then have a longer stay in ED which is eating up your
34 resources because that registrar doesn't know how to sell
35 the story.
36

37 DR AYERS: I think for medical, give us an unbroken
38 pipeline. Give us an unbroken medical workforce pipeline
39 where we can identify rural students even from the, you
40 know, as you said, high school stage. Let's identify those
41 people who want to work in a rural setting in healthcare
42 somewhere, and it doesn't have to be in medical or nursing.
43 There are so many other jobs in healthcare as well. You
44 know, we need ambulance drivers. We need cleaners. We
45 need clerical staff. We need wardsmen. There are so many
46 rewarding professions within health. Let's identify those
47 people right from the start, right from the high school

1 stage. Let's nurture them as they go through university,
2 college, TAFE, all those structures. Let's keep them in a
3 rural setting and let's do that, not just from the ACT but
4 from New South Wales as well and then let's give them jobs
5 in their first and second year, unbroken, so that they
6 don't have to go to metropolitan sites to learn. They can
7 learn in rural settings. Let's give them that progression
8 of training because they have wonderful healthcare
9 experiences that they can be exposed to.

10
11 The trauma that goes through Cooma, for example, is
12 astonishing, but we have also got other sites in inland
13 where they can learn so much and on the coastal, there are
14 other different experiences and within this district, they
15 can move between those different sites and have a really
16 joined up, coherent experience, that makes them passionate
17 to want to stay. Let's grow them from the very beginning
18 and offer them jobs as specialists, and let's reward them
19 and recognise their specialty as rural generalists, and
20 let's have us all work together, not just as a hospital
21 system, but as hospital and general practice and community,
22 together. Because I think all too often, we forget that
23 some of the - if you like, some of the workload that we see
24 and the raising exponential rise in the workload in acute,
25 and in the hospital system, is because we're not supporting
26 our general practice colleagues enough. If we could do
27 that more, if we could support general practice community,
28 ensure somehow that their incentives for working in those
29 spaces are correctly aligned, to staying in those spaces,
30 and have that beautiful continuum between primary,
31 secondary and tertiary care, I think we would all win and
32 it would lead to better wellbeing in the community, better
33 health in the community, not just better healthcare.

34
35 MR MUSTON: Just picking up on that, what is it that we as
36 a system could be doing, do you think, to support primary
37 care?

38
39 DR AYERS: So one of the things that I've talked about
40 with them, and our district has been talking to them about,
41 is this concept of supporting training no matter where that
42 trainee ends up. Let's not just think about the hospitals
43 as training doctors who end up working in hospitals. Let's
44 share our training resources so that we are training all
45 the clinicians who are going to go back out into the
46 community as well. Let's support each other.

47

1 One of the things that I noticed when I worked in the
2 Northern Territory, where the market is even thinner, it is
3 even harder to get staff there, is that that that
4 collegiate support of the hospital with its community is so
5 important. The general practitioners and the hospital
6 clinicians would get together on a regular basis,
7 collaborate, and share and support each other. The
8 expertise would flow seamlessly between hospital and
9 community, and we would support each other socially as
10 well. So there were lots of - because, as you can imagine,
11 working in a rural setting can be isolating.
12

13 One of the words that one of the candidates
14 I interviewed yesterday used that in general practice, in a
15 rural setting, sometimes it can be isolating compared to a
16 hospital practice, but that's where we could do more to
17 support our colleagues and to make sure that they feel part
18 of a wider professional family and, in doing that, I think
19 we all win. But the contracts, the incentives, the
20 architecture behind that, that we don't have control over
21 at the local level, that is controlled at State level or
22 national level, that needs to be aligned to help that
23 happen because I hear from my general practice colleagues
24 that, you know, obviously their frustrations with Medicare
25 and the payment system, that they have had significantly
26 fewer trainees wanting to do general practice in the future
27 and that's very, very sad. If general practice loses, we
28 all lose.
29

30 MR MUSTON: What about as a possibility in a community
31 that might have a thin to non-existent general practice
32 market, the idea of a salaried general practitioner or
33 rural generalist working within a clinic setting, perhaps
34 co-located at the hospital, but equally delivering service
35 into the hospital as part of that role, in much the same
36 way as traditionally a GP VMO in a small town like - it's
37 not that small - a town like Cooma - might once have
38 operated?
39

40 DR AYERS: It is in fact something that I have strongly
41 advocated for and begun to make happen at Cooma with
42 support from the district. It is a very important move and
43 this is why earlier on, I said that the current award is
44 not up to date. It needs to be revised and updated.
45 Because if you look at the appendix at the back, I think
46 it's at the back, it doesn't recognise RACGP or ACRRM as
47 being specialist colleges. That is really deeply

1 insulting, if I am honest, and I think that absolutely has
2 to change.

3
4 Now, don't get me wrong, in the award itself, there
5 are clauses that allow you locally to employ a GP or a
6 fellow of the ACRRM college as a staff specialist, but you
7 have to hunt for that clause within the award and it's
8 really a local --

9
10 THE COMMISSIONER: You are talking about the Staff
11 Specialist Award?

12
13 DR AYERS: Staff Specialist Award, yes, correct, but you
14 have to hunt for that clause and it is open to
15 interpretation and you have to have the wider support of
16 your LHD in order to do that and, obviously, in rural LHDs,
17 that's more common. But how about we just recognise their
18 colleges as being specialist colleges.

19
20 MR MUSTON: Part of that is recognising the colleges and
21 employing those individuals as staff specialists. Part of
22 it is also the role that they are potentially delivering in
23 health service and running properly continuous primary care
24 through potentially co-located rooms at a hospital
25 facility, like at Cooma, or co-located rooms that we saw
26 when we travelled down the road to Bombala, it has not
27 traditionally been part of what the public health system in
28 New South Wales, at least, sees as its function. Do you
29 have a view in relation, first, to whether it should be its
30 function?

31
32 DR AYERS: Well, let me put it this way. We have to be
33 innovative and we have to evolve. It may be that in the
34 past, that split system was okay, but we are not in that
35 world anymore. As I said, the way that we train doctors
36 and nurses has evolved; has changed. The priorities of our
37 workforce have changed, especially after COVID. We have to
38 really change the way we think about things and the way we
39 conceptualise how healthcare is delivered in order to move
40 with the times and with the needs of our workforce.

41
42 If you just look at the number of vacancies in
43 healthcare positions across New South Wales, the numbers
44 speak for themselves. We're not attractive, but we have to
45 ask the "Why?", and we have to do something to retain that
46 workforce. You imagine the cost of training just one of
47 those individuals, just one, in a graduate degree now. So

1 they have gone through an undergraduate degree and then
2 they have gone through a post-graduate degree in order to
3 get through medicine or nursing, the cost of training that
4 one person, and then you can't create the conditions that
5 make them want to stay, there is certainly increasing
6 anecdotal evidence that many of our junior doctors are
7 wanting to take a gap year, a year out, because they are so
8 disappointed with the environments that it doesn't offer
9 them the flexibility or the choice. So we have to change
10 that. We have to evolve in order to give the workforce
11 sustainability and create the services that really deliver
12 health and healthcare more locally; not rely on transfer
13 out to metropolitan centres because, as you have heard,
14 that's challenging and it is not necessarily what the
15 community wants either. They want to be treated locally
16 and there is good evidence to show that they're not looking
17 for a metropolitan tertiary hospital on every doorstep.
18 That's not what they are looking for.

19
20 If you talk to rural communities, they just want that
21 core service, the basic things done well, and I don't think
22 that's a lot to ask. I think that is absolutely doable,
23 but we need to think outside of the box. We need to be
24 more innovative and more creative in the way that we
25 organise the workforce and the way that we develop
26 contracts, awards, determinations, to meet the present
27 needs; not the past.

28
29 MR MUSTON: Okay. I will move to another challenge that
30 I am pretty sure you did tell us about in Cooma which is
31 something, I think, described as a "capital deficit" and
32 that term doesn't give us much of a picture of what that
33 really is as a lived experience, but could you,
34 Ms Cawthorne, tell us a little bit about what "capital
35 deficit" means in the context of Cooma Hospital's
36 operations.

37
38 MS CAWTHORNE: So this is one of those conditions that we
39 learn to deal with on a daily basis that's another
40 competing demand on our clinical, and it is part of our
41 work around on a daily basis, and I am sure you saw, as you
42 walked into the building, the challenges of finding your
43 way around the building and the add-ons and the add-ons and
44 the add-ons. When I talk to that, I am referring to the
45 equipment that we are utilising. So, in particular, our
46 operating theatres, delays in essential upgrades or
47 essential repairs and maintenance of our equipment.

1
2 We had a delay of approximately two years for our
3 endoscopy upgrade. In that, that has left us with tens of
4 thousands of dollars of recommissioning fees, of getting
5 technicians, service technicians to come in after-hours or
6 paying our maintenance teams to come in and do workarounds
7 to make the equipment work. We are getting loan equipment.
8 So, we are spending so much more on just fixing broken
9 because there doesn't appear to be - and just to put it,
10 I am a site level manager so I am aware, through a very
11 small lens and I am sure there is a bigger picture, but
12 we're not getting the tools and the equipment we need to
13 function, and I am haemorrhaging money for loan equipment
14 and for repairs and maintenance that we don't seem to have
15 a budget for, and it seems to be across the district. So
16 repairs and maintenance, assets and backlogs of getting our
17 equipment fixed is, apart from our premium labour, I see as
18 a site level manager, one of our biggest frustrations as
19 clinicians on the floor. If you don't have the right tools
20 to do what you need and, you know, we have got a backlog -
21 and I can personally talk to my own computer, and I know it
22 is a very, very small item and in a non-clinical role, but
23 my role still has clinical implications, if I can't do what
24 I need to - I spend 40 minutes waiting for my computer to
25 start-up. There is a backlog to get these fixed. There is
26 a plan to get them fixed. They are not coming until
27 late September at this stage is my understanding, but the
28 clinicians in ED are doing the same. So, repairs and
29 maintenance and assets, we need to have a really robust
30 dedication to actually having a funding pocket for this so
31 that we can actually get what we need to do the basic
32 things that we need to do on a daily basis. I think
33 that --

34
35 THE COMMISSIONER: Can you just help me with some of that?
36 Essential upgrades to equipment, now, should I understand
37 that to mean we need an essential upgrade? Does that mean
38 we need to replace - first of all, replace some of what we
39 have with new?

40
41 MS CAWTHORNE: Yes, absolutely.

42
43 THE COMMISSIONER: And just pausing there, the old,
44 I perfectly understand what you are telling me about the
45 old equipment is seemingly regularly requiring maintenance
46 and repair.

47

1 MS CAWTHORNE: Yes.

2

3 THE COMMISSIONER: For which you say we don't have the
4 budget, but at the time that the equipment is still
5 functioning, is it still functional or is it so out of date
6 it is almost useless? What should I understand by
7 essential upgrades? Is it just the constant breaking down?

8

9 MS CAWTHORNE: Correct. And I had one of my colleagues on
10 Tuesday, when we spoke to you, talk to some endoscopy
11 equipment that is actually no longer - it is no longer --

12

13 THE COMMISSIONER: Yes.

14

15 MS CAWTHORNE: -- serviceable in the sense that we send it
16 back to technicians. It is over - it has expired its usage
17 time, essentially. However, it still functions with
18 repairs, so we send it off for repairing and we wait until
19 that time when they say, "It can no longer be repaired".
20 So, I had this with a drill just recently in theatres and
21 I had to buy brand new drills because we could no longer
22 service it any more.

23

24 THE COMMISSIONER: For me to understand that, because it
25 seems, as someone from outside the health system, quite
26 bizarre and a disconnect between the people, ie, the
27 clinicians that have to use the equipment and whoever is
28 making the decision about the money to replace it, there
29 seems to be this disconnect between the people with the
30 money, whoever they are, to pay for the replacement - and
31 tell me if I am wrong - seemingly have a view that it is
32 better to wait until the equipment is either unrepairable
33 or entirely obsolete, rather than paying to replace it,
34 even though by not paying to replace it, you're having to
35 pay all this money to constantly repair.

36

37 MS CAWTHORNE: So I can't talk to the decisions at a high
38 level, but certainly from a site level, it is --

39

40 THE COMMISSIONER: That's the site level that we're --

41

42 MS CAWTHORNE: -- it is escalated and their common theme
43 is we are triaging the small pocket of money that we have,
44 prioritising the replacement of essential equipment right
45 across our district, so --

46

47 THE COMMISSIONER: That seems like some sort of

1 communication failure to the people that provide the funds
2 because surely no-one, if they looked at a set of numbers
3 and went, "It is costing us more to repair this stuff than
4 it is to actually replace it", they would make the logical
5 decision to replace.
6
7 MS CAWTHORNE: It certainly feels that way on the floor.
8 I can't talk to it from a higher level. I think that sits,
9 yeah, much higher.
10
11 THE COMMISSIONER: Thank you.
12
13 MR MUSTON: From the perspective of the floor, though,
14 you're confident that that particular challenge, namely,
15 the equipment that's either not functional in a way that it
16 should be for clinical reasons --
17
18 MS CAWTHORNE: Yeah.
19
20 MR MUSTON: -- and, more importantly, not functional in a
21 way that means it is costing more money to - well, costing
22 you large amounts of money to repair and maintain is
23 something which is being communicated to the local health
24 district?
25
26 MS CAWTHORNE: Yes.
27
28 MR MUSTON: By you?
29
30 MS CAWTHORNE: Yes.
31
32 THE COMMISSIONER: Sorry, can I just ask about the
33 40 minutes for a computer to start. First of all, do
34 I understand that you push the button to turn it on and it
35 takes 40 minutes before it is usable?
36
37 MS CAWTHORNE: Correct.
38
39 THE COMMISSIONER: How long has that been the state of
40 affairs?
41
42 MS CAWTHORNE: So, I logged a job through our portal
43 in November, approximate - it was late November,
44 early December. I went on leave for two months.
45
46 THE COMMISSIONER: 2023?
47

1 MS CAWTHORNE: Twenty - yeah, last year, and it was
2 replaced at the end of February, or just after I returned
3 from leave.
4
5 THE COMMISSIONER: And are all the computers currently in
6 a state where it takes 40 minutes?
7
8 MS CAWTHORNE: Not all --
9
10 THE COMMISSIONER: Not all of them.
11
12 MS CAWTHORNE: -- but we do have a number across the site.
13
14 THE COMMISSIONER: And the computers, I assume, are used
15 to record patient data, treatment, that sort of thing?
16
17 MS CAWTHORNE: Yes. Mine is administrative but I have two
18 in ED at the moment that are due to be replaced
19 in September.
20
21 THE COMMISSIONER: But you will get new ones in September.
22
23 MS CAWTHORNE: Yes.
24
25 THE COMMISSIONER: Which presumably will take less than
26 40 minutes to power up, correct?
27
28 MS CAWTHORNE: Yep.
29
30 THE COMMISSIONER: When you do get new ones, they turn on
31 fairly properly, do they?
32
33 MS CAWTHORNE: Yes.
34
35 THE COMMISSIONER: Okay. Good.
36
37 DR AYERS: We are so reliant on computers. I am sure you
38 know --
39
40 THE COMMISSIONER: Yes, it was explained.
41
42 DR AYERS: Yes, that everything was taken off paper because
43 doctors and nurses, but mainly doctors, have bad
44 handwriting.
45
46 THE COMMISSIONER: Really.
47

1 DR AYERS: For the sake of legibility and safety.
2
3 THE COMMISSIONER: Well, there are all sorts of good
4 reasons to digitise because you can send information.
5
6 DR AYERS: Absolutely. But they are essential, but
7 I would say it is not unique to our LHD. This is the
8 fourth LHD I have worked in in New South Wales and I guess
9 ICT is an interesting beast, isn't it, because it is often
10 delivered as a project, but a project has a finite lifespan
11 and so how do you appropriately cost for the depreciation
12 and the wear and, I guess, the way that equipment becomes
13 obsolete. So if you introduce, let's say, brand new
14 hospital, you suddenly buy all the equipment all at once,
15 doesn't it therefore suggest that all your computers might
16 reach the end of its life at roughly the same time? So
17 then short funding cycles are not helpful.
18
19 THE COMMISSIONER: Yes.
20
21 DR AYERS: There needs to be short, medium and long term
22 thinking around this.
23
24 THE COMMISSIONER: You are talking about the 12-month
25 budgetary cycle there.
26
27 DR AYERS: Yes.
28
29 THE COMMISSIONER: Which, no doubt, somewhere there is a
30 component for buying computers that turn on more quickly
31 than 40 minutes.
32
33 DR AYERS: But it's on average, right? So it is thinking
34 about an average of, let's say, one - I'll use this just as
35 an example, it is not a real example, but let's say one of
36 your 200 computers failing every year, let's say, but
37 that's not the reality because if you purchased all 200
38 computers at the same time, at the beginning of your ICT
39 project, doesn't it then logically follow that they might
40 fail, or reach the end of their lifespan at roughly a
41 similar time --
42
43 THE COMMISSIONER: Well --
44
45 DR AYERS: -- which then doesn't fit in nicely to that
46 12-month budgetary cycle.
47

1 THE COMMISSIONER: I don't think that should be either of
2 your responsibility. Working out the algorithm for
3 replacing computers isn't my responsibility either.

4
5 DR AYERS: No.

6
7 THE COMMISSIONER: But it does seem odd that if a computer
8 is taking 40 minutes, in a health system, to power up why
9 it is not replaced immediately, but maybe there is a really
10 good reason for that that I don't know about.

11
12 MR MUSTON: A logical reason might be building a hospital
13 and budgeting for the staff that will be needed to operate
14 it.

15
16 THE COMMISSIONER: Sure.

17
18 MS CAWTHORNE: This is the same as the redevelopment works
19 at Cooma that have taken several years to deliver. You
20 know, we have been working in environments that have been
21 very challenging and, you know, you get a pocket of money
22 to build - and, again, I am speaking from a lens that's at
23 a site level, but we are trying to build and maximise what
24 we can with a pocket of money that is not enough to do what
25 we need and when you open that can of worms of building old
26 on to new, then we are left to pick up the pieces.

27
28 Just this week I am trying to work out how to get
29 coverings for the doors from a Health Infrastructure build
30 that's gone into our industry, and I am extremely grateful
31 for the moneys that has come to us, but don't start
32 something unless you have got the right money to do the
33 whole job. Because now we have these leftovers that's now
34 for the site, or the district, to now try and find a pocket
35 of money to fix. I am trying to get an awning for my door.
36 It is a main entrance into the building that - you know,
37 I am putting mats out, I am improvising. You know, I've
38 got --

39
40 MR MUSTON: This is in a town where it sometimes snows?

41
42 MS CAWTHORNE: Correct, and, in fairness, it doesn't rain
43 a lot. So you have also got an area that's got duress -
44 and I talked to you about our duress tags on Tuesday. So
45 I have old infrastructure --

46
47 THE COMMISSIONER: That was where the duress tag, the

1 staff member is - wherever they are --

2

3 MS CAWTHORNE: It's on level B.

4

5 THE COMMISSIONER: -- and they are on the floor above?

6

7 MS CAWTHORNE: Correct. Yes. So that's due to be fixed
8 but it wasn't budgeted as part of the original because you
9 have old on new and, neither the twain shall meet. So,
10 again, it is another challenge that has been left to rural
11 staff to do a work around. And let me tell you we're
12 performing, we're doing what we need to do. We are
13 delivering the care, we are doing what we need to; it is
14 coming at a cost.

15

16 MR MUSTON: Just so I can understand that, that little
17 example you have given about the emergency or the distress
18 tags, the duress alarms, I should say, that, I think you
19 told us, related to the fact that the Wi-Fi access points
20 that were installed as part of the new build didn't
21 necessarily talk to the Wi-Fi access points which were
22 pre-existing in part of the old build, such that the duress
23 alarms --

24

25 MS CAWTHORNE: So it is two systems is what I have been
26 told. I am a mere mortal clinician, so I won't even delve
27 too much into the ICT, but I have been told it is two
28 systems and it needs to be made into one. There just needs
29 to be money to do that.

30

31 THE COMMISSIONER: There is always teething problems.
32 I mean it showed up --

33

34 MS CAWTHORNE: I think we've had more than our fair share.

35

36 MR MUSTON: Do you remember if the rebuild process at
37 Cooma, such as it is, the sort of technicians who are no
38 doubt having to be brought in to upgrade or consolidate the
39 two systems, were they the same sort of technicians who
40 were on-site installing the new Wi-Fi access points in the
41 new part of the build, do you know?

42

43 MS CAWTHORNE: I don't know in that space, yeah.

44

45 DR AYERS: It all goes back to the bucket of money that
46 you're given and, if you like, under-estimation of what we
47 do and how much funding that requires. So if you have got

1 a limited bucket of money and you've got all these upgrades
2 that you have to do, going back to the computer one, and
3 you have to choose, and you know, for example, that ICU
4 needs a new ventilator versus the laptop that takes
5 40 minutes to boot up, what would you choose? Of course
6 you are going to update the ventilator, but you are having
7 to make that choice because the bucket of money is too
8 small.

9
10 And there's not a, if you like, not a sophisticated
11 enough understanding of the amount of funding that a rural
12 health service actually requires, because if you only look
13 at historical demand, there are so many other things that
14 you are not factoring in, as Jo was describing. You're not
15 necessarily understanding - if you are only looking at
16 averages, you're not understanding the fluctuations that
17 can happen between seasons. You're not understanding the
18 fact that there may be a new housing estate springing up on
19 the edge of town and therefore suddenly increasing demand.
20 You're not, maybe, factoring in the fact that you have lost
21 the GPs in your local community, so suddenly there's a much
22 greater demand on acute healthcare because people have to
23 seek healthcare somewhere, and if the GPs are no longer in
24 town, where else are they going to go? So then you can't
25 necessarily predict that or model that if you don't have
26 that granular detail.

27
28 MS CAWTHORNE: Just on that, though, we have got the
29 special activation precinct that is coming in for Jindabyne
30 and the surrounding Snowy Mountains. So it is being looked
31 at. They are expecting that we are going to be growing.
32 They are expecting that they are going to be attracting
33 tourism to our region for their outdoor activities. We
34 need to plan for that.

35
36 DR AYERS: But if you are just adding incrementally from
37 historical numbers and historical demand and not even
38 factoring unmet demand, never mind growth, how is that
39 equation ever going to come out equal? You somehow have to
40 go back to looking at the real need in that community and
41 understanding that at a much greater detail.

42
43 THE COMMISSIONER: The real need and the real cost.

44
45 DR AYERS: And then working out, yes --

46
47 MR MUSTON: The real need --

1
2 DR AYERS: -- accurately the costs of carrying out care in
3 that setting

4
5 MR MUSTON: And the real need in the community, I gather
6 from some of the answers you've just given, is a dynamic
7 thing?

8
9 DR AYERS: Absolutely. And therefore, your historical
10 projections may not tell you what is going to happen
11 tomorrow. And that's then the lived experience that the
12 teams have at each site, where they are saying, "Well, hang
13 on, we admitted 10 people overnight. Who could have
14 predicted that?" That's how it translates into a real life
15 example.

16
17 MR MUSTON: Just on that, can I ask you, Ms Cawthorne,
18 what is your lived experience of the impact of our Snowy
19 Hydro 2.0 in a broad sense - not only patient flow, but in
20 a broad sense on your ability to deliver workforce and
21 deliver care through that workforce to the people who are
22 needing it?

23
24 MS CAWTHORNE: Yep. So lived experience, most definitely
25 probably the greatest impact for us has been our staff
26 being able to get affordable accommodation. The site, the
27 hospital, has rented homes so we can actually bring staff
28 in and put them into accommodation. I personally have been
29 to real estates to find homes for people, to say, "Can you
30 please prioritise my team," which they've been very good at
31 trying to accommodate, but there is increasing costs that
32 come with that.

33
34 And child-care. So I have a workforce that are
35 remaining casual, or they have very limited availabilities
36 to their shifts, and this is where it is challenging with
37 shift workers in particular for our site, certainly getting
38 managers into positions as well, because they can't get out
39 of school care. They can't get day-care. I personally,
40 I have a one-year-old. It took us nearly six months of
41 being on a waiting list to know whether we were going to be
42 able to come back to work. My partner is also in nursing,
43 and for - it was going to be which one is going to stay
44 home, is that's where we're at, and the Snowy project,
45 and - certainly not to blame, but the town dynamics have
46 changed, and getting into day-care, you could do very, very
47 easily. But to wait months is ridiculous, and I think

1 that's probably the greatest impact I have had, and to
2 cover our shifts, I have got a nurse that says, "Yes, I can
3 probably do some night shifts." She picks up at least six
4 shifts as a casual and then she cancels them because it -
5 they can't give me.
6

7 THE COMMISSIONER: You told us at the round table,
8 I think, that in terms of extra demand on the hospital
9 services, you said - I think you said the corporates are
10 actually looked after by Snowy --
11

12 MS CAWTHORNE: Yeah.
13

14 THE COMMISSIONER: -- but the rest of the workforce, it's
15 New South Wales?
16

17 MS CAWTHORNE: Yes, so we've got the local population
18 growth that has occurred and I have seen over the last
19 three years, looking at the data, we've had over 400
20 Medicare ineligibles that are now coming through. So
21 whilst that is factored in to our administration, we've got
22 after-hours admin that's come on shift now to try and
23 capture that. We could lose up to, you know, thousands of
24 dollars if we don't capture these Medicare-ineligible
25 consumers coming through. It is having an impact, and it's
26 not a lot, but it's enough. And it's coming through our
27 maternity department more so than most of them, because
28 they have come to the community, they're actually - they're
29 within their 12 months of having their private health, so
30 they're now being charged full fees. It is a change in
31 dynamics for us but I need the admin staff to support that
32 change that's occurring for the site.
33

34 So, yes, we have our revenue team, they can send out
35 their invoicings, but there is a local amount of invoicing
36 and chasing that occurs as well. So it is a change in our
37 dynamics, and we have actually put on - I think, yeah, it
38 was over 400 in the last two years that we have had come
39 through from the Snowy. And looking at the data, the
40 majority of them are 2630 post code, so the Cooma post
41 code. So they are local. This is not overseas or
42 travelling people. So yeah, it most definitely has had a
43 change to how we function.
44

45 MR MUSTON: Last question. You mentioned in an earlier
46 answer some of the particular challenges that you faced
47 just in a practical and logistical sense arising out of the

1 facility prior to it being rebuilt or partly rebuilt.

2

3 MS CAWTHORNE: Yeah.

4

5 MR MUSTON: And then during the rebuild. Just so we can
6 understand what those challenges look like from a
7 day-to-day perspective, what sort of figure are we talking
8 about?

9

10 MS CAWTHORNE: So we were referring to COVID? Was that
11 our conversation with COVID --

12

13 MR MUSTON: That conversation.

14

15 MS CAWTHORNE: -- and getting quite - so during COVID,
16 Cooma Hospital ran a tent in the carpark to accommodate for
17 the changing epidemic. I know the whole country, the whole
18 world, was in a moving feast at the time to try and
19 accommodate people and work in isolation. We don't have
20 negative-pressured rooms. We have a nine-day emergency
21 department, as you would have seen. It is very close
22 proximity, and the bays are extremely small.

23

24 MR MUSTON: This is post-upgrade?

25

26 MS CAWTHORNE: This is post-upgrade. However, we were
27 working between a redevelopment where we had an old build
28 and a new build. We had a temporary ED and we had a tent.
29 So we were working in a tent to keep people isolated and
30 keep them segregated, so we - that was all we had to - that
31 shows you that rural is very good at being crafty and
32 making do. As the pandemic and our understanding of the
33 transmission of COVID changed, we were able to co-locate
34 them in a department. However, that's not the gold
35 standard. It's enough. It's enough to get by, is what we
36 need to do.

37

38 But, you know, we are co-locating all of our
39 respiratory patients on a general ward, and we can put them
40 in single rooms, but they have got shared air-conditioning.
41 That's the state of rural, and it is something we have to
42 accept. It's certainly, from an on-the-ground managing
43 staff perspective and their concern for their consumers
44 working in an environment that was challenging and not
45 meeting what was delivered as an infection control best
46 practice, but there was, "If you have this available, then
47 this is acceptable." We were at the "this is acceptable"

1 stage.

2

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

5

6 THE COMMISSIONER: Just before I invite Mr Chiu as to
7 whether he has any questions, as with the four doctors on
8 the previous panel, I don't want either of you to leave
9 here without - if you feel as though there is something
10 critical that you haven't had an opportunity to say, so if
11 there is something critical further you would like to say,
12 please go ahead. I will start with you first, Dr Ayers.
13 Is there something you didn't feel as though - that you
14 wanted to raise, that you didn't get the chance to?

15

16 DR AYERS: I think for our district, certainly, and our
17 situation with having two borders, I think I would love to
18 see a situation where we can really have New South Wales
19 rural trainees training with us and that we're not just
20 training ACT students and ACT doctors. I love the fact
21 that we do have this close relationship with the ACT
22 because, as you can appreciate, they are our referral
23 partner, they're the closest tertiary referral centre to
24 us. And those relationships and those working
25 relationships are really important to us. But I would
26 still love to see us grow our own rural workforce. And
27 there are examples of that elsewhere, you know, so
28 Albury-Wodonga achieves that very effectively. There is no
29 reason why we can't do the same and have a blend of ACT and
30 New South Wales trainees working together.

31

32 I would love to see that happen, but I would also love
33 to see us growing our First Nations workforce in a much
34 more intentional way, and be supported in that with the
35 right funding. It would be a win/win for our rural region
36 to be able to create that workforce that will help us
37 deliver the kinds of models of care that really have
38 cultural meaning and cultural safety for our First Nations
39 peoples, and it is something that I am really passionate
40 about after having worked in both the Northern Territory
41 and in WA in remote places. I would love to see that a
42 reality in my career lifetime.

43

44 THE COMMISSIONER: Thank you. Ms Cawthorne, is there
45 anything further?

46

47 MS CAWTHORNE: Just from my perspective, I think one key

1 point that I did actually bring up on Tuesday was the size
2 of our site and what we actually see through Cooma. Our
3 inpatient unit, what we admit, our emergency department,
4 what we see, you know, and I think the key takeaway point
5 we are too big to be little, we are too little to be big.
6 We are stuck in the middle, but we are expected to perform.

7
8 We aren't funded appropriately. Just because they
9 have "RN" after their name or "Dr" in front of their name,
10 they need to be the right skill set. They need to be
11 supported in an education program that's not just a
12 site-led, "You have got your advanced life support." We
13 need to look at what a training program looks like for
14 rural specialty, rural nurses, allied health professionals
15 working in rural. They need to be professionally
16 recognised for that, make it attractive, make it why they
17 need to come to rural. So professionally recognised,
18 financially recognised. Make sure that we can actually
19 keep these people with us in rural.
20

21 Not everybody needs to have the same remuneration. If
22 you're in metro, that's fine you choose to be in metro. If
23 you are in rural, we are special, we have a special skill
24 set, and we need to stop putting metro models into rural.
25 We need to start seeing rural as its own specialty and
26 recognise that. We need to fund it for what it is. We are
27 not metro, and health is not health in metro health is not
28 health. In rural, we are completely separate entities. If
29 we are having low numbers coming through our community
30 nursing department, we get a very small pocket of money to
31 get the right equipment, the right procurement to deliver
32 chronic and complex care for these consumers. Instead,
33 we're putting very basic dressings on because we don't have
34 the money to be able to do what we need to, and it is
35 costing us more, and that's the same with our assets. So
36 please could we have a look at what it is that needs to
37 drive rural. Our current funding model doesn't work for
38 us. I also don't want a block of money and say, "Just go
39 forth and do it." We need to have a look at what it is
40 that we need to do, but it will cost you more because of
41 where we are and what we need to drive that.
42

43 THE COMMISSIONER: Sorry to ask you the question, but I am
44 not a clinician so I tell you, when you use the term like
45 "very basic dressings" and leave me with the impression
46 that there is something more appropriate that should be
47 used if you had it --

1
2 MS CAWTHORNE: Yes.

3
4 THE COMMISSIONER: -- (a) is that basic understanding
5 right, and (b) can you give me a little bit more precision
6 about what you mean?

7
8 MS CAWTHORNE: So in regards to some of our chronic and
9 complex wound care, the dressings will cost hundreds. And
10 that one dressing, for instance, could remain with that
11 consumer for a week, and that provides best care. But,
12 instead, we're not buying that because we could be limited
13 to a \$1,000 budget. And I don't like to get down to the
14 detail, because I was trying not to do that too much today,
15 but, you know, if you have a budget of \$1,000 to actually
16 run your community nursing and I'm going to spend \$250 on
17 one person's dressing, I'm going to not give best outcomes
18 for everybody else, so I'm going to make do with what I've
19 got. And it takes longer to heal if you don't use the
20 right stuff.

21
22 THE COMMISSIONER: That was my next question. Is there --

23
24 MS CAWTHORNE: It is a bit like the assets. If you don't
25 spend the money, it costs you more in the long run.

26
27 THE COMMISSIONER: Should I understand that to mean
28 that --

29
30 DR AYERS: We don't have the purchasing power.

31
32 THE COMMISSIONER: I mean, when you are using an
33 expression like "it will take longer to heal", are the
34 basic dressings that you have to buy because of the budget
35 adequate in terms of the healthcare needs or are they less
36 than that?

37
38 MS CAWTHORNE: They would be less than that, and I feel
39 very comfortable in saying that, because you --

40
41 THE COMMISSIONER: These are dressings for what kind of
42 wound?

43
44 MS CAWTHORNE: Chronic and complex. So chronic leg
45 ulcers. So my wound care CNC, I am sure she is watching,
46 she has a skill set. She knows what she needs to do to do
47 the job. We don't have the buy-in or the procurement cost

1 to be able to deliver the care that we need.

2

3 DR AYERS: Because it is activity-based funding. So we
4 can't - if you like, we can't purchase in huge numbers
5 because we won't get the input in terms of patient numbers.
6 So if it comes in a box of 500, let's say, and you only use
7 10, so --

8

9 THE COMMISSIONER: I mean, don't take this as a criticism,
10 but I don't view that as - maybe it has got something to do
11 with activity-based funding, but in the end it is a
12 decision being made as to your budget.

13

14 DR AYERS: Yes.

15

16 THE COMMISSIONER: And it leaves you with less than
17 optimal options in terms of the dressings you can buy.
18 That's how I should understand it, right?

19

20 MS CAWTHORNE: Yes.

21

22 THE COMMISSIONER: Sorry, I cut you off. You finish.

23

24 DR AYERS: Yes. Look, I think clinicians who are working
25 in the rural space just feel that, certainly in all the
26 conversations I have, we feel that the rural health system
27 is disadvantaged compared to our metropolitan neighbours,
28 because they can get the throughputs, they can get the
29 numbers, and so therefore their activity is much, much
30 larger. We'll never be able to compete in terms of
31 activity.

32

33 THE COMMISSIONER: No, of course not.

34

35 DR AYERS: And so we all feel that something structurally
36 needs to happen for us to be able to feel that rural is
37 being treated equitably. It is about that equity of
38 healthcare access services, resources.

39

40 THE COMMISSIONER: That's not just clinicians and the
41 workforce being treated equitably?

42

43 DR AYERS: Absolutely.

44

45 THE COMMISSIONER: That's the patients as well --

46

47 DR AYERS: Absolutely. The whole thing.

1
2 THE COMMISSIONER: -- in terms of the issue you just
3 raised.

4
5 DR AYERS: Yeah, the whole thing. So not just talking
6 about clinicians but talking about the wider system. We're
7 looking for change because we feel very strongly that the
8 current system advantages the metropolitan centres because
9 the activity-based counting and payments are therefore
10 driving you to see more, do more. But we've only got
11 limited number in our community, so what more can we do?
12 As Jo said, for example, the 150 births a year, you know,
13 there are only so many people out there that we serve in
14 our communities, but it doesn't mean that they don't
15 deserve as good care, and it doesn't mean that they don't
16 deserve as good care as local to them as, you know, they
17 would want. They are always going to accept that they need
18 to do some form of travelling.

19
20 THE COMMISSIONER: Yes.

21
22 DR AYERS: I mean, rural people are very resilient and
23 robust when it comes to that. We understand. But have to
24 travel all the way into a capital city, to say that our
25 referral centre is, let's say, Sydney, or even Canberra for
26 some of our most southern patients and communities, that's
27 hard. That could be a mother and child separated from the
28 rest of their family for extended periods of time,
29 receiving treatment. I think we can do better. I really
30 do. And I think that there's more that the structures that
31 are outside of our control could do to help us and assist
32 us. Like HETI, like the training colleges, like our, you
33 know, nursing and medical structures that, if you like,
34 grants those expertise labels that give people the sense
35 that they have achieved expertise. There's more that the
36 specialist colleges certainly could do to recognise rural
37 work as being its own entity and own thing, and the value
38 in spending time in rural.

39
40 THE COMMISSIONER: I will ask you first. Did anything
41 flow? Nothing? Nothing further from you? Mr Chiu, do you
42 have any questions?

43
44 MR CHIU: Nothing.

45
46 THE COMMISSIONER: Thank you both very much for coming.
47 We are grateful for your time, and you are excused.

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MS CAWTHORNE: No, thank you.

DR AYERS: Thank you so much. Thank you for this opportunity.

<THE WITNESSES WERE RELEASED

THE COMMISSIONER: Do we adjourn till - is it 9.30 again tomorrow? Is it 10 tomorrow? That will be fine, despite the fact we have limited time after? All right. If everyone is in agreement, I will adjourn until 10 tomorrow. Adjourn till then.

THE HEARING WAS ADJOURNED TO 10AM ON FRIDAY, 16 AUGUST 2024

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