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

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

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

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

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

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

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

Walawaani: [Yidaki played].

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: And your age, probably.

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

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

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

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

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

<PRUDENCE BUIST, AFFIRMED [9.49 am]

<ANDREW GOW, AFFIRMED

<EXAMINATION BY MR GLOVER:

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

MS BUIST: Prudence Buist.

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

MS BUIST: Correct.

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

MS BUIST: I did.

MR GLOVER: For the purposes of the transcript, it's SCI.0011.0351.0001. Do you have a copy of it there with you?

MS BUIST: Indeed, I do.

MR GLOVER: And although you only signed it yesterday, have you read it again this morning?

MS BUIST: I have indeed.

MR GLOVER: And are you satisfied that it is true and correct to the best of your knowledge and belief?

MS BUIST: I do.

MR GLOVER: Mr Gow, if I turn to you, could you tell us your full name, please?

MR GOW: Yep, Andrew Gow.

MR GLOVER: And you are the director of strategy and performance of Coordinaire?

MR GOW: Yes.

MR GLOVER: And you have held that role since about July 2015?

MR GOW: Yes, that's right.

MR GLOVER: And you also have prepared a statement dated 14 August 2024. For the transcript, it is SCI.0011.0379.0001. And have you read your statement again this morning?

MR GOW: Yes, I have.

MR GLOVER: And although signed yesterday, you are still satisfied that it is true and correct?

MR GOW: I am, thanks.

MR GLOVER: Ms Buist, if I start with you and I take you to paragraph 5 of your statement, there you describe some features of the area that falls within your PHN's footprint. You have heard Mr Muston describe some of the

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

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

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

MS BUIST: Of course.

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

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

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

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

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

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

MS BUIST: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

insightful information on local needs and requirements.

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

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

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

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

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

MR GOW: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS BUIST: Yes.

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

longer period than is currently available?

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

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

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

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

MS BUIST: Its needs analysis work?

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

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

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

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

MR GOW: Yes, that's right.

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

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

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

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

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

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

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

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

MS BUIST: Yes.

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

MS BUIST: Correct.

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

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

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

MS BUIST: Yes.

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

MS BUIST: Yes.

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

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

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

MS BUIST: Yes.

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

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

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

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

MS BUIST: Yes.

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

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

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

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

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

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

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

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

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

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

MS BUIST: I think one of the --

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

MR GOW: Yes, that's right.

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

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

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

MS BUIST: Yes.

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

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

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

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

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

MS BUIST: Yeah.

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

MR GLOVER: Yes.

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

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

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

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

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

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

MR GLOVER: But only to a certain level?

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

MR GLOVER: So it's not a substitute for an emergency department?

MS BUIST: No, absolutely not. So I suppose the point is to try and remove a lot of the stress on the current EDs. I certainly know there is a significant delay to attend most of the EDs in the region. The urgent care services are there to take the minor cases that are fast throughput, that quite often sit in the EDs for a significant period of time, but also a number of the cases potentially could be seen by general practitioners because they don't have X-ray facilities or suturing or, you know, cast facilities.

MR GLOVER: So it sits in between a GP practice and an ED --

MS BUIST: Yes, so they take those.

MR GLOVER: -- to take those lower acuity patients, is that fair?

MS BUIST: It complements things, yes.

MR GLOVER: Yes. And in that sense, it is not a substitute for primary care?

MS BUIST: No, it certainly isn't a substitute. Certainly in the Batemans Bay region where we have opened the urgent care service, we've got two new doctors that have moved to the region. Since it opened on 4 December, I think they have seen 6,900 patients, so an average of 29 patients a day. One of their busiest days was New Year's Eve, where they saw 61 patients, and the Batemans Bay/Moruya area there is commonly a six-week wait, and I think in the last couple of days I drew your attention to a six-week --

THE COMMISSIONER: A six-week wait to see a GP?

MS BUIST: Yes. I think I drew your attention to the fact that one of the Moruya general practices, when I met with one of the principals, had said that three of his lead GPs had actually gone on maternity leave and they weren't able to backfill them, so that just compounds the issue.

THE COMMISSIONER: What is the staffing level at the clinics? Is it two doctors?

MS BUIST: No. So we get funding component which allows for one GP and one nurse, two working per shift.

THE COMMISSIONER: They are employed?

MS BUIST: Yeah, they are employed. In the local example, I think we've had Malaysia and the UK where the doctors have come. They'll work 12-hour shifts, so 8 till 8. The new request is so that we're actually increasing the hours till 10 o'clock, which is actually going to make it very, very difficult to schedule shifts for nurses and doctors to cover that --

THE COMMISSIONER: Sorry, I thought the urgent care was open from 8 to 6 pm.

MS BUIST: It's 8 to 8, and then by June next year we've got to go 8 till 10.

THE COMMISSIONER: Right. And that is one doctor?

MS BUIST: One employed doctor. Yes, absolutely.

THE COMMISSIONER: Full-time, obviously?

MS BUIST: Full-time, yes.

THE COMMISSIONER: And seven days a week, they don't get a day off, is that?

MS BUIST: That's why you have got two doctors.

THE COMMISSIONER: There's two doctors?

MS BUIST: They have two employed doctors, and they work 12-hour shifts.

THE COMMISSIONER: Got it, yep.

MS BUIST: And then they do use other locums and things, should they - you know, people go on leave or if there is illness and what have you. So I suppose that is certainly one of the things that, you know, during periods of flux in Batemans Bay, when we've got a significant amount of people, we probably need to increase those services, you know, to make sure that we've got the right care and people

don't have to wait like an ED.

MR GLOVER: And I think you said from June next year, it will go 8 till 10?

MS BUIST: Yes.

MR GLOVER: And is it currently 8 to 8 or 8 to 6?

MS BUIST: 8 to 8.

MR GLOVER: Was the PHN involved in designing the service?

MS BUIST: Yes. So we've got to - just to highlight that in the region, we've got five current urgent care centres, and we've got another one - sorry, urgent care and urgent care services. So the urgent care services are State funded, and then we have got the Commonwealth funded. So in my --

MR GLOVER: Is there a difference?

MS BUIST: Yes, through is.

MR GLOVER: What is it?

MS BUIST: So if I run you through the regions, so we've just opened urgent care service in Queanbeyan, we have got an urgent care service which is also the Commonwealth one in Batemans Bay. In Goulburn we just opened an urgent care service which is State funded. We have got an attendant urgent care service in Nowra. We've got --

THE COMMISSIONER: If the word "service" is used, does it means it is New South Wales, and if it is "clinic", it is Commonwealth; is that right?

MS BUIST: Yes. And then in the Wollongong region is where it gets really complex, because we have the LHD funded Bulli service. We opened the Commonwealth urgent care service in Corrimal and then Dapto when we opened it initially was a state-based one. So we had three very close in proximity services which have slightly different models. They are urgent care in that they see the same categories of patients, but with the State-funded services, what the patients are intended to do is to ring Health Direct and be triaged by a nurse and then have an

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

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

MS BUIST: Yes.

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

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

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

MS BUIST: Yes.

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

MS BUIST: Yes, so --

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

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

direct approach for a corporate service, and then we've - I got permission --

THE COMMISSIONER: Just so I understand it, the tender is addressed to what people?

MS BUIST: The general practitioners, AMSs.

THE COMMISSIONER: This is GPs, to set it up?

MS BUIST: Yes, an urgent care service. There were quite specific requirements in that --

THE COMMISSIONER: You just said "service". Is it a clinic or a service? Is this Commonwealth?

MS BUIST: Sorry, this is a centre.

THE COMMISSIONER: Yeah, so it's Commonwealth?

MS BUIST: Commonwealth.

THE COMMISSIONER: Yeah.

MS BUIST: Sorry, it's very confusing.

THE COMMISSIONER: No, that's - you didn't make this up, so - yeah. Can I just ask you on this, Mr Glover just took you to paragraph 28. Can I just ask you about paragraph 27, where you have raised the petition with 18,000 signatures, people opposed to the closing of the emergency department at Batemans Bay Hospital.

MS BUIST: Yes.

THE COMMISSIONER: That sort of numbers tells me at least, prima facie, if I use the term "social licence", it's not statutory and it's probably not a Commonwealth concept, but that seems to indicate to me, prima facie, that the community haven't completely accepted that it is a good idea for the ED to close, even with some other clinic or centre --

MS BUIST: Yes.

THE COMMISSIONER: -- urgent care centre, replacing it, and tells me that there still exists a real problem of

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

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

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

MS BUIST: Yes.

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

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

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

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

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

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

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

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

MS BUIST: Yes.

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

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

THE COMMISSIONER: Sure.

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

MS BUIST: In terms of for?

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

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

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

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

MS BUIST: Look, I mean, if --

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

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

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

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

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

MS BUIST: Yes.

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

MR GLOVER: Absolutely.

THE COMMISSIONER: Yes, okay.

MR GLOVER: Mr Gow, do you agree with that?

MR GOW: Absolutely, I agree with that.

MR GLOVER: Ms Buist, in answer to one of the Commissioner's questions, you referred to a proposal to, perhaps, alter some of the services out of the centre that will be here in Batemans Bay.

MS BUIST: Yes.

MR GLOVER: You tell us about that in paragraph 30 of your statement.

MS BUIST: Yes.

MR GLOVER: That would involve it being a 24-hour model, correct?

MS BUIST: Yes.

MR GLOVER: And being able to accept a higher acuity of patient?

MS BUIST: Yes.

MR GLOVER: Where is that process up to?

MS BUIST: So I have delivered the proposal to both State and federal governments and have worked with all of the local members of parliament, and I understand there are discussions being made at both State and federal level with the health ministers.

MR GLOVER: And in paragraph 33, you tell us that, in your view, if the expanded clinic centre is not implemented, once the ED closes the overall effectiveness of the Batemans Bay urgent care centre will not be realised. Why do you say that?

MS BUIST: Just because it is only opened for a short amount of time and we've got limited resources, ie, one doctor and one nurse.

THE COMMISSIONER: Can I just ask you, at paragraph 32, you said there is a formal protocol in place that allows

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

MS BUIST: Yes.

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

MS BUIST: Yes.

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

MS BUIST: I'm not aware about that.

THE COMMISSIONER: Do you know, Mr Gow?

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

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

MS BUIST: Yes.

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

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

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

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

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

THE COMMISSIONER: That is a shorter trip.

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

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

MS BUIST: Absolutely.

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

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

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

service would be run from a State service.

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

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

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

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

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

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

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

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

MR GLOVER: Yes, please.

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

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

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

MR GOW: Yes, that's right.

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

MS BUIST: Yes.

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

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

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

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

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

MS BUIST: Sure.

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

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

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

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

MS BUIST: Absolutely.

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

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

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

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

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

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

MR GLOVER: Does the framework that you are establishing

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

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

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

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

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

MS BUIST: Absolutely. So there is an integration.

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

MS BUIST: Yes.

MR GOW: Yes.

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

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

MS BUIST: Thank you very much.

MR GOW: Thank you.

<WITNESSES RELEASED

MR GLOVER: The next witness is Jennifer Gordon.

<JENNIFER GORDON, AFFIRMED [12.18 pm]

<EXAMINATION BY MR GLOVER

MR GLOVER: Would you tell us your full name, please?
A. My name is Jennifer Jean Gordon.

Q. And you are the project manager of the SE NSW Regional Training Hub?
A. That's right.

Q. And that is operated out of the School of Medicine & Psychology Rural Clinical School of the ANU?
A. You've got it.

Q. You are also a board member of this local health district where we sit today?
A. I am a board member, yes.

Q. You have been a board member since the beginning of last year; is that right?
A. Yes.

Q. To assist the commission in its work, you made a statement dated 12 August?
A. I did.

Q. And you have it there with you, do you?
A. I do.

Q. And you are satisfied that its contents are true and correct?
A. I am.

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

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

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

Q. It is very descriptive.
A. Yes. So we don't have an awful lot of money, but we do join up parts of the pathway, particularly for medical training, and to identify gaps and do gap analysis around the workforce for training positions in hospital and the health sector for the medical workforce.

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

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

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

Q. With a view to encouraging them to return to Aboriginal rural locations?
A. Absolutely. I had a young man contact me this week

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

Q. How long have you been in that role?
A. I've been in it now for just over five years.

Q. Do you have a sense of its success in luring those students back to rural and regional areas?
A. I do have a sense of success, but an absolute sense of frustration as well.

Q. We will start with the success and then I will come to the frustration. We will start with the good bit first?
A. Okay. All right. So I think Coordinaire just spoke about the young people who have actually come into the single employer pathway, and those young people have actually come through this system. So Steph is, you know, one of our graduates who is - and in my discussions with Steph, we actually mapped out how she would get from where she was to complete PGY1 and 2 and then get into her rural generalism pathway, which she is currently doing.

Q. Pausing there, do you see the single employer model as being helpful in facilitating that type of engagement and retention?
A. Absolutely. Absolutely. Young people are not the same, have been raised very differently to our older generations of GPs. So they don't use the language of "GP" anymore, they use the rural generalism. They want to be rural generalists, ie, a GP who actually has specific ASTs, and with those advance skills, they can actually practice into hospitals. They also want to have a lifestyle. They want to have all of the benefits that you can actually have as a public sector employee through the health system, but they also want to be part of the community by being the GP in a local community. So, yes, I think it is a brilliant thing and, you know, our next door neighbours at Murrumbidgee trialled it and it was really valuable.

Q. From that, do I take it that you see there being a transition from the way general practice has been done historically to what it might look like in the future, to attract and engage with the next generation of medical graduates?
A. Absolutely. Yes. Yes. But in that space, there

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

Q. I took us down this pathway of talking about the single employer model while you were describing some of the successes of the program.
A. That's okay.

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

Q. Is there more that can be done to support the program, to attract medical graduates to regions like this one?
A. There is, but there is always a matter of, you know, how much money is there for people to actually be able to sit and engage and talk with the students.

Q. Let's assume the money was available, what could be done in your view?
A. One of the things that I do do, and it's funded through southern, but it's part of - you know, I don't get paid by southern for this, but it is part of what I do, and I have a dinner tonight. So we have the JMA wellness program, and that happens in three locations across southern New South Wales LHD, and I meet with the junior medical officers, PGY1s and 2s every fortnight, and we have dinner. And in that space, we talk about the positive and the negative things that happen for them as junior doctors.

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

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

Q. A couple of us are familiar.
A. Yeah. The young man is having a great thrust in life, but the young woman, who is very quiet, ends up deceased, having taken her own life. I also talk --

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

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

THE COMMISSIONER: I didn't want to interrupt you, but can I just go back to something you said earlier when Mr Glover was asking you about successes of the program. One of the things you said was, "We are invisible under the HETI processes", which is something that you had mentioned in your statement as well, similar terms in 24(f), about the lack of visibility of the southern New South Wales LHD on the HETI network. Can you just explain what you mean, so I can understand what you mean by that?
A. Thanks. It has been my mantra for five years now.

THE COMMISSIONER: Yep.

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

THE COMMISSIONER: You don't exist. They exist, you don't exist?
A. No, no. Southern New South Wales does not exist under the HETI networks. It clearly doesn't. There is no documentation anywhere to say that southern New South Wales is part of any HETI network.

THE COMMISSIONER: And the consequences of that to you are?
A. The consequences of that are that southern New South Wales are counted as an ACT network by the Ministry of Health in New South Wales, and the ACT network is a very different process for junior medical officers than what happens in New South Wales. So we don't have any capacity, opportunity, or funding to go for rural preferential recruitment in this region. We are - there are several programs, they are documented, that we do not have any capacity to access as health facilities in this region and don't have the capacity to have junior medical officers come and be New South Wales medical officers in their facilities of Goulburn, Cooma, Bega, Eurobodalla - or, like, the two in Eurobodalla - or Queanbeyan, because they are counted as ACT facilities.

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

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

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

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

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

THE COMMISSIONER: You will be fine after morning tea.

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

Q. Can we just step through, firstly, how the arrangement would operate within other parts of New South Wales. So HETI's role in placing interns for other LHDs for the extent you have an understanding of?
A. Okay, so HETI has a group of programs specifically supporting rural and regional junior medical officers, and they are documented in here, which I don't know - I can't remember the number. But there is the Aboriginal Employment Program, there is the RPR program. There's multiple programs through HETI, which actually has funding from the ministry, which goes to the LHDs running those programs. Because we don't have any connection with HETI

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

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

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

Q. And that is because, as far as you understand it, under that secondment agreement, the ACT is responsible for placing pre-vocational graduates into southern New South Wales LHD?
A. And they are our tertiary training facility connected to this whole LHD.

Q. And the next of the practical implications you tell us about in 24(b), and one you've mentioned to the Commissioner, is that because of that, that is, because the ACT is responsible for placing those PTY1s and 2s --
A. 1s and 2s, yep.

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

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

Q. But also, rural and regional pathways and procedures and initiatives such as Rural Preferential Recruitment --
A. Yes.

Q. -- Aboriginal Medical Workforce, Direct Regional Allocation, et cetera. What is the impact of the district not having those measures available to it in terms of attracting PGY1s and 2s?
A. It is a huge impact. We cannot have our own training physicians located in our hospitals for PGY1s and 2s or for anyone, really. But without PGY1s and 2s in the pipeline, it severs the capacity of the hospitals to actually have a pipeline of training from PGY1 up until the specialists. It just creates havoc. It also has a financial implication in that, as I have just pointed out, ACT Health doesn't send any financial support around junior medical officer training, and there is a caveat on that, is that New South Wales does provide a small amount of funding for the GPATs and we have two GPATS who are very part-time, one located at Goulburn and one located at Bega, and I think there is a part-time one as well at Eurobodalla.

Q. Sorry, you just used an acronym. What was it?
A. Director of pre-vocational education and training.

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

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

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

obligation?
A. Yeah.

Q. Is the issue you are pointing to there the fact that if there was a graduate who had received - that was a beneficiary of that program, they couldn't come to a placement in this district because they would be deemed to be engaged by the ACT system, not the New South Wales system?
A. That's exactly the issue. The young woman who I talked about who has a position for Broken Hill for the intern program is under those circumstances. She has been on an RDN cadetship, she is a young Aboriginal woman, and she cannot do her return of service within this LHD regardless of the fact that she's done her third year long-term and was very innovative with the university, and she and one other person have created a fourth year long-term pilot program.

Q. Is that restriction a feature of the RDN's policies or NSW Health's, to the extent you know?
A. Which came first, the chicken or the egg?

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

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

Q. And perhaps the RDN is just passing on those conditions?
A. Yes.

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

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

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

Q. The next issue you raise in subparagraph (d), do we take it that is a subset of those that you have already mentioned, that is, as you know about the fact that you've got to go through the ACT system to get a placement in this district, it wouldn't be a viable option for graduates, including those who might have grown up here?
A. It's really important. Like, the ANU graduates are aware of it, because it is something we talk about all of the time and from my engagements with the students, but it's graduates who leave this area and go to university at other universities who aren't aware of the system, and I know that in this year's graduating class engagement and discuss about how to apply for intern positions, I actually got our student's council to open that up to the University of Wollongong as well, because a lot of our graduates from - sorry, a lot of our residents from this footprint who actually go to the University of Wollongong as well. We've got quite a few who go into Sydney, but at the moment I'm just, you know, engaged in the University of Wollongong this year to help them to understand that if they want to work in this space, they have to go through the ACT system.

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

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

Q. Is there anything else you wish to add to what you have written in that subparagraph on that particular document?
A. I have to share a story from this week.

Q. Please do.

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

Q. No, no, that is why you are here.
A. I was talking with the students in the ANU building this week in Goulburn, and one young lady who is called Pip, who is just beautiful, you know, and she is a long-term third year student. And she had been on the wards, and she was talking with the nurses and they said something about, "Oh, can't contact the doctor to be able to", you know, do whatever it was. And she said but, you know, have a look on the roster, see who is on the roster, and so she - the nurses said, "Oh, you check the roster." So she went over there and she's checked it, and she said, "Yes," she said, "Dr Va-cant. Dr Va-cant is the person who is here for this roster." And the nurses laughed at her, so she was sharing the story as, you know, she'd felt shamed. But the nurses laughed at her and said, "Have a look at the roster again, Pip. There's four Dr Va-cants on here." And if you read it carefully, it says "doctor vacant". So the JMOs are quite lacking on rotations on a regular basis, and that makes our - you know, if I put on my nursing hat, if I put on my board hat, if I put on any other hat, it makes the level of patient care incredibly difficult, but it makes the workload for our senior specialists hugely difficult because they have to do their job. They have to do the job of the registrar or the JMO who is not there, and it just becomes very - that creates the issues around the pipeline of training.

Q. And this may be completely obvious, but it would clearly be of benefit to the district to be able to draw PGY1s and 2s from other areas to the extent that the ACT arrangement can't fulfil the need in the region?
A. It would be really valuable to have PGY1s and 2s that belong to NSW Health and belong to the LHD.

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

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

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

Q. Has that been raised with the AMA, to your knowledge?
A. It has.

Q. And are you aware of what response has been received?
A. "We will try to include Goulburn and the other hospitals into the ACT survey." I haven't seen that yet, though.

Q. When was the last engagement with the AMA about that issue?
A. One or two years ago.

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

Q. Can you just describe what that funding package is first, and then I'll ask you some other questions about it?
A. Because we're not part of it, it is very hard to describe. I truly --

Q. Doing the best you can, what do you understand?
A. Doing the best that I can, because our hub - so the regional training hubs are networked as a New South Wales network of regional training hubs, then we have a national network of regional training hubs, and we are very aware in

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

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

Q. Did you get a response to HETI with the letter that you have referred to?
A. And the emails? Not a thing.

Q. When did you send it? Again, doing the best you can. It's not a memory test.
A. I would say at least two years ago, possibly a little further.

Q. Thank you. Can I take you ahead to paragraph 26 of your statement.
A. Yep.

Q. In this section, you tell us a little about the challenges associated with the Aboriginal Medical Workforce Pathway.
A. So the Aboriginal Medical Workforce Pathway under HETI basically guarantees any Aboriginal person in New South Wales that they can do their PGY1 and PGY2 training wherever they want.

Q. Do I take it from the way you have concluded that answer, because of the secondment agreement --
A. They can't.

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

A. Quite literally, they cannot do that.

Q. I certainly - yes, I think that was the way you understood my mangled question?
A. It is. It is, yes.

Q. You got a response from HETI?
A. Yes.

Q. Did you get a response from HETI to your email?
A. I actually keep all of those emails, so I have them there.

Q. Someone might follow you up for a copy of that when we conclude today.
A. The young - could I please provide a declaration that the young woman who is the Aboriginal young woman who has taken the position at Broken Hill is actually my eldest daughter, so I have to put that in there, because I would not like it to come back and say, you know, "You raised this." So I just need that declaration. Sorry.

Q. No trouble with that at all. The limitation that you have described in paragraphs 26 and 27, does it have the practical effect that if a First Nations person grew up in Batemans Bay, studied medicine, graduated, wanted to come back to country as a PGY1 --
A. They can't.

Q. -- they would not be able to do so?
A. No, they can't. They can't unless they are happy to go through the ACT system, but all the young people that I know that are Aboriginal from this region, most of them need to come through on the cadetship program. Their, you know, financial cadetship.

Q. The RDN cadetship program?
A. Yeah.

Q. Which would encounter that other difficulty that you mentioned?
A. Absolutely.

Q. In paragraph 34 and 35, you describe some potential solutions.
A. Yes.

Q. Before getting to those, I think the Commissioner might have asked you, and I have asked you in some discrete ways about whether these issues have been raised, but I take it that these challenges, these various challenges over time, have been pointed out to the ministry, to your knowledge?
A. Yes. I did have a discussion with the medical workforce person from the ministry when I was at the RMT, which is regional medical training group that I spoke about earlier. So I did that at that point in time. And that was actually when she made it very clear that it's not an issue for the hub, it's actually an issue for the LHD.

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

Q. And has the LHD taken up the fight since you have done it?
A. They're making changes, but you will have to ask the LHD. Thank you.

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

Q. Can you just describe in practical terms the structure that you are drawing a comparison with in the Albury-Wodonga health services?
A. So Albury-Wodonga health services was actually changed from being part of the Greater Southern Area Health Service to being Albury-Wodonga health service when I was actually their manager workforce planning at greater southern, which is actually eons back. So I actually had a conversation or have had several conversations with Albury-Wodonga about how come they have got HETI network status at Albury-Wodonga, because it is the most similar place across the whole jurisdiction of New South Wales. And so they were really very valuable in telling us - telling me about they've got a memorandum of understanding which states that for their pre-vocational training, they would have - they've got 30 positions. So they have 15 positions for the Victorian program, they have got 10 positions for the New South Wales HETI program, and they've got five positions which they call the end-to-end program. So they are local people who have done an extensive training at Albury-Wodonga that they keep at Albury-Wodonga to complete

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

Q. We have heard a little about the John Flynn program. Can you just tell us how it operates in this district?
A. From my perspective, I love it. It gives us a capacity to at least have some of our own people who come and live and work in New South Wales on a New South Wales training pathway through the John Flynn program. And the John Flynn program is designed for people who haven't quite decided yet whether they're going on a rural generalist or a GP pathway, but it gives them the opportunity to also try out some of the ASTs and in doing, you know, by doing an extended period of time in the hospital system and rotating out to the GP clinics, those hours are counted towards their ACRRM fellowship, if that's the pathway they choose later.

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

Q. -- the district can't completely sever ties with the ACT. Why do you say that?
A. In the medical world everybody knows that, you know, like - it's quite - quite tribal. And so, from the perspective of the referral pathways, patient services and everything else, there's a lot of referral from around this footprint into the ACT, because it is the "closest"

tertiary referral hospital.

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

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

Q. -- whilst maintaining those linkages?
A. Yeah. Campbelltown is not very far from Goulburn.

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

THE COMMISSIONER: Do you have any questions?

<EXAMINATION BY MR CHENEY

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

Q. And I think you had answered to a question as to what might be being done about that, you said that they're making changes by reference to the local health district. Are those changes to have a discussion with HETI to try to bring the model in southern - make the model in southern similar to what is in place in Albury-Wodonga?
A. Truly in - like, I'm not really privy to all of the operational ins and outs.

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

Q. But as a --
A. But in this space, I am aware --

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

Q. And those discussions are being carried out by Dr Mullins as well as Dr Ayers of the LHD?
A. That's exactly right, yes.

Q. And as to PGY3, is the situation from next year onwards that there would be - LHD will have access to trainees that are through the rural acute care SRMO program, that is part of the John Flynn program?
A. Yes, we have - there is a business case that went forward to the LHD from SERH, and I have worked with Dr Nathan Oates and around supporting, you know, how to get that business case done. He has done all the work on it, and the whole concept is if we could get that business case through at the LHD level, that it should be duplicated for Goulburn and the northern end. So rotating out to Crookwell, yes.

Q. So at least initially, that's six additional training places for the LHD?
A. Yeah.

MR CHIU: Thank you. No further questions.

THE COMMISSIONER: Thank you very much, Ms Gordon, for your time. We are very grateful.
A. Thank you.

THE COMMISSIONER: You are excused.

<THE WITNESS WAS RELEASED

THE COMMISSIONER: So we might take the break now until 11.50.

MR MUSTON: I think that due to - to accommodate some scheduling for the clinicians who are down as coming next, it's 12.

THE COMMISSIONER: They were down at noon? Right, not everyone's here. Why don't we see whether people are here at 11.50, and we'll start at 11.50? If they're not - that causes you a problem, yes?

MR CHIU: They have all been asked to be here at 11.45 anyway, Commissioner, but there is one additional thing I'd like to raise with you, if I might.

THE COMMISSIONER: Yes, go ahead.

MR CHIU: Just from something that fell from you earlier,

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

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

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

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

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

THE COMMISSIONER: Does it?

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

THE COMMISSIONER: Right.

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

THE COMMISSIONER: Right, okay.

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

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

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

THE COMMISSIONER: Thank you.

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

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

MR MUSTON: All coming in person?

THE COMMISSIONER: Yes.

MR MUSTON: Excellent. Okay.

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

SHORT ADJOURNMENT

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

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

MR CHIU: Yes.

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

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.

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

THE COMMISSIONER: Oh, yes.

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

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

MR MUSTON: Yes.

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

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

<SUSIE PIPER, SWORN [12.03 pm]

THE COMMISSIONER: Dr Stapleton, oath or affirmation?

DR STAPLETON: I do.

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

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

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

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

<STUART STAPLETON, SWORN [12.03 pm]

THE COMMISSIONER: Dr Oates, oath or affirmation?

DR OATES: An oath.

<NATHAN OATES, SWORN [12.03 pm]

THE COMMISSIONER: And Dr Clarke?

DR CLARKE: Affirmation, if you wouldn't mind.

<ANDREW CLARKE, AFFIRMED [12.03 pm]

THE COMMISSIONER: Yes, go ahead, Mr Muston

<EXAMINATION BY MR MUSTON

MR MUSTON: I might just quickly get each of you to introduce yourselves. Dr Piper, first could you give us your full name for the record?

DR PIPER: Susan Margaret Piper.

MR MUSTON: Can you tell us what role you currently hold within the local health district?

DR PIPER: I am the district medical lead for paediatrics for southern local health district, and I am a general paediatrician doing my clinical work at South East Regional Hospital.

MR MUSTON: How long have you held the role locally?

DR PIPER: So local role since March 2023, although I was in the district medical lead role since 2021.

MR MUSTON: And I think from - based on a statement you have given, were you in that role whilst at least physically located within the Illawarra Shoalhaven Local Health District.

DR PIPER: I was working in Wollongong and working for southern LHD one day a week.

MR MUSTON: You have prepared a statement to assist the inquiry with its work, dated 7 August 2024?

DR PIPER: Yeah.

MR MUSTON: Do you have a copy of that with you?

DR PIPER: I do.

MR MUSTON: Had you had an opportunity to review it before today?

DR PIPER: I have, yeah.

MR MUSTON: Are you comfortable that, to the best of your knowledge, it is true and correct?

DR PIPER: Yes.

MR MUSTON: That in due course will be tendered, Commissioner.

THE COMMISSIONER: Yes.

MR MUSTON: I'll move on to you, Dr Stapleton. Could you give us your full name for the record, please?

DR STAPLETON: Stuart Gordon Stapleton.

MR MUSTON: And tell us where you sit within the local health district?

DR STAPLETON: I am currently the interim director of the emergency departments in Eurobodalla Health Service, so I cover both Batemans Bay and Moruya hospitals.

MR MUSTON: How long have you been in that role?

DR STAPLETON: I've been in the role full time since February 2023. I had been doing part-time assisting work from approximately April 2022.

MR MUSTON: And you've prepared a statement to assist the inquiry with its work, dated 9 August 2024?

DR STAPLETON: That's correct.

MR MUSTON: You have got a copy of that with you?

DR STAPLETON: Yes.

MR MUSTON: You've had a chance to --

DR STAPLETON: I have reviewed it and I'm happy with it.

MR MUSTON: That will be tendered in due course, Commissioner.

THE COMMISSIONER: Yes.

MR MUSTON: Dr Oates, your full name for the record.

DR OATES: Nathan Mark Oates.

MR MUSTON: We know what the next question is. What's your role within the local health district?

DR OATES: Two roles. My clinical role is a VMO anaesthetist, and I am also the director of pre-vocational education and training at South East Regional Hospital.

MR MUSTON: How long have you held those two roles?

DR OATES: VMO anaesthetist since October 2016, and the director of prevocational education and training since around October 2019.

MR MUSTON: You've prepared a statement to assist the inquiry with its work, dated 8 August 2024, you've got a copy of it with you?

DR OATES: I do

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

DR OATES: Thank you, yes.

MR MUSTON: That will also be tendered.

DR OATES: Thank you.

MR MUSTON: Finally, Dr Clarke, your full name?

DR CLARKE: Andrew Charles Clarke.

MR MUSTON: And your role within the local health district?

DR CLARKE: I am a VMO ED doctor at Cooma emergency department and have been the acting clinical lead since February this year.

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.

MR MUSTON: We take from that that there are funded FTE positions within the local health district which, if people could be found and kept, would be permanently recruited into?

DR PIPER: Yes.

MR MUSTON: But at the moment those positions are either unfilled or it is hard to keep them filled --

DR PIPER: Yes.

MR MUSTON: -- in a way that is presenting workforce challenges?

DR PIPER: Yes.

MR MUSTON: You talked about the bang for the buck that you get from a permanently recruited specialist or VMO working into a position. What do you see - other than the obvious benefits from clinical care of having a person permanently there, what are some of the benefits you see attracting people to that?

DR PIPER: One of the biggest benefits for my clinical area is what we call continuity of care. We look after children from infancy till they are adults. It is really hard for those families if they have to see a different doctor and go through the whole story every time with a different doctor versus having a continuity of care with a doctor who knows them. So continuity of care is important.

THE COMMISSIONER: Is that particularly so with children?

DR PIPER: I think so. But yeah, I would say for adults with chronic and complex conditions, continuity is vital.

THE COMMISSIONER: Sure.

DR PIPER: Being part of the team is helpful. Even for clinical dilemmas, a difficult patient I don't know what to do, having another colleague that I can bounce that off of or ask about is really helpful. And people who are invested in the community, by living there and being part of the community, they're going to be motivated to see good health services for their local community.

THE COMMISSIONER: I am sure you are going to come to it, but just while it is in my mind, I think it would be useful to get on the transcript the evolution of the children's ward, at this time. I am sure you're going to come to it.

MR MUSTON: I am literally just about to come to that.

THE COMMISSIONER: Great minds.

MR MUSTON: The way I was going to come to it, and you now --

THE COMMISSIONER: You do it your way.

MR MUSTON: -- was do you see that there are benefits in terms of recruitment and retention, that is to say benefits to the team, of actually having those permanent members of the workforce in place?

DR PIPER: It is much easier to recruit to a team where someone - I'm recruiting and someone knows they are joining a team, so they're not going to be on their own, than to recruit to a solo position. And I think people's fear about being recruited to a solo position will be that they will be on their own, relentlessly on-call, working their butt off and getting exhausted and they will burn out and leave, versus knowing, "Okay, I am joining a team. My on-call will be reasonable. I've got colleagues to share the load." And there is a load. There is always patients, problems, issues that are complex, difficult and hard, and it is easier to look after that caseload when you know you're not the only one doing it and everyone is sharing the load.

THE COMMISSIONER: Can I just interrupt again, at the risk - you used the term "burnout" then. Should I understand that as something that's not just fatigue, that's something far deeper --

DR PIPER: Yes.

THE COMMISSIONER: -- and more psychologically draining, and a complete sort of - an adoption of cynicism as well as things like fatigue? You tell me what you mean by the term burnout.

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

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

DR PIPER: Yeah. Yep.

THE COMMISSIONER: Sorry.

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

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

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

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

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

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

DR PIPER: Oh, that's right.

MR MUSTON: -- to receive paediatric clinic?

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

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

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

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

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

THE COMMISSIONER: Right.

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

THE COMMISSIONER: That was my next question.

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

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

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

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

DR PIPER: Yeah.

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

DR PIPER: Yes.

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

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

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

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

DR PIPER: Yeah

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

DR PIPER: Yes.

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

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

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

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

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

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

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

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

MR MUSTON: What sort of processes?

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

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

MR MUSTON: Just give some tangible examples of that.

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

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

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

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

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

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

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

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

DR STAPLETON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR STAPLETON: Please.

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

DR STAPLETON: I think it is fair to say it was a political promise at the last election that the hospital would open as a level 4 hospital with an intensive care unit.

THE COMMISSIONER: Right.

DR STAPLETON: That was very much a political promise.

THE COMMISSIONER: Now, oncology "imploding" was your word.

DR STAPLETON: Yes.

THE COMMISSIONER: I take from that you mean imploding in the sense of a consultant shortage?

DR STAPLETON: Also other staff.

THE COMMISSIONER: And you mentioned safety as well. What do you want me to fully understand about that?

DR STAPLETON: Look. I think one of the things we have, again this gets back to how things have worked in the LHD for many years. There's a lot of nurse-run services, with very good nurses, but they have had minimal specialist level support. Now, oncology is one of the ones that sort of jumped up and suddenly started moving. Well, you've got to. You've got to have someone who, I'll be flippant, knows how to poison people properly. But what we are seeing happen, and some of it is to do with the organisational structure. There is no organisational structure for oncology at the moment that gives them clear lines of reporting for medical support through DMSs. It's just not there.

THE COMMISSIONER: Whose responsibility is that, to have the structure?

DR STAPLETON: Well, that structure comes from the LHD and the LHD executive. That's all management. That's beyond my pay grade

MR MUSTON: In order to deal with the particular challenges of rurality that you have told us about, how does that structure need to change, do you think? What is

it?

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

MR MUSTON: In what sense?

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

MR MUSTON: Who is making these decisions?

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

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

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

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

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

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

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

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

DR STAPLETON: Yeah.

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

DR STAPLETON: Through, years and it keeps going

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

DR STAPLETON: Yeah.

MR MUSTON: That oncologist should actually be continuing --

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

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

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

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

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

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

DR STAPLETON: Nursing staff.

MR MUSTON: -- nursing staff.

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

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

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

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

MR MUSTON: That would be.

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

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

DR OATES: Yep.

MR MUSTON: How does that dialogue go down?

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

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

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

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

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

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

MR MUSTON: Yes.

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Sure.

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

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

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

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

DR OATES: Yes.

MR MUSTON: -- that makes it --

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

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

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

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

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

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

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

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

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

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

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

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

DR OATES: Yep.

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

DR OATES: Echocardiogram. Ultrasound of your heart.

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

DR OATES: Absolutely

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

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

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

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

DR OATES: Yeah

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

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

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

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

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

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

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

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

THE COMMISSIONER: I am flexible.

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

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

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

THE COMMISSIONER: That's fine.

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

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

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

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

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

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

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

MR MUSTON: Like barristers.

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

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

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

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

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

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

THE COMMISSIONER: The numbers of presentations started to increase?

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

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

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

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

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

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

DR STAPLETON: Very bad. Very bad.

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

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

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

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

THE COMMISSIONER: Raise, train and sustain.

DR CLARKE: Raise, train and sustain.

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

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

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

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

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

same thing in New South Wales

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

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

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

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

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

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

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

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

When you graduate from medical school and go into your

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

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

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

MR MUSTON: Yes.

DR OATES: And - yeah.

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

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

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

DR OATES: Yeah

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

DR OATES: Yeah

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

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

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

MR MUSTON: Yes.

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

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

DR OATES: Yes.

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

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

MR MUSTON: Vocational training?

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

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

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

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

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

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

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

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

MR MUSTON: Please do.

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

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

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

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

MR MUSTON: Please.

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

MR MUSTON: I got the first two words.

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

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

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

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

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

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

THE COMMISSIONER: Yeah.

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

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

DR STAPLETON: That's all right.

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

DR STAPLETON: Both equipment and --

THE COMMISSIONER: Equipment and people.

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

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

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

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

DR OATES: Yeah.

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

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

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

MR MUSTON: Even if you are --

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

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

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

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

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

DR PIPER: Absolutely.

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

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

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

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

DR PIPER: Yeah

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

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

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

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

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

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

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

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

MR MUSTON: Yes.

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

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

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

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

DR STAPLETON: Yeah.

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

DR STAPLETON: Yeah.

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

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

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

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

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

THE COMMISSIONER: Busy roads. Right.

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Anyone else?

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

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

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

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

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

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

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

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

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

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

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

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

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

DR CLARKE: No

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

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

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

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

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

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

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

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

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

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

DR OATES: 0 of 1.

<THE WITNESSES WERE RELEASED

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

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

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

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

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

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

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

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

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

DR AYERS: Affirmation.

<SERENA AYERS, AFFIRMED [3.05 pm]

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

MS CAWTHORNE: Affirmation.

<JOANN CAWTHORNE, AFFIRMED [3.05 pm]

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

MS CAWTHORNE: Joann Robin Cawthorne.

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

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

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

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

DR AYERS: Serena Kian Ayers.

MR MUSTON: And your role within the local health distract?

DR AYERS: I am the inland network director of medical services.

MR MUSTON: How long have you held that role?

DR AYERS: Six months now.

MR MUSTON: And you have prepared a statement to assist with its work, dated 8 August 2024?

DR AYERS: Yes, I have.

MR MUSTON: Do you have a copy of that with you?

DR AYERS: Yes, I have.

MR MUSTON: Have you had a chance to review it before giving your evidence today?

DR AYERS: Yes, I have.

MR MUSTON: Are you satisfied that its contents are, to the best of your knowledge, true and correct?

DR AYERS: Yes, I have.

MR MUSTON: That will be tendered in due course, Commissioner. I say to the two of you in relation to the process today, whilst I'll be asking you some questions and perhaps directing questions at one or other of you along the way, please don't think that if I haven't directed a question at either one of you, that you are not free to jump in and answer. And in fact, if you think in order to best flesh out some of the issues which you guys have a lived experience of and ability to help us with, if asking one another questions throughout this process is something that you think would be useful to tease out an idea that I am not managing to tease out, then please feel free to do it.

Can I start by just looking at some of the challenges that we have heard quite a bit about throughout our travels and come to understand how those challenges manifest, at

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

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

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

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

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

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

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

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

MR MUSTON: This is the place.

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

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

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

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

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

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

MS CAWTHORNE: Yes.

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

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

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

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

MS CAWTHORNE: Our geography is our biggest concern.

MR MUSTON: Yes.

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

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

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

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

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

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

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

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

friends are there.

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

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.

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

DR AYERS: Yes.

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

DR AYERS: I will be honest --

MR MUSTON: Please do.

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

MR MUSTON: In what sense?

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

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

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

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

MS CAWTHORNE: Across border.

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

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

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

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

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

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

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

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

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

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

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

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

MS CAWTHORNE: So, from Cooma's perspective, we have got all of our education - all of your educators on site. They are all doing "Train the Training" so then we can actually do onsite education. We have got our CMCs within the district, but they are thin on the ground and they are trying their best to cover what they can.

We have been very fortunate that the district has supported us to send our staff out for training. However, that comes at a cost, a cost that we are not budgeted for and, essentially, we're relying on SP&T accounts and donations that actually prop up our education. There is no pocket of money sitting there for it, and if you're, per the award, you have certain days and you have built into your FTE very few days for education and training, and the rest of it comes down to the site's discretion as to whether you release your staff for that. We are invested in doing that. It comes at a cost. It's not budgeted.

So from a site level, we have all of our educators training, to the point that I actually have all of our educators sharing the space where they share their education across a site. I have even got an educator and community nurse that goes out to the aged care facilities, outside of our remit, to train them to try and keep people out of our hospital. So, we have a very robust training.

I had a new grad say to me the other day, "I feel so supported here in Cooma, but" - and her colleagues within the Sydney metro have actually pulled out of nursing

because they haven't felt supported. So, we are providing a support, but we are doing it at a cost, and a cost that we are not funded for.

MR MUSTON: Before we come to growing your own medical workforce, I gather a lot of that training work that you are talking about is training which is being delivered to brand new graduates who have come out of nursing programs into Cooma?

MS CAWTHORNE: Yep.

MR MUSTON: Before they get into those nursing programs, is there any work done by you, or by the local health district, in an attempt to sort of tap the resource that is the kids of Cooma --

MS CAWTHORNE: Yep.

MR MUSTON: -- some of whom might, one day, become a great member of the workforce at Cooma Hospital.

MS CAWTHORNE: So, it is fortunate I have a generalist educator to site who has worked very, very tirelessly over the last 12 months. She is new to the role. She is a person we attracted out of Sydney, which is lucky, and we have been developing her skills. She has gone through from being a registered nurse on the ward to being a nurse educator, to now being a part-time NUM of our ward. So growing her has also inspired her to grow others. She has tapped into the local schools. We have got a single process of where we can actually - we are reaching out to the careers advisers at the school with attending the careers education days and we have, probably, the largest number of year 10 work experience students coming through Cooma in this last 12 months. With that, we offer them the opportunity to do community nursing, to go into oncology. They are also been spreading out into our allied health space because I - you know, not to forget them because they are under the same suffering that we are. It is not just medical and nursing, just to make it clear, it's - we need to entice them. So if we give them a little bit of everything, then they can make a choice, and Cooma is fortunate that we have such a strong management team that we embrace that and these people have come in. They are part of our team for a week and they go out then - I think our last one was pretty keen to come back as a physio for

Cooma, so these are our own locals that want to come back to us. So, it is very, very good, but I also don't want to limit their careers by saying "Come to Cooma just because we need you". I actually want you to have that career trajectory when you are here as well and experience. Very, very hard to do that in rural. So, if I use our social work positions in Cooma as an example, they are level 1-2s. They come here. They work in rural. They have a specialty skill set that far exceeds what their grading is and they're expected to perform. They come, they get their ticket, then they leave because they can't go any further. So, we need to look at how we actually celebrate that, how we educate them, how we support them and how we keep them.

MR MUSTON: Just in relation to that career progression and the importance of it from a retention perspective, I recall you telling us, when we were visiting Cooma, that there is an issue in relation to providing career progression to staff who come under the rural incentive schemes. Is that memory correct? That is to say, promoting someone within the hospital who has commenced under a rural incentive scheme and then been employed in a different or higher position within the organisation, say, a nurse who becomes a nurse educator, is that not --

MS CAWTHORNE: I'm not sure. I'm not sure whether I was going with that one.

MR MUSTON: It must have been someone else who was telling us about that.

MS CAWTHORNE: Yeah.

MR MUSTON: We'll work it out.

MS CAWTHORNE: No. Sorry.

MR MUSTON: That's okay. In terms of the medical workforce, sort of, the growing your own medical workforce, obviously is a slightly different prospect because it takes a lot of years to become a doctor.

DR AYERS: It does.

MR MUSTON: And one tends to have to leave one's town to do it.

DR AYERS: Yes and no.

MR MUSTON: No?

DR AYERS: So it is really interesting, isn't it. So there have been universities who have recognised the need to grow a rural health workforce and they are working hard to produce these rural clinical schools.

I guess one of the things I would love to see southern be able to do is to grow beyond and, if you like, expand beyond just a relationship with the ACT. So, my understanding is that historically, we developed a relationship with the ACT because there was a need for Canberra to have an area, a region, where it sent its medical students and where those medical students would be grown up, if you like. So, we have these historical relationships with the ACT, but I think the time has come for southern to be more sophisticated in its relationships.

ACT Health is a metropolitan health service. They want to grow city doctors, and I understand that. Southern New South Wales is a rural health service. We want to grow rural clinicians. So you can see that we may not have strategic alignment, you know, we're different.

Only yesterday I was involved in the rural generalist interviews with HETI and we interviewed five candidates and it was really interesting what they said. They are heading for a career where they are solely rural practitioners. They don't want to go to the city. They want to stay in rural. So many of them spoke of how they have grown up in a rural setting. Their family is in a rural setting and they have done all their medical school placements in a rural setting. And so a number of them were tripped up on a question that asked them to compare a metropolitan workforce with a rural one. A number of them had to say, "I don't actually know because I haven't worked in a metropolitan setting", and that is exactly the problem.

So, if we are aligned with ACT Health and we're reliant on them for our medical students and for our first and second year doctors, well, in order to be placed in southern, which is a rural health service, you actually, ironically, are having to go and approach a metropolitan health service for a job. But if you are wanting, truly, to grow up as a rural generalist, to be a specialist in a

rural setting, you want to work in a rural setting. So you want to be able to apply to a rural setting, but it seems odd that the only way that you can be placed at southern as a first or second year doctor or, currently, as a medical student, is to apply to the ACT. It doesn't seem to make sense and we are largely - I'll use the word "invisible" to applicants at the first and second year level post-graduation for jobs. And, as I have said, if you wait until they are later in their career and expect them to come back, you are going to have to really use quite powerful instruments, shall we say, to incentivise them to come back into rural. We can't do that.

We have to be training medical students who are passionate about rural and then converting them to our first and second year doctors, and embedding that passion, that rural expertise which, as Jo was pointing out, the same goes for nursing, it is different from the metropolitan expertise.

There is this myth, and it is unfortunate, that somehow you need to go to the metropolitan services to skill up to become an expert. I would say that that is purely a myth. Rural clinicians have a different skill set but they're just as expert. It is not to take away anything from our metropolitan colleagues because I have spent a lot of time in metropolitan centres and leading metropolitan services, but it's a different skill set.

In the rural setting, we are all wearing multiple hats, as Jo described. The medical workforce is exactly the same. We are wearing multiple hats and, on the same day, you may have multiple functions within the hospital and that's why the loss of just one team member can make such a difference. If you are in a big metropolitan team and you have 25, 30, 40 team members, the loss of one person is proportionally not as devastating. If you are in a team of four, the loss of one team member is devastating. It's 25 per cent of your team.

MR MUSTON: Devastating in that --

THE COMMISSIONER: Can I just ask: when you say "wearing multiple hats", what do you want me to understand by a different skill set for a rural clinician to a metropolitan clinician? I am imagining part of it is having to wear multiple hats, but can you help me with a little bit more

precision as to what you mean.

DR AYERS: Yeah.

THE COMMISSIONER: Because, in my mind, I am thinking, well, a metropolitan clinician is treating a human being and a rural clinician is treating a human being, I get the circumstances are different --

DR AYERS: Yes.

THE COMMISSIONER: -- but you tell me what you mean by that, a different skill set.

DR AYERS: Yes. So let me give you an example from the emergency department, for example. In a metropolitan emergency department - and I have worked at a big - many big metropolitan emergency departments, you have multiple teams that come down and assist you. So say, for example, we receive a trauma patient. You will have the trauma team come down to assist the emergency department team to manage that patient. It is a team approach. So you will have surgeons there, you will have anaesthetists there, you will have intensivists there, you will have the ED team, and not just doctors but nursing. Nursing specialists from different teams who come in and help. So it's a team approach.

In a rural setting, you are all those people and you are having to, if you like, manage that patient with not just less numbers, but fewer sub-specialty teams who can come down. So in your rural hospital, you may have general medicine, general surgery. You may or may not have orthopaedics, for example, or you may not even have resident surgeons. They may just be doing day surgery and flying in and out, so you only have the rural generalists who may have trained across multiple specialties in their training. So, our rural generalist may have done training in general medicine, in surgery, in anaesthetics, in obstetrics, in ED, as well as general practice. So, you see, they're multiskilled in one person.

THE COMMISSIONER: Yes.

DR AYERS: Whereas in a metropolitan setting, what tends to happen is everybody sub-specialises. So you'll become expert but in a narrow field and, therefore, you lose that

ability to be a generalist. So that's really the difference.

It is evolving a highly developed specialist workforce, that is narrow but deep in their knowledge, versus having a broad generalism where you are able to put your hand to many different things and that's acquired through many, many years of training in different fields of medicine and in nursing.

THE COMMISSIONER: Sure. Thank you.

MS CAWTHORNE: May I just add something?

THE COMMISSIONER: Yes, please do.

MS CAWTHORNE: So just in regards to that as well, so, with nursing, it is not just that skill set that they have from a clinical perspective as well. As we mentioned before, you have got a clinical broader skill set. But in rural - and we look at nursing numbers of what you actually need for the activity coming through your department, but what you don't understand is that we have got - we have got our KPIs that we need to meet, but we also need to be aware that that same nurse that is on that nightshift is also in charge of hospital, trying to cover sick leave. That nurse is also trying to coordinate a theatre team to come in for the emergency caesarean that has coming on, whilst holding a clinical load. They could also be the security that's on shift for that night because the HASS has called in sick and we were unable to replace it, or ambulance is wanting them. The MOU has indicated that you have to provide somebody to do a mental health transport with them, so I have to find my nurse to go with them as well because that's their job as well. They are also trying to be the cleaner, because we don't have cleaners after hours. They are also trying to be admin, to make sure that we capture all the demographics and all the data and the information that needs to be entered into the system correctly in order for us to be paid. So, there is a lot of staff that is also not captured within the role of the rural nurse.

And Cooma's numbers, you know, when we are seeing over 12,000 a year through our ED department, it may not be a lot in the big scheme of things. You look at the FTE for what you require for that, but what else are they doing, and that is what is breaking our nurses.

If you are a skilled clinician, that's okay, because you can cope with your own clinical skill set, but if you are learning to be an advanced clinician, as well as being in charge of hospital and trying to learn the operational needs, trying to make sure that you are managing your nursing hours for patient day and cancelling if you don't have enough patients on the ward for the staff, or you need to find another staff member, trying to teach novice staff how to do that, whilst they are trying to learn to be a clinician, they just leave. Why would they want to stay in rural? That is what I find challenging.

MR MUSTON: Assuming the jobs can be filled, is part of the issue that certain ratios or assumptions about the number of nurses on a shift in a particular facility, with a particular number of patients, maybe are not apt to capture the real workload that is being done by that group of nurses in a facility, like yours, as distinct from a larger metro or regional facility?

MS CAWTHORNE: And I think in a site the size of Cooma, and the fluctuations that we have, we are looking at averages. You look at the averages and you say, yes, you are sitting below your target, or whatever that may be from the numbers of patients, but the swings that you have got, it is very hard to manage. I know we can get down to six patients a day. I've worked in private enterprise. I don't want to waste money, but how do I plan for that? And you can look at our projected, and we can see that we have got our projected three admissions expected, but I can tell you for the last three weeks, our predicted have been blown out of the water and I can't staff for those swings. So I can have 12 patients in the morning and have three staff on. I come back the following morning and I am sitting on 20, with two staff, three staff rostered. I have rostered for profile, I have three on. I can't factor that. And that creates distress within nursing. I am certainly one not to fall into the dramas of individual behaviours, but I can't staff to that and it's very, very challenging. I don't know what the answer is. That is very, very challenging to work out how we manage those swings in rural, but we need to know that it happens and it happens frequently, and it does.

The same with the emergency department, but it is the other competing demands. You will look at blanket numbers

for the emergency department and there are some days where I will come in and say, you know, we had 30 presentations through ED, for instance, just to give an example. However, the acuity on that particular day was extremely high. What it doesn't factor is my category 4, my low acuity presentation. Elderly gentleman from the nursing home, still sitting there from 16 hours beforehand. He is still a person requiring attention. He may well have dementia. He is requiring one-to-one care because he could be behavioural, you know, but that was one occasion that that person is in the department. One occasion of service that they're there, but they are still there because I haven't called pathology in overnight for them, I haven't called radiology in overnight for them. I couldn't get transport home for them. I don't have a taxi service in Cooma after 11 o'clock at night. So, those 30 presentations could be hangovers from the night before. They could be hangovers because of other competing factors that I don't have a control over.

You know, if I look at my numbers of what we have actually got - and it is a perceived busyness to the department is what we have. I have a look at our triage category numbers and we see a vast proportion of those presentations that come through our ED are triage 3s and above. So we are seeing high acuity. It is certainly captured within our data that we are seeing acuity that is punching above our weight, but it is not just the acuity of the presentations. It is not a single number. It comes down to the skill of the doctors and the nursing that is looking after them, and the resources available for them.

So my category 1 presentations, on average, their length of stay is sitting close to five hours. That's an average. So they could be in the department waiting for transfers out, and we have got a one-to-one doctor, one-to-one nursing on that consumer that is waiting for that transfer out. So it is just - we have got to stop looking at individual numbers and look at what else is affecting their stay.

Our category 2s, on average length of stay, they are sitting in the department around four and a half hours. Again, we see a high proportion of category 2s coming through our department. They are filling up a bed. They're still there. Yes, they are one occasion of service; they are one little pocket of money.

Trauma patient. I could have a $1,500 nWow for this one occasion. They are still sitting there.

I heard my colleague Dr Clarke talking to a consumer, "Hey, we had a C1 fracture that was in our department for over 24 hours because we couldn't get them out". They are taking up a resource. They're backing up the departments, and they still require the care, but they are just one number, and we don't capture that.

DR AYERS: Some of that complexity is because it is not just inside the hospital, but outside the hospital, in rural, the whole infrastructure is thinner.

In the multiple hats example, for example - and going back to Jo's trauma patient, it might be one of our doctors who is jumping in the back of the ambulance to transfer them. That would almost never happen in metropolitan. So then, all of a sudden, you have lost your doctor in the back of the ambulance to make sure that that patient gets best care during the transfer and the transfer time from Cooma would be --

MS CAWTHORNE: It's about an hour and a half by --

DR AYERS: -- an hour and a half. So that's an hour and a half there, and that's not counting them getting back. So, you see - and that may be one of however many doctors, two doctors.

MS CAWTHORNE: It could be one.

DR AYERS: Yes.

MS CAWTHORNE: So after 8 o'clock at night, you have one doctor on, but that's no different to them going into theatre, to do a theatre case and it takes them out.

I have had occasions where I have actually been in the department without the doctor, and it happens, you know, semi-regularly, but it happens enough for it to be a risk to us, that when your doctor is in doing something else, you don't have coverage.

Dr Clarke talked to the caesarean sections where you have your ED doctors doing your baby resuscitation, your

anaesthetist is in there, all your on-calls have gone. It doesn't happen often but, when it does, it has a significant impact. The department backs up and you can't move. So it's a flow problem.

DR AYERS: It shows you the necessity to really grow adequate numbers to work in the rural space. Rural healthcare practitioners are really passionate people. If there is one thing that we have all learnt from working rurally, it's we continue to work in rural because we love it and we are with colleagues who feel exactly the same way as we do, and that's wonderful. But we do need to have the right numbers to treat our patients, our community, in the right way.

MS CAWTHORNE: So with the right --

DR AYERS: So, adequate numbers with the right skill set.

MR MUSTON: If there was a single significant change that you could make to the system that you think would better attract or lead to attraction and retention of medical and clinical workforce into rural spaces, like Cooma, what would that be, and you can both come up with a different one if you want to.

MS CAWTHORNE: I know from a nursing perspective, so it is what I touched on before, it is about having an advanced clinical skill set. It is about being professionally considered in that space. It needs to be acknowledged. It needs to be - we need to provide a training program that actually encaptures all of that. So I can have my educators on-site do our training for our mandatory compliance, but I need to have trauma nursing skill set for our emergency department because that is a major, major part of what we actually feed through our ED. I need to have - you know, we need to tap into our universities and acknowledge the skill set that the rural nurses need and actually have a compiled training program, not just for little educators on-site. And I don't - that's no disrespect to our educators. We need to have a university program, a bit like rural generalists, and acknowledge that and financially reward that, so then we are actually keeping our people. We need to stop rewarding the people that come part-time, and we need to start rewarding those that come, grow their skills, and stay and invest into it because that is what is going to support our sites.

I think education and a professional acknowledgement of what that skill set is is definitely what we need from a nursing and also from an allied health perspective. This is not just - as I touched on before, this is not just about nursing. This is about my colleagues that I work with on a daily basis, from a physio, from an allied health perspective, it absolutely has to happen.

Certainly I know from a doctor's perspective, and just to quickly touch on in regards to our medical workforce, I can have a registrar in the ED but it will impact on my flow through that department if I have got a registrar in there on their own, they - I did also hear Andrew talking, and I completely agree in the sense, they might ring Canberra and say, "I have got this patient." Canberra don't know what we don't have and that's half the problem. So they say, "Can you just do this test. Do this test. Do this test", and this is why category 1s sit in our department for five hours because they don't know what we can't manage. So as a role delineation 3, our job is to receive, diagnose, package, and send. I don't have an ICU. I can't do surgery on them. I need - I don't have cardiology. I need to get them out. It makes no difference if I am going to stay and do a series of investigations because then it just pushes them into a nighttime where I don't have an ambulance, I have them on-call. So, we have an ambulance service that is on-call on a nightshift, I am sending them down the road at a risk to the drivers, at a risk to the patient after-hours, taking out a service for ambulance during the day when I should have sent them out in the first place. So you then have a longer stay in ED which is eating up your resources because that registrar doesn't know how to sell the story.

DR AYERS: I think for medical, give us an unbroken pipeline. Give us an unbroken medical workforce pipeline where we can identify rural students even from the, you know, as you said, high school stage. Let's identify those people who want to work in a rural setting in healthcare somewhere, and it doesn't have to be in medical or nursing. There are so many other jobs in healthcare as well. You know, we need ambulance drivers. We need cleaners. We need clerical staff. We need wardsmen. There are so many rewarding professions within health. Let's identify those people right from the start, right from the high school

stage. Let's nurture them as they go through university, college, TAFE, all those structures. Let's keep them in a rural setting and let's do that, not just from the ACT but from New South Wales as well and then let's give them jobs in their first and second year, unbroken, so that they don't have to go to metropolitan sites to learn. They can learn in rural settings. Let's give them that progression of training because they have wonderful healthcare experiences that they can be exposed to.

The trauma that goes through Cooma, for example, is astonishing, but we have also got other sites in inland where they can learn so much and on the coastal, there are other different experiences and within this district, they can move between those different sites and have a really joined up, coherent experience, that makes them passionate to want to stay. Let's grow them from the very beginning and offer them jobs as specialists, and let's reward them and recognise their specialty as rural generalists, and let's have us all work together, not just as a hospital system, but as hospital and general practice and community, together. Because I think all too often, we forget that some of the - if you like, some of the workload that we see and the raising exponential rise in the workload in acute, and in the hospital system, is because we're not supporting our general practice colleagues enough. If we could do that more, if we could support general practice community, ensure somehow that their incentives for working in those spaces are correctly aligned, to staying in those spaces, and have that beautiful continuum between primary, secondary and tertiary care, I think we would all win and it would lead to better wellbeing in the community, better health in the community, not just better healthcare.

MR MUSTON: Just picking up on that, what is it that we as a system could be doing, do you think, to support primary care?

DR AYERS: So one of the things that I've talked about with them, and our district has been talking to them about, is this concept of supporting training no matter where that trainee ends up. Let's not just think about the hospitals as training doctors who end up working in hospitals. Let's share our training resources so that we are training all the clinicians who are going to go back out into the community as well. Let's support each other.

One of the things that I noticed when I worked in the Northern Territory, where the market is even thinner, it is even harder to get staff there, is that that that collegiate support of the hospital with its community is so important. The general practitioners and the hospital clinicians would get together on a regular basis, collaborate, and share and support each other. The expertise would flow seamlessly between hospital and community, and we would support each other socially as well. So there were lots of - because, as you can imagine, working in a rural setting can be isolating.

One of the words that one of the candidates I interviewed yesterday used that in general practice, in a rural setting, sometimes it can be isolating compared to a hospital practice, but that's where we could do more to support our colleagues and to make sure that they feel part of a wider professional family and, in doing that, I think we all win. But the contracts, the incentives, the architecture behind that, that we don't have control over at the local level, that is controlled at State level or national level, that needs to be aligned to help that happen because I hear from my general practice colleagues that, you know, obviously their frustrations with Medicare and the payment system, that they have had significantly fewer trainees wanting to do general practice in the future and that's very, very sad. If general practice loses, we all lose.

MR MUSTON: What about as a possibility in a community that might have a thin to non-existent general practice market, the idea of a salaried general practitioner or rural generalist working within a clinic setting, perhaps co-located at the hospital, but equally delivering service into the hospital as part of that role, in much the same way as traditionally a GP VMO in a small town like - it's not that small - a town like Cooma - might once have operated?

DR AYERS: It is in fact something that I have strongly advocated for and begun to make happen at Cooma with support from the district. It is a very important move and this is why earlier on, I said that the current award is not up to date. It needs to be revised and updated. Because if you look at the appendix at the back, I think it's at the back, it doesn't recognise RACGP or ACRRM as being specialist colleges. That is really deeply

insulting, if I am honest, and I think that absolutely has to change.

Now, don't get me wrong, in the award itself, there are clauses that allow you locally to employ a GP or a fellow of the ACRRM college as a staff specialist, but you have to hunt for that clause within the award and it's really a local --

THE COMMISSIONER: You are talking about the Staff Specialist Award?

DR AYERS: Staff Specialist Award, yes, correct, but you have to hunt for that clause and it is open to interpretation and you have to have the wider support of your LHD in order to do that and, obviously, in rural LHDs, that's more common. But how about we just recognise their colleges as being specialist colleges.

MR MUSTON: Part of that is recognising the colleges and employing those individuals as staff specialists. Part of it is also the role that they are potentially delivering in health service and running properly continuous primary care through potentially co-located rooms at a hospital facility, like at Cooma, or co-located rooms that we saw when we travelled down the road to Bombala, it has not traditionally been part of what the public health system in New South Wales, at least, sees as its function. Do you have a view in relation, first, to whether it should be its function?

DR AYERS: Well, let me put it this way. We have to be innovative and we have to evolve. It may be that in the past, that split system was okay, but we are not in that world anymore. As I said, the way that we train doctors and nurses has evolved; has changed. The priorities of our workforce have changed, especially after COVID. We have to really change the way we think about things and the way we conceptualise how healthcare is delivered in order to move with the times and with the needs of our workforce.

If you just look at the number of vacancies in healthcare positions across New South Wales, the numbers speak for themselves. We're not attractive, but we have to ask the "Why?", and we have to do something to retain that workforce. You imagine the cost of training just one of those individuals, just one, in a graduate degree now. So

they have gone through an undergraduate degree and then they have gone through a post-graduate degree in order to get through medicine or nursing, the cost of training that one person, and then you can't create the conditions that make them want to stay, there is certainly increasing anecdotal evidence that many of our junior doctors are wanting to take a gap year, a year out, because they are so disappointed with the environments that it doesn't offer them the flexibility or the choice. So we have to change that. We have to evolve in order to give the workforce sustainability and create the services that really deliver health and healthcare more locally; not rely on transfer out to metropolitan centres because, as you have heard, that's challenging and it is not necessarily what the community wants either. They want to be treated locally and there is good evidence to show that they're not looking for a metropolitan tertiary hospital on every doorstep. That's not what they are looking for.

If you talk to rural communities, they just want that core service, the basic things done well, and I don't think that's a lot to ask. I think that is absolutely doable, but we need to think outside of the box. We need to be more innovative and more creative in the way that we organise the workforce and the way that we develop contracts, awards, determinations, to meet the present needs; not the past.

MR MUSTON: Okay. I will move to another challenge that I am pretty sure you did tell us about in Cooma which is something, I think, described as a "capital deficit" and that term doesn't give us much of a picture of what that really is as a lived experience, but could you, Ms Cawthorne, tell us a little bit about what "capital deficit" means in the context of Cooma Hospital's operations.

MS CAWTHORNE: So this is one of those conditions that we learn to deal with on a daily basis that's another competing demand on our clinical, and it is part of our work around on a daily basis, and I am sure you saw, as you walked into the building, the challenges of finding your way around the building and the add-ons and the add-ons and the add-ons. When I talk to that, I am referring to the equipment that we are utilising. So, in particular, our operating theatres, delays in essential upgrades or essential repairs and maintenance of our equipment.

We had a delay of approximately two years for our endoscopy upgrade. In that, that has left us with tens of thousands of dollars of recommissioning fees, of getting technicians, service technicians to come in after-hours or paying our maintenance teams to come in and do workarounds to make the equipment work. We are getting loan equipment. So, we are spending so much more on just fixing broken because there doesn't appear to be - and just to put it, I am a site level manager so I am aware, through a very small lens and I am sure there is a bigger picture, but we're not getting the tools and the equipment we need to function, and I am haemorrhaging money for loan equipment and for repairs and maintenance that we don't seem to have a budget for, and it seems to be across the district. So repairs and maintenance, assets and backlogs of getting our equipment fixed is, apart from our premium labour, I see as a site level manager, one of our biggest frustrations as clinicians on the floor. If you don't have the right tools to do what you need and, you know, we have got a backlog - and I can personally talk to my own computer, and I know it is a very, very small item and in a non-clinical role, but my role still has clinical implications, if I can't do what I need to - I spend 40 minutes waiting for my computer to start-up. There is a backlog to get these fixed. There is a plan to get them fixed. They are not coming until late September at this stage is my understanding, but the clinicians in ED are doing the same. So, repairs and maintenance and assets, we need to have a really robust dedication to actually having a funding pocket for this so that we can actually get what we need to do the basic things that we need to do on a daily basis. I think that --

THE COMMISSIONER: Can you just help me with some of that? Essential upgrades to equipment, now, should I understand that to mean we need an essential upgrade? Does that mean we need to replace - first of all, replace some of what we have with new?

MS CAWTHORNE: Yes, absolutely.

THE COMMISSIONER: And just pausing there, the old, I perfectly understand what you are telling me about the old equipment is seemingly regularly requiring maintenance and repair.

MS CAWTHORNE: Yes.

THE COMMISSIONER: For which you say we don't have the budget, but at the time that the equipment is still functioning, is it still functional or is it so out of date it is almost useless? What should I understand by essential upgrades? Is it just the constant breaking down?

MS CAWTHORNE: Correct. And I had one of my colleagues on Tuesday, when we spoke to you, talk to some endoscopy equipment that is actually no longer - it is no longer --

THE COMMISSIONER: Yes.

MS CAWTHORNE: -- serviceable in the sense that we send it back to technicians. It is over - it has expired its usage time, essentially. However, it still functions with repairs, so we send it off for repairing and we wait until that time when they say, "It can no longer be repaired". So, I had this with a drill just recently in theatres and I had to buy brand new drills because we could no longer service it any more.

THE COMMISSIONER: For me to understand that, because it seems, as someone from outside the health system, quite bizarre and a disconnect between the people, ie, the clinicians that have to use the equipment and whoever is making the decision about the money to replace it, there seems to be this disconnect between the people with the money, whoever they are, to pay for the replacement - and tell me if I am wrong - seemingly have a view that it is better to wait until the equipment is either unrepairable or entirely obsolete, rather than paying to replace it, even though by not paying to replace it, you're having to pay all this money to constantly repair.

MS CAWTHORNE: So I can't talk to the decisions at a high level, but certainly from a site level, it is --

THE COMMISSIONER: That's the site level that we're --

MS CAWTHORNE: -- it is escalated and their common theme is we are triaging the small pocket of money that we have, prioritising the replacement of essential equipment right across our district, so --

THE COMMISSIONER: That seems like some sort of

communication failure to the people that provide the funds because surely no-one, if they looked at a set of numbers and went, "It is costing us more to repair this stuff than it is to actually replace it", they would make the logical decision to replace.

MS CAWTHORNE: It certainly feels that way on the floor. I can't talk to it from a higher level. I think that sits, yeah, much higher.

THE COMMISSIONER: Thank you.

MR MUSTON: From the perspective of the floor, though, you're confident that that particular challenge, namely, the equipment that's either not functional in a way that it should be for clinical reasons --

MS CAWTHORNE: Yeah.

MR MUSTON: -- and, more importantly, not functional in a way that means it is costing more money to - well, costing you large amounts of money to repair and maintain is something which is being communicated to the local health district?

MS CAWTHORNE: Yes.

MR MUSTON: By you?

MS CAWTHORNE: Yes.

THE COMMISSIONER: Sorry, can I just ask about the 40 minutes for a computer to start. First of all, do I understand that you push the button to turn it on and it takes 40 minutes before it is usable?

MS CAWTHORNE: Correct.

THE COMMISSIONER: How long has that been the state of affairs?

MS CAWTHORNE: So, I logged a job through our portal in November, approximate - it was late November, early December. I went on leave for two months.

THE COMMISSIONER: 2023?

MS CAWTHORNE: Twenty - yeah, last year, and it was replaced at the end of February, or just after I returned from leave.

THE COMMISSIONER: And are all the computers currently in a state where it takes 40 minutes?

MS CAWTHORNE: Not all --

THE COMMISSIONER: Not all of them.

MS CAWTHORNE: -- but we do have a number across the site.

THE COMMISSIONER: And the computers, I assume, are used to record patient data, treatment, that sort of thing?

MS CAWTHORNE: Yes. Mine is administrative but I have two in ED at the moment that are due to be replaced in September.

THE COMMISSIONER: But you will get new ones in September.

MS CAWTHORNE: Yes.

THE COMMISSIONER: Which presumably will take less than 40 minutes to power up, correct?

MS CAWTHORNE: Yep.

THE COMMISSIONER: When you do get new ones, they turn on fairly properly, do they?

MS CAWTHORNE: Yes.

THE COMMISSIONER: Okay. Good.

DR AYERS: We are so reliant on computers. I am sure you know --

THE COMMISSIONER: Yes, it was explained.

DR AYERS: Yes, that everything was taken off paper because doctors and nurses, but mainly doctors, have bad handwriting.

THE COMMISSIONER: Really.

DR AYERS: For the sake of legibility and safety.

THE COMMISSIONER: Well, there are all sorts of good reasons to digitise because you can send information.

DR AYERS: Absolutely. But they are essential, but I would say it is not unique to our LHD. This is the fourth LHD I have worked in in New South Wales and I guess ICT is an interesting beast, isn't it, because it is often delivered as a project, but a project has a finite lifespan and so how do you appropriately cost for the depreciation and the wear and, I guess, the way that equipment becomes obsolete. So if you introduce, let's say, brand new hospital, you suddenly buy all the equipment all at once, doesn't it therefore suggest that all your computers might reach the end of its life at roughly the same time? So then short funding cycles are not helpful.

THE COMMISSIONER: Yes.

DR AYERS: There needs to be short, medium and long term thinking around this.

THE COMMISSIONER: You are talking about the 12-month budgetary cycle there.

DR AYERS: Yes.

THE COMMISSIONER: Which, no doubt, somewhere there is a component for buying computers that turn on more quickly than 40 minutes.

DR AYERS: But it's on average, right? So it is thinking about an average of, let's say, one - I'll use this just as an example, it is not a real example, but let's say one of your 200 computers failing every year, let's say, but that's not the reality because if you purchased all 200 computers at the same time, at the beginning of your ICT project, doesn't it then logically follow that they might fail, or reach the end of their lifespan at roughly a similar time --

THE COMMISSIONER: Well --

DR AYERS: -- which then doesn't fit in nicely to that 12-month budgetary cycle.

THE COMMISSIONER: I don't think that should be either of your responsibility. Working out the algorithm for replacing computers isn't my responsibility either.

DR AYERS: No.

THE COMMISSIONER: But it does seem odd that if a computer is taking 40 minutes, in a health system, to power up why it is not replaced immediately, but maybe there is a really good reason for that that I don't know about.

MR MUSTON: A logical reason might be building a hospital and budgeting for the staff that will be needed to operate it.

THE COMMISSIONER: Sure.

MS CAWTHORNE: This is the same as the redevelopment works at Cooma that have taken several years to deliver. You know, we have been working in environments that have been very challenging and, you know, you get a pocket of money to build - and, again, I am speaking from a lens that's at a site level, but we are trying to build and maximise what we can with a pocket of money that is not enough to do what we need and when you open that can of worms of building old on to new, then we are left to pick up the pieces.

Just this week I am trying to work out how to get coverings for the doors from a Health Infrastructure build that's gone into our industry, and I am extremely grateful for the moneys that has come to us, but don't start something unless you have got the right money to do the whole job. Because now we have these leftovers that's now for the site, or the district, to now try and find a pocket of money to fix. I am trying to get an awning for my door. It is a main entrance into the building that - you know, I am putting mats out, I am improvising. You know, I've got --

MR MUSTON: This is in a town where it sometimes snows?

MS CAWTHORNE: Correct, and, in fairness, it doesn't rain a lot. So you have also got an area that's got duress - and I talked to you about our duress tags on Tuesday. So I have old infrastructure --

THE COMMISSIONER: That was where the duress tag, the

staff member is - wherever they are --

MS CAWTHORNE: It's on level B.

THE COMMISSIONER: -- and they are on the floor above?

MS CAWTHORNE: Correct. Yes. So that's due to be fixed but it wasn't budgeted as part of the original because you have old on new and, neither the twain shall meet. So, again, it is another challenge that has been left to rural staff to do a work around. And let me tell you we're performing, we're doing what we need to do. We are delivering the care, we are doing what we need to; it is coming at a cost.

MR MUSTON: Just so I can understand that, that little example you have given about the emergency or the distress tags, the duress alarms, I should say, that, I think you told us, related to the fact that the Wi-Fi access points that were installed as part of the new build didn't necessarily talk to the Wi-Fi access points which were pre-existing in part of the old build, such that the duress alarms --

MS CAWTHORNE: So it is two systems is what I have been told. I am a mere mortal clinician, so I won't even delve too much into the ICT, but I have been told it is two systems and it needs to be made into one. There just needs to be money to do that.

THE COMMISSIONER: There is always teething problems. I mean it showed up --

MS CAWTHORNE: I think we've had more than our fair share.

MR MUSTON: Do you remember if the rebuild process at Cooma, such as it is, the sort of technicians who are no doubt having to be brought in to upgrade or consolidate the two systems, were they the same sort of technicians who were on-site installing the new Wi-Fi access points in the new part of the build, do you know?

MS CAWTHORNE: I don't know in that space, yeah.

DR AYERS: It all goes back to the bucket of money that you're given and, if you like, under-estimation of what we do and how much funding that requires. So if you have got

a limited bucket of money and you've got all these upgrades that you have to do, going back to the computer one, and you have to choose, and you know, for example, that ICU needs a new ventilator versus the laptop that takes 40 minutes to boot up, what would you choose? Of course you are going to update the ventilator, but you are having to make that choice because the bucket of money is too small.

And there's not a, if you like, not a sophisticated enough understanding of the amount of funding that a rural health service actually requires, because if you only look at historical demand, there are so many other things that you are not factoring in, as Jo was describing. You're not necessarily understanding - if you are only looking at averages, you're not understanding the fluctuations that can happen between seasons. You're not understanding the fact that there may be a new housing estate springing up on the edge of town and therefore suddenly increasing demand. You're not, maybe, factoring in the fact that you have lost the GPs in your local community, so suddenly there's a much greater demand on acute healthcare because people have to seek healthcare somewhere, and if the GPs are no longer in town, where else are they going to go? So then you can't necessarily predict that or model that if you don't have that granular detail.

MS CAWTHORNE: Just on that, though, we have got the special activation precinct that is coming in for Jindabyne and the surrounding Snowy Mountains. So it is being looked at. They are expecting that we are going to be growing. They are expecting that they are going to be attracting tourism to our region for their outdoor activities. We need to plan for that.

DR AYERS: But if you are just adding incrementally from historical numbers and historical demand and not even factoring unmet demand, never mind growth, how is that equation ever going to come out equal? You somehow have to go back to looking at the real need in that community and understanding that at a much greater detail.

THE COMMISSIONER: The real need and the real cost.

DR AYERS: And then working out, yes --

MR MUSTON: The real need --

DR AYERS: -- accurately the costs of carrying out care in that setting

MR MUSTON: And the real need in the community, I gather from some of the answers you've just given, is a dynamic thing?

DR AYERS: Absolutely. And therefore, your historical projections may not tell you what is going to happen tomorrow. And that's then the lived experience that the teams have at each site, where they are saying, "Well, hang on, we admitted 10 people overnight. Who could have predicted that?" That's how it translates into a real life example.

MR MUSTON: Just on that, can I ask you, Ms Cawthorne, what is your lived experience of the impact of our Snowy Hydro 2.0 in a broad sense - not only patient flow, but in a broad sense on your ability to deliver workforce and deliver care through that workforce to the people who are needing it?

MS CAWTHORNE: Yep. So lived experience, most definitely probably the greatest impact for us has been our staff being able to get affordable accommodation. The site, the hospital, has rented homes so we can actually bring staff in and put them into accommodation. I personally have been to real estates to find homes for people, to say, "Can you please prioritise my team," which they've been very good at trying to accommodate, but there is increasing costs that come with that.

And child-care. So I have a workforce that are remaining casual, or they have very limited availabilities to their shifts, and this is where it is challenging with shift workers in particular for our site, certainly getting managers into positions as well, because they can't get out of school care. They can't get day-care. I personally, I have a one-year-old. It took us nearly six months of being on a waiting list to know whether we were going to be able to come back to work. My partner is also in nursing, and for - it was going to be which one is going to stay home, is that's where we're at, and the Snowy project, and - certainly not to blame, but the town dynamics have changed, and getting into day-care, you could do very, very easily. But to wait months is ridiculous, and I think

that's probably the greatest impact I have had, and to cover our shifts, I have got a nurse that says, "Yes, I can probably do some night shifts." She picks up at least six shifts as a casual and then she cancels them because it - they can't give me.

THE COMMISSIONER: You told us at the round table, I think, that in terms of extra demand on the hospital services, you said - I think you said the corporates are actually looked after by Snowy --

MS CAWTHORNE: Yeah.

THE COMMISSIONER: -- but the rest of the workforce, it's New South Wales?

MS CAWTHORNE: Yes, so we've got the local population growth that has occurred and I have seen over the last three years, looking at the data, we've had over 400 Medicare ineligibles that are now coming through. So whilst that is factored in to our administration, we've got after-hours admin that's come on shift now to try and capture that. We could lose up to, you know, thousands of dollars if we don't capture these Medicare-ineligible consumers coming through. It is having an impact, and it's not a lot, but it's enough. And it's coming through our maternity department more so than most of them, because they have come to the community, they're actually - they're within their 12 months of having their private health, so they're now being charged full fees. It is a change in dynamics for us but I need the admin staff to support that change that's occurring for the site.

So, yes, we have our revenue team, they can send out their invoicings, but there is a local amount of invoicing and chasing that occurs as well. So it is a change in our dynamics, and we have actually put on - I think, yeah, it was over 400 in the last two years that we have had come through from the Snowy. And looking at the data, the majority of them are 2630 post code, so the Cooma post code. So they are local. This is not overseas or travelling people. So yeah, it most definitely has had a change to how we function.

MR MUSTON: Last question. You mentioned in an earlier answer some of the particular challenges that you faced just in a practical and logistical sense arising out of the

facility prior to it being rebuilt or partly rebuilt.

MS CAWTHORNE: Yeah.

MR MUSTON: And then during the rebuild. Just so we can understand what those challenges look like from a day-to-day perspective, what sort of figure are we talking about?

MS CAWTHORNE: So we were referring to COVID? Was that our conversation with COVID --

MR MUSTON: That conversation.

MS CAWTHORNE: -- and getting quite - so during COVID, Cooma Hospital ran a tent in the carpark to accommodate for the changing epidemic. I know the whole country, the whole world, was in a moving feast at the time to try and accommodate people and work in isolation. We don't have negative-pressured rooms. We have a nine-day emergency department, as you would have seen. It is very close proximity, and the bays are extremely small.

MR MUSTON: This is post-upgrade?

MS CAWTHORNE: This is post-upgrade. However, we were working between a redevelopment where we had an old build and a new build. We had a temporary ED and we had a tent. So we were working in a tent to keep people isolated and keep them segregated, so we - that was all we had to - that shows you that rural is very good at being crafty and making do. As the pandemic and our understanding of the transmission of COVID changed, we were able to co-locate them in a department. However, that's not the gold standard. It's enough. It's enough to get by, is what we need to do.

But, you know, we are co-locating all of our respiratory patients on a general ward, and we can put them in single rooms, but they have got shared air-conditioning. That's the state of rural, and it is something we have to accept. It's certainly, from an on-the-ground managing staff perspective and their concern for their consumers working in an environment that was challenging and not meeting what was delivered as an infection control best practice, but there was, "If you have this available, then this is acceptable." We were at the "this is acceptable"

stage.

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

THE COMMISSIONER: Just before I invite Mr Chiu as to whether he has any questions, as with the four doctors on the previous panel, I don't want either of you to leave here without - if you feel as though there is something critical that you haven't had an opportunity to say, so if there is something critical further you would like to say, please go ahead. I will start with you first, Dr Ayers. Is there something you didn't feel as though - that you wanted to raise, that you didn't get the chance to?

DR AYERS: I think for our district, certainly, and our situation with having two borders, I think I would love to see a situation where we can really have New South Wales rural trainees training with us and that we're not just training ACT students and ACT doctors. I love the fact that we do have this close relationship with the ACT because, as you can appreciate, they are our referral partner, they're the closest tertiary referral centre to us. And those relationships and those working relationships are really important to us. But I would still love to see us grow our own rural workforce. And there are examples of that elsewhere, you know, so Albury-Wodonga achieves that very effectively. There is no reason why we can't do the same and have a blend of ACT and New South Wales trainees working together.

I would love to see that happen, but I would also love to see us growing our First Nations workforce in a much more intentional way, and be supported in that with the right funding. It would be a win/win for our rural region to be able to create that workforce that will help us deliver the kinds of models of care that really have cultural meaning and cultural safety for our First Nations peoples, and it is something that I am really passionate about after having worked in both the Northern Territory and in WA in remote places. I would love to see that a reality in my career lifetime.

THE COMMISSIONER: Thank you. Ms Cawthorne, is there anything further?

MS CAWTHORNE: Just from my perspective, I think one key

point that I did actually bring up on Tuesday was the size of our site and what we actually see through Cooma. Our inpatient unit, what we admit, our emergency department, what we see, you know, and I think the key takeaway point we are too big to be little, we are too little to be big. We are stuck in the middle, but we are expected to perform.

We aren't funded appropriately. Just because they have "RN" after their name or "Dr" in front of their name, they need to be the right skill set. They need to be supported in an education program that's not just a site-led, "You have got your advanced life support." We need to look at what a training program looks like for rural specialty, rural nurses, allied health professionals working in rural. They need to be professionally recognised for that, make it attractive, make it why they need to come to rural. So professionally recognised, financially recognised. Make sure that we can actually keep these people with us in rural.

Not everybody needs to have the same remuneration. If you're in metro, that's fine you choose to be in metro. If you are in rural, we are special, we have a special skill set, and we need to stop putting metro models into rural. We need to start seeing rural as its own specialty and recognise that. We need to fund it for what it is. We are not metro, and health is not health in metro health is not health. In rural, we are completely separate entities. If we are having low numbers coming through our community nursing department, we get a very small pocket of money to get the right equipment, the right procurement to deliver chronic and complex care for these consumers. Instead, we're putting very basic dressings on because we don't have the money to be able to do what we need to, and it is costing us more, and that's the same with our assets. So please could we have a look at what it is that needs to drive rural. Our current funding model doesn't work for us. I also don't want a block of money and say, "Just go forth and do it." We need to have a look at what it is that we need to do, but it will cost you more because of where we are and what we need to drive that.

THE COMMISSIONER: Sorry to ask you the question, but I am not a clinician so I tell you, when you use the term like "very basic dressings" and leave me with the impression that there is something more appropriate that should be used if you had it --

MS CAWTHORNE: Yes.

THE COMMISSIONER: -- (a) is that basic understanding right, and (b) can you give me a little bit more precision about what you mean?

MS CAWTHORNE: So in regards to some of our chronic and complex wound care, the dressings will cost hundreds. And that one dressing, for instance, could remain with that consumer for a week, and that provides best care. But, instead, we're not buying that because we could be limited to a $1,000 budget. And I don't like to get down to the detail, because I was trying not to do that too much today, but, you know, if you have a budget of $1,000 to actually run your community nursing and I'm going to spend $250 on one person's dressing, I'm going to not give best outcomes for everybody else, so I'm going to make do with what I've got. And it takes longer to heal if you don't use the right stuff.

THE COMMISSIONER: That was my next question. Is there --

MS CAWTHORNE: It is a bit like the assets. If you don't spend the money, it costs you more in the long run.

THE COMMISSIONER: Should I understand that to mean that --

DR AYERS: We don't have the purchasing power.

THE COMMISSIONER: I mean, when you are using an expression like "it will take longer to heal", are the basic dressings that you have to buy because of the budget adequate in terms of the healthcare needs or are they less than that?

MS CAWTHORNE: They would be less than that, and I feel very comfortable in saying that, because you --

THE COMMISSIONER: These are dressings for what kind of wound?

MS CAWTHORNE: Chronic and complex. So chronic leg ulcers. So my wound care CNC, I am sure she is watching, she has a skill set. She knows what she needs to do to do the job. We don't have the buy-in or the procurement cost

to be able to deliver the care that we need.

DR AYERS: Because it is activity-based funding. So we can't - if you like, we can't purchase in huge numbers because we won't get the input in terms of patient numbers. So if it comes in a box of 500, let's say, and you only use 10, so --

THE COMMISSIONER: I mean, don't take this as a criticism, but I don't view that as - maybe it has got something to do with activity-based funding, but in the end it is a decision being made as to your budget.

DR AYERS: Yes.

THE COMMISSIONER: And it leaves you with less than optimal options in terms of the dressings you can buy. That's how I should understand it, right?

MS CAWTHORNE: Yes.

THE COMMISSIONER: Sorry, I cut you off. You finish.

DR AYERS: Yes. Look, I think clinicians who are working in the rural space just feel that, certainly in all the conversations I have, we feel that the rural health system is disadvantaged compared to our metropolitan neighbours, because they can get the throughputs, they can get the numbers, and so therefore their activity is much, much larger. We'll never be able to compete in terms of activity.

THE COMMISSIONER: No, of course not.

DR AYERS: And so we all feel that something structurally needs to happen for us to be able to feel that rural is being treated equitably. It is about that equity of healthcare access services, resources.

THE COMMISSIONER: That's not just clinicians and the workforce being treated equitably?

DR AYERS: Absolutely.

THE COMMISSIONER: That's the patients as well --

DR AYERS: Absolutely. The whole thing.

THE COMMISSIONER: -- in terms of the issue you just raised.

DR AYERS: Yeah, the whole thing. So not just talking about clinicians but talking about the wider system. We're looking for change because we feel very strongly that the current system advantages the metropolitan centres because the activity-based counting and payments are therefore driving you to see more, do more. But we've only got limited number in our community, so what more can we do? As Jo said, for example, the 150 births a year, you know, there are only so many people out there that we serve in our communities, but it doesn't mean that they don't deserve as good care, and it doesn't mean that they don't deserve as good care as local to them as, you know, they would want. They are always going to accept that they need to do some form of travelling.

THE COMMISSIONER: Yes.

DR AYERS: I mean, rural people are very resilient and robust when it comes to that. We understand. But have to travel all the way into a capital city, to say that our referral centre is, let's say, Sydney, or even Canberra for some of our most southern patients and communities, that's hard. That could be a mother and child separated from the rest of their family for extended periods of time, receiving treatment. I think we can do better. I really do. And I think that there's more that the structures that are outside of our control could do to help us and assist us. Like HETI, like the training colleges, like our, you know, nursing and medical structures that, if you like, grants those expertise labels that give people the sense that they have achieved expertise. There's more that the specialist colleges certainly could do to recognise rural work as being its own entity and own thing, and the value in spending time in rural.

THE COMMISSIONER: I will ask you first. Did anything flow? Nothing? Nothing further from you? Mr Chiu, do you have any questions?

MR CHIU: Nothing.

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

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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