Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Tamworth District Court
Marius St & Fitzroy Street,
Tamworth NSW 2340

Tuesday, 17 September 2024 at 10am

(Day 50)

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 Richard Cheney SC with Mr Hernan Pinto-Lopez
for NSW Health

1 THE COMMISSIONER: Good morning, everyone. Just before
2 I take appearances and hear anything by way of opening
3 statements, because this is the first day of the hearings
4 here in Tamworth for this inquiry, I'd like to acknowledge
5 that we meet today on the traditional lands of the Gomeroi
6 people. I recognise their continuing connection to this
7 land and pay my respects to Elders past and present, and
8 I extend that respect to any Aboriginal people present
9 today or who might be listing or watching online.
10
11 Mr Glover.
12
13 MR GLOVER: Commissioner, I appear with my learned friend
14 Mr Fuller for this hearing block.
15
16 MR CHENEY: Commissioner, with your leave I appear with Mr
17 Pintos-Lopez for NSW Health.
18
19 THE COMMISSIONER: Thank you, Mr Cheney.
20
21 MR GLOVER: Commissioner, the hearing block this week
22 commences the last of our regional hearings. By the end of
23 the week, we will have sat in Wagga, Wagga, Dubbo, Broken
24 Hill, Batemans Bay and now Tamworth. Save for Albury, this
25 week also concludes our visits to the regional parts of
26 New South Wales.
27
28 Throughout the work of the inquiry we have now
29 visited each rural and regional LHD, met with and heard
30 from many people: clinicians, health administrators, and
31 members of the public. Although much of the focus of the
32 work of this inquiry has necessarily been on the
33 identification of issues and challenges facing the delivery
34 of healthcare in New South Wales, what has remained
35 constant throughout our travels, including over the last
36 few weeks, is the dedication of those working within the
37 healthcare sector, within NSW Health and outside of it, to
38 caring for their patients and communities across the State.
39
40 This week also is the culmination of the inquiry's
41 visits to the northeast part of New South Wales, visiting
42 the northern New South Wales LHD, the Mid North Coast LHD
43 and now Hunter New England. We began our travels a couple
44 of weeks ago now in the Northern NSW LHD, visiting Lismore,
45 Ballina and Tweed Heads. Whilst in Lismore, we visited the
46 Lismore Base Hospital and met with clinicians and
47 management in a round table setting. As always, and

1 I might say this a few times in this brief opening this
2 morning, those discussions with incredibly valuable in
3 understanding the challenges faced by those on the ground
4 in the region but also some of the successes they've had in
5 the face of adversity.
6
7 On that note, we heard from those involved in
8 delivering care through the devastating floods that
9 impacted Lismore in 2022. For those of us who watched from
10 afar during that period, it is somewhat difficult to
11 comprehend the devastation that affected that community,
12 but what we heard were some incredible stories of
13 resilience and commitment by those in that region. For
14 example, we heard of staff who, despite having lost their
15 own homes to those floods, attended the hospital for their
16 shift no less than 48 hours later. We also heard of some
17 ingenuity in people getting medical services to where they
18 were needed, including transporting some rather high tech
19 medical equipment in taxis to ensure it got where it needed
20 to be.
21
22 Whilst in Lismore, we also had the benefit of meeting
23 with the local Aboriginal community Controlled Health
24 Organisation, Rekindling the Spirit, and with the drug and
25 alcohol service, Namatjira Haven. Engaging with those
26 involved in delivering care to Indigenous communities in
27 the regions has been a valuable part of the work of the
28 inquiry, and the opportunities to do so in Lismore and in
29 the other places we visited was no exception.
30
31 We have also heard evidence throughout the inquiry of
32 the benefits of training being undertaken in rural and
33 regional areas and we were fortunate to visit the
34 University Centre for Rural Health in Lismore. There, we
35 heard again the benefits of students spending more time in
36 rural and regional areas during their undergraduate,
37 training but also of the benefits of students across
38 disciplines training and living together, with a view to
39 fostering the type of integrated care approach and
40 understanding between those in different disciplines of the
41 work that they each do.
42
43 In Ballina, we met with the PHN that covers the vast
44 district of the northern New South Wales LHD and the Mid
45 North Coast LHD, Healthy North Coast. There, we heard of
46 the benefits of joint planning and commissioning across the
47 primary and acute care sectors and what might be done to

1 improve that to lead to better delivery of services. We
2 also saw what might be the future of an integrated primary
3 care practice at First Light Healthcare.
4
5 In Tweed Heads, we met with the Bulgarr Ngaru Medical
6 Corporation and heard about their initiatives to
7 deliver better healthcare to the Indigenous communities of
8 that region, and their views on how services might be
9 better integrated between those of services like theirs and
10 those offered by NSW Health.
11
12 From there, we travelled north to the newly opened
13 Tweed Valley Hospital. That facility was opened only
14 in May of 2024. Whilst there, we had the fortune of being
15 introduced to the site by Cameron, a local Indigenous
16 artist, who explained to us the significance of the site on
17 which the hospital is built to the Indigenous community,
18 but also how art has been integrated into the build to make
19 it a more welcoming and safe experience for those
20 First Nations communities. The round table at Tweed Valley
21 Hospital was again very worthwhile.
22
23 At times, we have heard evidence during this inquiry
24 of the disparity in award conditions between
25 New South Wales and neighbouring states. The disparity is
26 in sharp focus in the northern parts of the State with the
27 lure of Queensland, and we heard from some clinicians in
28 the very early stages of their careers about the very real
29 decisions they have to make as to whether they stay south
30 of the border in New South Wales or whether they take the
31 short trip north to better conditions, and I expect you
32 will hear some evidence about that over the next few days.
33
34 The next stop in our visit was the Mid North Coast
35 LHD, beginning in Coffs Harbour. Whilst in the regions, we
36 again had a number of beneficial meetings with local
37 clinicians and Aboriginal medical services, and I think it
38 is fair to say that there was a general consensus across
39 each of those meetings that there is a need for enhanced
40 coordination and joint planning of services between those
41 in the primary care and the Indigenous care space and those
42 in the acute care sectors.
43
44 Whilst in Coffs Harbour, we visited the Coffs Harbour
45 Health Campus. There, we saw some of that facility and met
46 with more clinicians and managers. We heard of the
47 challenges in recruiting and retaining staff and, indeed,

1 the lure of Queensland from that far south in the State.
2 We also heard firsthand of the effects on the hospital
3 services of the lack of aged care facilities and NDIS
4 facilities, leading to a large number of patients remaining
5 in hospital when they are ready for discharge. Not only is
6 that a bad outcome for those patients, but we had some
7 demonstration of the knock-on effects that that may have to
8 hospital services, including in surgery lists and in the
9 emergency department.
10
11 We then visited the Bowraville HealthOne facility.
12 That is a service that includes general practice and is one
13 that is operated by the LHD. You will hear a little bit
14 more about that initiative, but it is an example of the LHD
15 stepping in to provide primary care where there was no
16 market. As might be expected, we are told that the initial
17 evaluations of that service have led to greatly increased
18 health outcomes, but also flow-on effects to the delivery
19 of other services in the LHD.
20
21 From there, we travelled to Port Macquarie and Port
22 Macquarie Base Hospital. That round table involved some
23 thought-provoking discussions about what the public health
24 system might look like, echoing some of the comments that
25 were made by Commissioner Garling in his inquiry about the
26 need to have a discussion about how one designs the public
27 health service to ensures its sustainability going forward.
28
29 Yesterday, whilst in Tamworth we visited the Tamworth
30 Hospital and we had two round tables: one concerning the
31 delivery of maternity and obstetric services and another
32 focusing on the challenges like we heard in Mid North Coast
33 around patient length of stay.
34
35 We were also fortunate to receive a presentation on
36 some innovative steps taken in the district around
37 sustainability in housing, and we heard that those
38 initiatives have already delivered significant benefits,
39 both environmentally and financially, to the district.
40
41 Members of the inquiry team also met with the Tamworth
42 Aboriginal Medical Service and we were hosted by the
43 University of Newcastle's regional training hub. Similar
44 to the benefits of rural training that we heard and saw
45 first-hand in Lismore, we again heard about the benefits of
46 long-term exposure to students across the disciplines, both
47 medical, nursing and allied health, to training and

1 placements in rural and regional areas.
2
3 In this block of hearings, Commissioner, you will hear
4 some evidence that is drawn from each of the LHDs that we
5 visited over the last few weeks, and in addition to those
6 witnesses that are to be called, there are a number of
7 statements that will be tendered, although you won't hear
8 directly from those witnesses this week.
9
10 With that short opening, the first witness to be
11 called is Dr David Scott, and Mr Fuller will take that
12 witness.
13
14 THE COMMISSIONER: You don't want to say anything,
15 Mr Cheney?
16
17 MR CHENEY: No, your Honour.
18
19 THE COMMISSIONER: Yes, Dr Scott. I am not actually sure
20 where the witness box is. It's over there, is it? Very
21 good.
22
23 **<DAVID ROBERT SCOTT, AFFIRMED [10.12 am]**
24
25 THE COMMISSIONER: Yes, Mr Fuller.
26
27 **<EXAMINATION BY MR FULLER**
28
29 MR FULLER: Q. Thank you, Commissioner. Dr Scott, would
30 you state your full name please?
31 A. David Robert Scott.
32
33 Q. Your professional address is Dean Street, Tamworth,
34 New South Wales, 4340; is that right?
35 A. That's right.
36
37 Q. You are a physician and gastroenterologist VMO at
38 Tamworth Rural Referral Hospital; that's right?
39 A. That's right.
40
41 Q. And you are also chair of the Tamworth Hospital
42 Medical Staff Council; that's right?
43 A. That's right.
44
45 Q. You've prepared a statement to assist the inquiry?
46 A. I have.
47

1 Q. I'll ask you just be given a hard copy of that to make
2 it easier for you, but the document number is
3 [MOH.0011.0055.0001] and it is proposed to be exhibit K-41
4 in the tender bundle, Commissioner.
5
6 THE COMMISSIONER: Yes.
7
8 MR FULLER: Q. Dr Scott, you have a got a copy of your
9 statement. Have you had the opportunity to review your
10 statement recently?
11 A. I have.
12
13 Q. Is everything in it true and correct to the best of
14 your knowledge?
15 A. It is, yep.
16
17 Q. Thank you. That will be tendered in due course,
18 Commissioner.
19
20 THE COMMISSIONER: Yes.
21
22 MR FULLER: Q. Dr Scott, you have worked as a VMO at
23 Tamworth Hospital since 2010; is that right?
24 A. That's right.
25
26 Q. What's the nature of your VMO appointment? Is it a
27 sessional appointment or a fee-for-service appointment? Do
28 you know what I mean?
29 A. Both. So ward rounds and clinics are sessional, and
30 then - but I do procedures as a gastroenterologist and they
31 are fee-for-service.
32
33 Q. What proportion of your time do you spend working at
34 Tamworth Hospital in comparison with your other work that
35 you have told us about in your statement?
36 A. It'd be two-fifths of the week, probably.
37
38 Q. You told us you also work at Tamara Private Hospital?
39 A. Yeah.
40
41 Q. That's right? Is that also in Tamworth?
42 A. That is. Just down the road.
43
44 Q. And you also work at Gunnedah Hospital; is that right?
45 A. Once every two months.
46
47 Q. Can I ask you, please, to have a look at paragraph 7

1 of your statement. You've told us there - thank you, it is
2 just coming up electronically as well. You told us in that
3 paragraph about decreasing numbers of GPs in rural and
4 regional facilities and privately, that's in the first
5 sentence. Are you able to quantify in any way the decrease
6 that you're referring to?
7 A. Well, I guess there is a distinction between decrease
8 in GPs in the town and decrease in GPs at the hospital.
9 When I first came to Tamworth, Gunnedah would have had,
10 I would have thought, six to eight GPs who had practices in
11 the town and would admit patients to the hospital and that
12 number I think would be less than that now, quite a bit
13 less, I'd imagine. I know, for example, like, at Inverell
14 it is not uncommon we get calls from the emergency
15 department there with patients that might need a brief
16 admission but there is no-one who can admit the patient to
17 the hospital because a doctor in emergency can't admit and
18 vice versa, so there is a distinction between those who
19 work in the town and those who work at the hospital.
20
21 Q. Starting with the hospital in at least Gunnedah and
22 Inverell, you have observed a decrease in the number of GPs
23 since your time --
24 A. Working at the hospital, absolutely. Absolutely.
25
26 Q. And what about privately, which is the other part of
27 what you referred to?
28 A. Look, harder to judge, because a lot more GPs come as
29 registrars or they come for a brief time. So a lot of
30 names come across, but I am never quite sure who is still
31 there and who is not, so I probably couldn't give an exact
32 answer. I suspect it would be less overall. That's what
33 people tell me, but I couldn't give you a number on that.
34
35 THE COMMISSIONER: Q. Is - I mean, you don't have the
36 precise data but having long experience in the medical
37 system, you'd get anecdotal sort of comments made to you
38 about whether GP numbers in private practice are decreasing
39 and that's the sense you get from that feedback?
40 A. I know more than - a number of patients from Gunnedah
41 now have GPs in Tamworth because they couldn't get one
42 locally, and I met one recently who has got a GP in Sydney
43 because that just was actually more convenient. They're
44 near where their daughter lives. They're having to travel
45 a lot further to find a private GP.
46
47 Q. In relation to these Gunnedah patients you are talking

1 about, is it the case that they can't get a GP at all in
2 Gunnedah or they can't see one in a timely manner? Or
3 both?
4 A. Possibly both, but at least some have told me they
5 can't - the books are closed, so to speak.
6
7 THE COMMISSIONER: Yes, okay.
8
9 MR FULLER: Q. You've referred in paragraph 7 - tell me
10 if I've got this right - to those, the issues you've
11 described, creating pressure on the ED at Tamworth
12 Hospital. Is that a correct understanding of what you are
13 saying?
14 A. That's right.
15
16 Q. Can you just describe how that actually plays out in
17 practice, based on your observations?
18 A. So maybe a few different ways. The lack of GPs in
19 general who could have dealt with some urgent but minor
20 issues mean that those patients might end up at the
21 emergency department, and patients may choose to come to
22 Tamworth emergency department for the lack of just general
23 practice. Secondly, the Gunnedah Hospital, for example,
24 but a lot of hospitals like that, have troubles getting GPs
25 or doctors to be there on-site, and so the patients may be
26 able to present the emergency department but then get sent
27 to Tamworth because there is no doctor there who can deal
28 with the particular issue. Or even if they meet a
29 telehealth doctor in those local - those smaller hospitals,
30 they might still feel a patient needs to go to Tamworth
31 Hospital. And then beyond that, not just having doctors in
32 town, in the hospital, but also the doctors with the right
33 skills. So that some of the doctors who work in these
34 towns have extraordinarily broad skills, procedural skills,
35 which can deal with a lot of issues in situ, but as the
36 skill level drops of the average doctor in those emergency
37 departments, the need to transfer to a bigger centre
38 increases, and so that also flows into Tamworth Hospital.
39
40 THE COMMISSIONER: Q. What are the consequences for
41 your practice as a physician to both the care you provide,
42 but also for your patients if that patient doesn't have
43 ready access to a GP?
44 A. As an outpatient?
45
46 Q. Yes.
47 A. Oh, there's a lot. So other than the presentations to

1 hospital to deal with these short-term issues, just
2 long-term preventative healthcare automatically takes a
3 second place behind dealing with the acute problem.
4 I can't discharge patients from my care to make room for
5 more because I've got to keep seeing them to deal with
6 these sort of long-term things which are not - which a GP
7 could do very comfortably. And just the need to hang on to
8 people in hospital as well, just a few extra days, just
9 because - with this situation everything is really set
10 before they go, rather than the thing's mostly right, "See
11 your GP next week and just make sure."
12
13 Q. You don't have that security?
14 A. That's right.
15
16 Q. Primary care VMO.
17 A. Yeah, yeah. So just it puts more burden on the
18 hospital and on the specialist to just hang onto them a bit
19 longer. And obviously the patient. Amongst others, has a
20 more difficult process as well, especially if they are from
21 outside town.
22
23 MR FULLER: Q. Do you perceive those issues as being a
24 significant or substantial problem for Tamworth Hospital?
25 A. Yes. Yes.
26
27 Q. You have told us at the end of paragraph 7 of your
28 statement about the introduction of urgent care clinics in
29 your area. Firstly, where have those been introduced in
30 the area that affects your work?
31 A. So I am only aware of one. It started in Tamworth.
32 I'm not quite sure of the exact model, but the idea is it
33 is a walk-in-type system. And I gather they've been
34 quite - the uptake has been quite good in the sense they
35 have been seeing lots of patients. When I asked my
36 emergency department colleagues whether they felt a
37 perceptible difference from that urgent care clinic
38 starting, they haven't felt that. Now, the numbers may
39 not - the numbers may show there has been a decline, but
40 I guess they are working at a capacity all the time and one
41 wouldn't feel that difference. But as a model, it seems
42 like a good thing to do.
43
44 THE COMMISSIONER: Q. This isn't necessarily a question
45 for Dr Scott, but is this urgent care clinic in Tamworth,
46 is it one of the Commonwealth ones or is it a State service
47 one? You don't know?

1 A. I wouldn't know, no.
2
3 THE COMMISSIONER: "Clinic" usually, I think, is, what,
4 for the Commonwealth? Yes.
5
6 MR FULLER: Q. In terms of your own practice and
7 delivery of services to your patients, has the urgent care
8 clinic impacted on that in any way?
9 A. Not that I've noticed.
10
11 Q. In paragraph 8 - and I think you mentioned this
12 earlier - you told us about fewer rural GPs having extended
13 scope of practice than they used to - do you have any
14 observations as to why that change has happened?
15 A. So all of the factors that people find would deter
16 them from a career in rural general practice would apply,
17 but in particular it is harder to take on these more
18 advanced skills where the gain might be higher but the risk
19 is also very high. And you might be doing some of these
20 procedures occasionally, you know, in the middle of the
21 night when things are tough, versus some specialist
22 colleagues do them in a hospital setting, daylight hours,
23 but you are nevertheless compared against what you can
24 provide compared to that. So the risk is quite high in
25 providing that service. There are ways to get trained in
26 it if you make the effort, but the risk in providing it is
27 quite high and I can see why people don't. It would seem -
28 it doesn't make sense that the reward for that sort of
29 service is equivalent and the standard is equivalent when
30 you try and provide that service as well.
31
32 Q. Just in terms of the risk, do you perceive that as
33 having increased over time? And if not, what's the reason
34 why it has caused a reduction for rural GPs?
35 A. I mean, I guess perception, yes, it has increased.
36 I think community expectations are higher now. I think the
37 community wants, and it is entitled to want, a high-level
38 service delivered in their home town, and sort of the "near
39 enough is a good enough" approach that the local doctor
40 might have provided, you know, if it ever was acceptable,
41 it isn't now. And there's more standardisation of
42 technique, and so unless you are really on top of all
43 those, you know, developments and changes to protocols,
44 which is hard when you are only doing one of these every so
45 often, the chance that you have done something which wasn't
46 considered standard of care would be higher.
47

1 Q. At the end of paragraph 8, you've said that payment
2 structures may need to change to reward people with
3 extended skills in areas of need. Is that what you were
4 referring to just before about the idea of providing an
5 incentive for people to develop these skills in rural
6 areas?
7 A. I think so. You can't expect - if you are paying
8 someone the same to do a job which is difficult and they
9 don't do often and in a complex situation, paying the same
10 as a person who does it all the time every day, where in
11 fact - especially if it gets more than the GP does
12 sometimes for some procedures, it just doesn't make sense
13 if you're going to - people are going to want to take those
14 skills to these towns.
15
16 Q. Do you have any other views based on your observations
17 and experience about changes that could be made to improve
18 the - increase the attractiveness of that kind of work in
19 developing that skillset in rural general practice?
20 A. Well, incentives are more than just financial. The
21 reward needs to be flexible enough that they're not bound
22 by the same, you know, obligations, and there can be some -
23 not just financial but in terms of conditions, in terms of
24 facilities, you know, opportunities for more training,
25 equipment that they might want. That all needs to be part
26 of a package, to say if you come to a town, provide these
27 sort of services, we want to encourage you and support you
28 to do that, rather than slapping the same award in front of
29 them and saying, "This is all there is."
30
31 Q. Do you have any particular kinds of conditions in mind
32 that you think might help if they were more flexible?
33 A. Well, maybe - yeah, beyond what I just said, probably
34 not. Just, yeah, opportunities for more education and
35 equipment as well. Sometimes it's easy to get the time off
36 to go to a conference and you come home with all these
37 great ideas but you can't buy the kit to do it, so that
38 needs to be part of it as well.
39
40 Q. Do you think, particularly for more junior
41 practitioners, having some sort of support from more senior
42 practitioners, whether in person every so often or
43 remotely, might assist?
44 A. Probably. Probably. That's always handy, but in
45 practice, often these things have to be done at the time
46 and there's usually not a lot of time to sort of chat about
47 it.

1
2 Q. Do you, based on your experience in a small hospital,
3 do you perceive on-call as being a particular issue for
4 practitioners who might work in those hospitals?
5 A. Oh, absolutely. Yep. Yep.
6
7 Q. And so that might be a kind of commission that could
8 be looked at if someone were to receive a higher payment
9 for working on-call?
10 A. Yeah. The sort of doctor that works in the country in
11 general and, in particular these towns, is - they are
12 normally very committed. They're clinicians. They like
13 seeing sick people and trying to make them better. And so
14 sometimes the on-call is not the burden, it is part of why
15 they do what they do. So I wouldn't want to be simplistic
16 and say they all want less on-call, but there needs to be a
17 sense when they walk in, doing the on-call, that the system
18 is going to facilitate what they want, what they're trying
19 to do.
20
21 Q. So to your mind it's perhaps more about, or at least
22 as much about having adequate supports in place for these
23 doctors as it is about pay, for example?
24 A. Yes. So pay is part of it, people as they are, but
25 it's more than that, yes.
26
27 Q. In paragraph 9 of your statement, you talk about
28 virtual services like My Emergency Doctor. You told us you
29 think they may be an effective temporary solution but not
30 an effective replacement of clinical staff. Can you just
31 elaborate on your views about that?
32 A. Look, so I certainly understand why it's come about in
33 the sense that there is a lot of smaller hospitals who
34 can't run a 24-hour roster with the local staff, and so
35 these either fill gaps or can replace an entire section of
36 the care. So I can understand that, and obviously we can't
37 just turn it off overnight. But the stories you get from
38 the patients and the staff that are in those facilities, it
39 is certainly far short of having the doctor there. So one
40 of the nurses in Gunnedah mentioned - I think I put some of
41 it in here - that she might have a child - the only nurse
42 in Gunnedah emergency overnight, no doctor, so a child
43 comes in with a sore ear or whatever. She has to then sit
44 in the consultation with the My Emergency Doctor, who takes
45 the whole story again, gets her to examine the patient sort
46 of in front of them on the computer, then he has a
47 discussion and then there is a prescription maybe and, you

1 know, all the time she has also got other patients out
2 there that are needing help and with a doctor on site,
3 she'd say, "You look after this one, I'll look after this
4 one." Also then there's a, sitting in the sort of Tamworth
5 Hospital, our view is a bit distorted, but it sounds like
6 that these doctors, they don't understand the local
7 strengths and weaknesses. They don't say, "Well if we can
8 just get them over till tomorrow morning, so-and-so will
9 come on call tomorrow morning," or, "Tomorrow morning the
10 scanner will be open and if we can do - deal with the
11 problem there." They don't understand sort of the local
12 vagaries or, "This guy is on holidays so there is no
13 someone - there is no-one there on Monday morning. You've
14 got to send this patient out." Like, those subtleties are
15 lost, which local people would be all over. And so, more
16 often than maybe needs to be, the patients end up flowing
17 to Tamworth where they wouldn't have had to otherwise.
18 Then of course you have got all the training of the staff.
19 I mean, these doctors aren't involved in teaching or
20 training. They are just there to see the patient, they
21 move on. There is no sense of buy-in to the community or
22 to the hospital in general. They are not going to
23 contribute to advocating for better conditions or equipment
24 or whatever. They are not the equivalent in all those
25 other ways. They are not going to teach medical students.
26 They are so far short. So from a patient's point of view
27 they're short and from a hospital's point of view they're
28 well short of the local doctor.
29
30 Q. Do you see a long-term place for virtual care in rural
31 and regional locations at all, and if so, what is it?
32 A. Look, I guess I do. From the trends. Not because
33 I think it's the best model of care, but just the way
34 workforces patterns are developing. I don't think it has
35 to be like that, but it seems to be the way. If I had some
36 choice, I'd probably disincentivise that model of care. I
37 think if you have just trained as an emergency physician,
38 you've got a - you know, you are living in Sydney or
39 somewhere, you know, there are all these jobs around the
40 countryside you can go and do, or you can just sit in
41 Sydney and do them all, you know, whenever you want to.
42 There is little incentive to come. If My ED Doctor didn't
43 exist or at least wasn't so widely used, you'd say, "Well,
44 I have got to feed my kids. I better go get one of these
45 jobs." So disincentivising people to do these virtual
46 things as part of a solution does sort of feed on itself in
47 some ways.

1
2 Q. Would it be fair to say that your view is that it
3 would be better use of resources to invest in incentivising
4 people to actually go and live and work in these rural
5 communities rather than virtual care in your view?
6 A. Yeah. I don't pretend it to be cheaper, but it would
7 be better.
8
9 Q. In paragraph 10 and following, you tell us your views
10 about the centralisation and decentralisation of services
11 in Hunter New England LHD. Firstly, can I - by its
12 services and equipment. Can I just ask you to summarise
13 the kinds of services and equipment that you have in mind
14 when you're talking about - let me ask that in a different
15 way.
16
17 You talked about services and equipment being
18 centralised at John Hunter Hospital. What sort of services
19 and equipment are you concerned about having been
20 centralised?
21
22 THE COMMISSIONER: Q. You've given the example of
23 pacemaker insertion as one example you have given.
24 A. Yeah. So it's more - so, ultimately, there will have
25 to be some centralisation of some, you know, more complex
26 procedures and therapy. You know, that's fine. But we
27 concede that ground easily. So pacemaker insertion has
28 been happening in Newcastle for a long time. We had a
29 cardiologist who moved to town a few years ago, who was up
30 to date with all those skills, wanted to bring it here, but
31 it seemed like such a big effort to bring it in. And when
32 it already exists in Newcastle, there seems no reason - the
33 doctors there are no more qualified than here. There seems
34 no reason why it couldn't happen here. Faecal
35 transplantation, a similar thing. The process already
36 exists in Newcastle, but bringing it here was a big
37 palaver. You know?
38
39 Q. Sticking with pacemaker insertion, what should I take
40 from that, that there is an absence of a cath lab here and
41 there could be one??
42 A. No, we have a cath lab here. But once again picking
43 on - well, picking on cardiology, there are fewer
44 cardiologists in Tamworth compared to any equivalent-sized
45 town in the State. There is fewer - there is less cath lab
46 access in this town compared to the other cath labs in
47 equivalent-sized hospitals in the State. And there seems

1 no good reason for that. We have the demand. Certainly we
2 have the people who want and are able to do the work.
3
4 Q. So "demand" means you've got people in Tamworth and
5 surrounds have cardiovascular disease at the same rates?
6 A. A couple of them, yeah. Well, no, higher rates.
7
8 Q. Higher rates?
9 A. Than those living in Newcastle and Sydney. Higher
10 rates.
11
12 Q. And you think there wouldn't be a trouble in finding
13 the right physicians to --
14 A. So we have a --
15
16 Q. -- provide those services?
17 A. We have a doctor at the moment in Tamworth who is
18 working sort of as a sort of fellowship role. He is
19 trained, but obviously working with a fellowship role. He
20 would like to stay here with his wife, who is also a
21 doctor, live in Tamworth, work as a cardiologist here. It
22 has been tried by our local management to get him appointed
23 here, which would only bring us equal with then the worst
24 covered hospital in the State, equivalent-sized hospital,
25 but we've received no positive feedback that he would be
26 able to get a job here. We would like to make the cath lab
27 head towards a 24/7 cath lab; at the moment, it is just a
28 sort of four-days-a-week, you know, daylight hours kind of
29 situation. We would like to make it 24/7, but we need more
30 staff and there is the reluctance to get more staff. And
31 once again, proportionally other hospitals, including John
32 Hunter Hospital, have a lot more cardiologists per
33 population. We should have in fact have more per
34 population than they should. Why do we have the trouble
35 getting that extra cardiologist when there are dozens in
36 Newcastle?
37
38 Q. But is getting the cardiologist a funding problem or
39 is it actually a problem of even if we had the funding,
40 we'd struggle to find the cardiologists that would move and
41 work here?
42 A. Depending on specialty, it could be either. But in
43 this situation, we have a cardiologist already living here
44 who will have to go find a job somewhere else at the end of
45 this year unless we can find him a job here.
46
47 Q. And that's a --

1 A. That's frustrating for the local doctors.
2
3 Q. Well, for the reasons you have mentioned in
4 paragraph 11, that doesn't make sense to you?
5 A. No. No. You know, we have three orthopaedic
6 surgeons - four orthopaedic surgeons. Newcastle have 30.
7 Now, if they have, you know, seven or eight times the
8 population to serve, then sure, that makes sense. But they
9 don't; they have three times the number of presentations to
10 emergency that we have. Three times more, but only three
11 times. Why are we proportionally so disadvantaged when we
12 have people that could come?
13
14 Q. When you have mentioned in paragraph 11 in the third
15 line the sentence that commences:
16
17 *Patients wait in hospital for days for a*
18 *bed at the destination hospital become*
19 *available. This would be unnecessary if*
20 *services were decentralised and available*
21 *locally.*
22
23 Are there other services that you have in mind there other
24 than pacemaker insertion or faecal transplantation? Are
25 there others you had in mind in relation to that?
26 A. Well, we would like generally more services in
27 Tamworth full stop. Neurosurgery, anything. We don't know
28 why it can't be done here, within reason. I mean, recently
29 radiology has had some trouble with staffing in Tamworth.
30 I had a patient that needed a relatively simple
31 radiological procedure, so by the radiologist themselves,
32 but that doctor went on leave for two weeks, so we spoke to
33 Newcastle but they waited a week to get the bed in
34 Newcastle and then a week for the procedure in
35 Newcastle and then ended up having the procedure in
36 Newcastle on the same day they would have had it here, and
37 then waited for a week for the bed in Tamworth to become
38 available to come back so we can continue their care. You
39 know, the services are there and we feel, this is
40 subjective, but we feel --
41
42 Q. When you say "we feel", you're talking about --
43 A. Sorry, on behalf of the --
44
45 Q. Are you speaking as the chair of the medical staff
46 council at the moment?
47 A. I am. So I feel, and others feel, that if you want to

1 provide a service in any place on the map, if you put it in
2 Newcastle, then you are covered, you know, but it's just
3 not --
4
5 Q. It is a long way south?
6 A. It is a long way south, yeah.
7
8 MR FULLER: Q. Just taking the example of pacemaker
9 insertion, I take it you have to make representations to
10 district executive to get that service started up at
11 Tamworth; is that right?
12 A. Not me personally, but there were representations
13 made, yes.
14
15 Q. Are you aware of what the process was for doing that?
16 A. I'm probably not the best person to comment on that
17 particular - I know from the doctor who wanted to do it, he
18 found it quite prolonged and frustrating, but I don't know
19 the details.
20
21 Q. Do you know at all from that doctor why he found it
22 prolonged and frustrating?
23 A. Other than it was prolonged, yeah, no, I don't know.
24 No. I mean, we do pacemakers now, so the end result was we
25 do pacemakers. Not as many as we'd like to, but we do. So
26 I can't say there wasn't progress, but it shouldn't be that
27 hard. It shouldn't be difficult.
28
29 Q. Do you know how long it did take?
30 A. No, I probably couldn't, yeah.
31
32 Q. In paragraph 13 of your statement, you talk about
33 rural and regional facilities feeling left out when it
34 comes to decision-making for the district, and you have
35 given an example of recruitment. Are you able to just
36 elaborate on what sort of involvement you think at your
37 local facility you should have in decision-making around
38 recruitment, for example?
39 A. So I think I mentioned it in paragraph 14 as an
40 example. So the district needs more anaesthetists, but in
41 particular Tamworth. And others, but in particular
42 Tamworth needs more anaesthetists. I'm having lots of
43 lists cancel due to a lack of anaesthetists. Huge locum
44 bills. So there was a district-wide campaign to attract
45 anaesthetists. So the district as a whole applied,
46 advertising campaign, et cetera, interviews. And while
47 there were applicants and there were, I think, appointments

1 also from that process, none of the applicants were
2 interested in moving to Tamworth because working in
3 Newcastle, a big hospital by the ocean, is very different
4 to working in a smaller hospital in the countryside and
5 there's not a lot of people who are prepared to have
6 either. They usually know what they want, and they tend to
7 want the beach. So we - although we were part of this
8 district right up - you know, we didn't get anything from
9 it and we lost out there. So we're trying to take that
10 forward now as a local advertising process. Once again,
11 you know, efficiencies in doing things at a district level,
12 but we're a diverse district. And we are a little bit
13 unique. As you probably know, all the other regional
14 centres in New South Wales have their own health district.
15 We are the only regional centre that has an urban centre
16 and a large regional centre, basically. So, you know, it
17 is hard to combine all our issues in together. We have to
18 be more fragmented in the way we --
19
20 THE COMMISSIONER: Q. Do you want me to take from
21 paragraph 14 that your opinion is that if Tamworth led the
22 recruitment campaign, it would do a better sales job than
23 if it is done by the district?
24 A. It is yet to be proven, but in theory, yes. I think
25 common sense --
26
27 Q. It is just an opinion?
28 A. Yeah. Yeah. So there was an advertising campaign for
29 Tamworth. Part of it had, like, a picture of a desert and,
30 like, kangaroos for 100 kilometres or some sort of - and,
31 you know, we are not the desert, not usually.
32
33 Q. What about a picture of a guitar?
34 A. Yeah, just sort of hokey sort of stuff. So, you know,
35 we provide really high-quality cutting-edge sort of
36 medicine here, and we are really proud of the service we
37 provide largely. If people want to do serious work, they
38 can come here and do serious work. We are not just about
39 riding your bikes and stuff.
40
41 Q. But locals might have a better idea about what might
42 attract someone than --
43 A. That's the theory, and that's why we have the working
44 group which I mentioned briefly as well.
45
46 MR FULLER: Q. You mention in paragraph 14 obviously
47 advertising is one aspect of recruitment. Is there any

1 other involvement in recruitment that you think would be
2 better if you had at the local level?
3 A. Maybe if I could talk about the recruitment working
4 group? It is just an idea we had a couple of years ago,
5 that medical recruitment would be enhanced if doctors could
6 be involved. So partly to tailor the advertising to what
7 doctors might want to - or what might attract doctors. We
8 also have contacts. So most doctors don't find jobs by
9 just sort of scrolling through Seek. You know, it's not -
10 it's word-of-mouth or opportunity. So we might know people
11 who have been registrars here who have moved back to the
12 city, finished their training, looking for a job. We might
13 keep them on our radar, keep in touch with them. People
14 who apply for jobs, we come along aside the recruitment
15 process and say, "Can I let you know about the town from a
16 doctor's point of view? Where your kids might go to
17 school, where you might want to buy a house." That sort of
18 thing. And then also help people integrate. This
19 recruitment working group is meant to try and work with the
20 formal recruitment process to enhance that, because we are
21 giving local knowledge rather than just the sort of more
22 generic approach.
23
24 Q. This is the working group that you talk about in
25 paragraph 22 of your statement?
26 A. That's right.
27
28 Q. And you say "currently unproven". So it is quite
29 recent, is it?
30 A. It has been going formally for a year and we've been
31 doing things. Of course, we don't know for sure whether
32 people wouldn't have come and do come or wouldn't have
33 stayed or do stay because of it. It is hard to get that
34 sort of information. But it seems well supported by their
35 local management. They seem to think it is helpful and we
36 think it's helpful so, yeah.
37
38 Q. Have you recruited doctors or other staff through via
39 the working group?
40 A. I mean, ultimately they still need to go through a
41 formal process. So they still need to find the ad, apply
42 to the ad, do all that kind of stuff. But we like to think
43 we've contributed to it. And as much of that, retention is
44 a big thing. Getting in the door is one thing, but holding
45 them here. So getting around them when they come here and,
46 you know, helping them settle in. That would be -
47 hopefully, that's part of it.

1
2 Q. Can I ask you now about your role on the medical staff
3 council. You have been chair of the medical staff council
4 at Tamworth Hospital for four years; that's right?
5 A. That's right.
6
7 Q. How many members are there of the MSC, or does it
8 change from time to time?
9 A. There's no formal membership. It is just any doctor
10 who is on staff at Tamworth Hospital is a member, I guess.
11 So, yeah.
12
13 Q. You have talked about having meetings of the MSC in a
14 relatively informal way. How many doctors would you get
15 normally attending those meetings?
16 A. Twenty to 30 at a meeting.
17
18 Q. How often do the meetings --
19 A. Quarterly.
20
21 Q. Sorry?
22 A. Quarterly.
23
24 Q. Do you have any formal terms of reference or anything
25 like that?
26 A. Oh, look, apparently there is. There is a document
27 outlining our role and - et cetera. I don't know it very
28 well. It's more of a --
29
30 THE COMMISSIONER: Q. Locally drafted by the LHD itself,
31 is it?
32 A. I suspect it is, yeah. Yeah. And so, I'm aware of
33 it. It's informal. So it's more - the meetings themselves
34 are - we have them in the local pub. It is an hour. It is
35 a chance just to report back. It is a chance to avoid the
36 silos which can develop in hospitals as they grow that keep
37 different departments talking to each other, sharing ideas
38 and issues. But a lot of work happens between the meetings
39 as well. Meetings, we make our representations for people,
40 supporting people, putting people in touch with other
41 people. It is a rolling thing, yeah.
42
43 MR FULLER: Q. If you had to summarise your view as
44 chair as to what the role of your medical staff council is,
45 how would you do that?
46 A. So amongst ourselves to break down the barriers
47 between departments which naturally form in a bigger

1 hospital and then also to be a conduit between the doctors
2 and management, and management and doctors. That would be
3 the main summary.
4
5 Q. So it's fair to say there is a social aspect to it,
6 there's a relationship aspect to it as between doctors in
7 different departments, and then there is a communication
8 aspect to management of the hospital?
9 A. Yes. We have no funds. We're not - we have no
10 legislation. Like, it is informal.
11
12 THE COMMISSIONER: Q. And you tell us in 25 that
13 because you're the chair, you also go to the meetings of
14 all the other medical staff council chairs, and one of -
15 the chair of that attends the LHD board meetings. And does
16 that enable you to get good feedback and transparency about
17 what the board is doing in the exercise of its clinical
18 governance functions and budgetary functions? Do you feel
19 like you get good feedback in relation to the board
20 decision-making and why they are making decisions?
21 A. I think so. It is relatively recent. So the medical
22 staff executive council I think has fallen by the wayside,
23 and Mary Morgan, who is one of the doctors at Newcastle,
24 amongst others, really got it going again, and so credit to
25 her. And I can see how it has to a degree but will and
26 could be a great way for us to hear what the board is
27 thinking. 'Cause what I've learnt is the board deals with
28 much more a government, a bigger picture strategy level;
29 the day-to-day decisions which affect us are not made at
30 that board. So it is helpful to us to know how the cogs
31 turn at that sort of level, yeah.
32
33 Q. And you say - is it relatively recently that the chair
34 of that executive has been - are they a board member or are
35 they just invited to the board meeting?
36 A. They're invited.
37
38 Q. Is that a new innovation?
39 A. I suspect they have always been invited if there was
40 an equivalent, I suspect.
41
42 THE COMMISSIONER: Thanks.
43
44 MR FULLER: Q. The executive MSC, you said it sort of
45 fell away for a period of time. Do you know why that was?
46 A. I don't know. I don't know how active it is in other
47 districts as well. Partly, it could be because the issues

1 that affect, you know, a VMO GP in Scone are different from
2 me as a physician in Tamworth, are different from a head of
3 ICU in Newcastle. They'd be quite - and so, finding
4 commonality on matters to purpose and agenda I think could
5 be difficult. But that said, like other things, it's good
6 to hear what's affecting each other and trying to find
7 solutions that are simple just by communication.
8
9 THE COMMISSIONER: Q. These things only work if there is
10 some form of governance structure set up and then they are
11 also driven by medical staff that are actually interested
12 in pursuing this?
13 A. Yeah. Yeah. So I've been to all the meetings so far.
14 Mary Morgan, as I said, has done a great job. I think
15 there is variable interest amongst the other chairs, but
16 I think it has potential to be good, which is why we are
17 sticking with it.
18
19 MR FULLER: Q. Before the executive MSC was
20 re-established, what was your line of communication, if
21 any, to the district executive or board?
22 A. So we try and involve our local general manager as
23 much as possible, Yvonne Patricks. We'd take an issue to
24 her and we would expect she would deal with or take it to,
25 you know, higher management. That said, so Ms McCosker has
26 come to Tamworth before and I am sure would be open to
27 receiving communication from us, but you'd want to know why
28 we're going around the local management. So generally, we
29 have tried to go to Yvonne locally. Yeah.
30
31 Q. Have you found that to be effective in raising issues
32 that the medical staff at Tamworth Hospital might want to
33 raise, need to be escalated to the district level?
34 A. Personally, yes, I have. Not everything. I mean,
35 I don't pretend to understand how to run a hospital.
36 I don't expect them to come into my clinic and tell me how
37 to run a patient. So I'm happy to be told "no", as
38 frustrating as that can be sometimes.
39
40 Q. Do you have any other views or any views as to how
41 engagement between clinicians and management could be
42 better facilitated?
43 A. Some of it comes down to personalities and if you're
44 willing to - and then I've known, you know, Yvonne Patricks
45 for quite a while now, so there is probably, hopefully, a
46 degree of trust both ways. Sometimes I feel like decisions
47 are opaque and some things, for example, like spending a

1 huge amount of money on locum bills but we can't afford to
2 employ an extra cardiologist or whatever, no-one can
3 understand how that works and we would love it if
4 management could be just a little bit more transparent in
5 actually why that is harder to fix than it sounds. So
6 I think there could be - they let us know why the
7 decisions, that would be helpful, I think.
8
9 Q. Do you think --
10
11 THE COMMISSIONER: Q. The answer is either that you
12 can't get the permanent staff or it's not a great decision.
13 A. Not a great decision in terms of?
14
15 Q. Having locums if you could get someone permanent?
16 A. Yeah, I mean, that's right. So locums, obviously,
17 sometimes we have them because we can't get local staff,
18 absolutely.
19
20 Q. Yes.
21 A. But for example, like, in other fields we can get
22 people, and not even having locums for that particular
23 field, but, you know, you want to enhance the service
24 overall.
25
26 Q. But there may be other reasons, too?
27 A. And we would be open to be - have those explained to
28 us maybe in more detail than what we are getting.
29
30 MR FULLER: Q. Do you think there is a good reason for
31 local clinicians to be involved in decision-making about
32 those broader workforce structural issues, for example?
33 A. So yes and no. So, look, as we're not managers, we
34 don't understand how to run a budget. You wouldn't want us
35 to run the budget. But we also see - you know, we know
36 so-and-so is going to retire, then so-and-so is going to
37 retire. In fact, in five years, three or four people are
38 going to retire. We need to start preparing for that now.
39 While we feel at a management level it's like if there's a
40 whole lot of boxes that are ticked, "This is an unticked
41 box. When that one retires, well then, we'll untick that
42 box." And it just seems very mechanical. So I think
43 having doctors who can maybe see the trends and see the
44 patterns and know the people, I think that local knowledge
45 could be helpful to keeping service delivery.
46
47 Q. Do you have any views about a mechanism - kind of

1 mechanism for how that might be facilitated?
2 A. I think having communication. If the medical staff
3 and the administration become antagonistic, that's
4 obviously not going to happen. But at the same time, the
5 medical staff don't want to be taken for a ride and don't
6 want to be just left suffering, "Well, you can increase
7 your on-call or increase your workload because this guy has
8 retired and we haven't got around to looking for a
9 replacement yet." That's sort of - it's just frustrating
10 at our level.
11
12 Q. Is that something that has been raised, for example,
13 with Ms Patricks at the medical staff council meetings? Is
14 that the sort of --
15 A. Absolutely.
16
17 Q. -- forum in which that can be raised?
18 A. Absolutely. Yep. Yep. Yep. And outside those
19 meetings, yeah.
20
21 Q. And equally, presumably, that is a forum in which you
22 think it would be appropriate for that information to be
23 communicated to medical staff from management?
24 A. Yep. Absolutely.
25
26 MR FULLER: That's all I have for this witness. Thank
27 you, Dr Scott.
28
29 THE COMMISSIONER: Mr Cheney, is there any questions you
30 have?
31
32 MR CHENEY: No, Commissioner.
33
34 THE COMMISSIONER: Thank you very much, Doctor. You are
35 excused. We are very grateful for your time.
36
37 THE WITNESS: Thank you very much.
38
39 **<THE WITNESS WAS RELEASED**
40
41 MR FULLER: Commissioner, the next witness is John Slaven,
42 and I call him.
43
44 THE COMMISSIONER: I noticed he was listed at 11.15.
45 There is a chance he's not here.
46
47 MR FULLER: I might just ask for some inquiries to be made

1 about that. In the meantime, his statement is
2 [MOH.0011.0066.0001].
3
4 THE COMMISSIONER: Which tab is he behind?
5
6 MR FULLER: A-53.
7
8 THE COMMISSIONER: Okay, got that. Mr Slaven, welcome,
9 come forward. This is the witness box here. Sir, would
10 you like to give your evidence by way of oath or
11 affirmation?
12
13 THE WITNESS: Oath.
14
15 THE COMMISSIONER: Someone will help you with that.
16
17 **<JOHN LESLIE SLAVEN, SWORN [10.52 am]**
18
19 **<EXAMINATION BY MR FULLER**
20
21 MR FULLER: Q. Mr Slaven, my name is Dan Fuller. I am
22 one of the counsel assisting the Commissioner. Would you
23 state your full name, please?
24 A. John Leslie Slaven.
25
26 Q. Your professional address is 35 Graham Street, Port
27 Macquarie; is that right?
28 A. That's correct.
29
30 Q. And you are the director of finance and performance
31 for the Mid North Coast Local Health District?
32 A. Yes, I am.
33
34 Q. You have given a statement - made a statement to
35 assist the inquiry; that's right?
36 A. Yes, I have.
37
38 Q. Have you got a copy of that there with you?
39 A. Yes, I do.
40
41 Q. Thank you. Have you had the opportunity to review
42 that recently?
43 A. Thank you, I have.
44
45 Q. And is everything in the statement true and correct to
46 the best of your knowledge?
47 A. To the best of my knowledge, it's correct.

1
2 Q. You commenced your most recent term as director of
3 finance and performance in January this year; that's right?
4 A. That's correct.
5
6 Q. Before that, you held the same role between September
7 2018 and September 2021; is that right?
8 A. That sounds correct, yeah.
9
10 Q. That's what you've said in the statement?
11 A. No, no.
12
13 Q. I just want to check that that's about right?
14 A. It's - yeah. I haven't - that's correct. That's
15 absolutely - yeah.
16
17 Q. And in between you were working for St Vincent's
18 health network in Sydney?
19 A. In Sydney, correct. A very similar role as well.
20
21 Q. Can I ask you, please, to have a look at paragraph 6
22 of your statement. Between paragraphs 6 and 8, you,
23 I think, identify the various Mid North Coast Local Health
24 District facilities and the funding type for each facility.
25 Have I understood that correctly?
26 A. Correct.
27
28 Q. Just starting with paragraph 6, the Bellinger River
29 District Hospital, you see you have identified the funding
30 type as "small rural hospitals funding model".
31 A. That's correct.
32
33 Q. Can you just explain your understanding of what does
34 that model look like from your district's perspective?
35 A. So from my district's perspective, there seems to be
36 the hospitals fall into two categories: the larger ones
37 which are pretty much fully funded by ABF, and then the
38 ones which have the smaller services, where the ABF model
39 doesn't fit as well, if at all, then they're essentially
40 block funded. Why they are block funded, we do in spirit
41 calculate the NWAU to check the efficiency of the hospital,
42 but generally speaking that's obviously not as, because of
43 its size, it's not as efficient as a large one. So hence,
44 it is block funded.
45
46 Q. But from your perspective the small rural hospitals
47 funding model is effectively a method of block funding; is

1 that right?
2 A. Yes, I believe that to be true.
3
4 THE COMMISSIONER: Q. Where is the border between the
5 site that gets small rural hospital funding and a site
6 that's ABF? The reason I ask that is we've had a
7 reasonable amount of evidence of, particularly on our
8 regional visits, of people telling us, "Well, this site is
9 ABF funded but, boy, the ABF model doesn't work very well
10 for this hospital because our costs are much greater than
11 the funding that's coming in." Is there some demarcation
12 or --
13 A. I don't believe there to be one. I think it was deals
14 that were struck many years ago with the Commonwealth with
15 regard to - there is a list of ABF funded facilities and
16 non-ABF.
17
18 Q. Presumably it's based on?
19 A. Size.
20
21 Q. Level of activity and --
22 A. And locations.
23
24 Q. -- locations? Yeah, yeah.
25 A. Because costs are impacted. The further you get from
26 the cities, the cost of doing business goes up and also the
27 cost of business goes up, the smaller they become because
28 you don't get the economies of scale.
29
30 MR FULLER: Q. Do you have any say at the district
31 level in which of your facilities is block funded and which
32 is ABF funded?
33 A. No, we don't have a say as to what is funded and what
34 is block funded. We have some say within our service
35 planning as to what services we provide at an individual
36 location. For instance, we may do more surgery over a
37 period of time because we have a need. We may do more in a
38 smaller hospital and staff it accordingly and then drop it
39 back down again, but we - essentially, the funding is
40 pretty much fixed.
41
42 THE COMMISSIONER: Q. Who makes the ultimate decision
43 as to whether a hospital is an ABF hospital or small rural
44 hospitals? Is it the Commonwealth?
45 A. I believe it would be the Commonwealth. There will be
46 an application and then it gets further complicated with
47 19(2) sites as well.

1
2 THE COMMISSIONER: Yes, of course.
3
4 MR FULLER: Q. In terms of just sticking with the block
5 funded facilities, does the district have any say in the
6 amount of block funding that is provided for those
7 facilities?
8 A. The block funding is usually sat - is usually
9 calculated based on historical basis, with a CPI increase.
10
11 Q. And who does that calculation? Is that in the
12 ministry?
13 A. That's done by the Ministry of Health.
14
15 Q. Is there any negotiation with the district around the
16 amount of block funding that is providing to your
17 facilities?
18 A. We have over the years had the opportunity to
19 negotiate with the ministry on funding and funding levels
20 and special projects and block funding. However, it has
21 been very limited over the last couple of years as a result
22 of coming out of COVID and the financial challenges the
23 State is facing. So extremely limited, and to be honest
24 I haven't actually seen an increase other than CPI in block
25 funding in the time I've been doing the job.
26
27 Q. You talked about having the ability to negotiate
28 funding for special projects. That's not the sort of
29 day-to-day or year-to -year funding of hospitals; is that
30 right?
31 A. No. No, that's not.
32
33 Q. Excuse me. That being the case, to what extent does
34 the funding for those hospitals, sticking with block funded
35 hospitals, take into account the day-to-day service needs
36 of that hospital and the patients in that local community,
37 if at all?
38 A. The best way I could probably say is the funding is
39 the funding for that hospital. The LHD may elect to
40 provide additional services in that, but that would be at
41 additional cost, but the funding is essentially fixed plus
42 CPI. So demand in those hospitals is fairly static and
43 fairly low. It's more an opportunity-for-service rather
44 than a high-demand type of facility. So probably doesn't
45 impact the day-to-day too much because they are a fairly
46 low-level activity, to be frank, but there are certain
47 times when costs do go up.

1
2 Q. In terms of demand staying relatively static, is that
3 something that you measure within the district?
4 A. Well, that's measured with the length of stay
5 separations NWAU that are generated through the facility.
6 So we have some good metrics to understand what the
7 activity is actually going through that facility, and the
8 purpose we use that particular facility for.
9
10 Q. Based on what you told us earlier, it sounds like
11 those metrics don't actually - whether they change or not,
12 they don't actually influence the amount of funding you
13 get?
14 A. Not at an LHD level. Maybe locally, but not an LHD
15 level.
16
17 Q. Moving to the ABF funded hospitals, do you have a view
18 from your position as to whether that method of funding
19 accurately reflects the demand for services for those
20 hospitals?
21 A. It's a very good question. It doesn't measure
22 accurately down at individual service level an NWAU,
23 because cost flows one way at hospital and activity flows a
24 different direction. So you are allocating costs to
25 services, and they're done based on cost buckets and
26 weights, et cetera. So within a hospital, any particular
27 service provider, it's a best estimate what that service
28 cost in the DHG and SRGs. But at a facility level, because
29 all the NWAU, essentially, as you go to transfer patients,
30 it is within one facility. So the total is accurate
31 because you have, you know, you encapsulate your total
32 costs and your total activity. Unless you've got services
33 which have been transferred between hospitals, for
34 instance, you might have medical staff at one hospital
35 providing service at another one and unless those - and
36 it's sometimes that could be ad hoc, not every day. So we
37 may not always capture those costs if they're not recorded
38 correctly in the transfer of medical staff or nursing staff
39 to service a need. But essentially, the costs are
40 reasonably accurate within a hospital.
41
42 Q. Does the funding that is provided to the hospitals you
43 described as ABF-funded hospitals accurately reflect or in
44 a different way cover the cost of providing services at
45 that particular hospital?
46 A. Not always, but it depends on the efficiency of the
47 hospital, which is driven by many factors. The efficiency

1 can be based on the supply of nursing or the supply of
2 medical. It could be the time people are coming in. It
3 could be a change in local community. So the funding model
4 is set based on a projected demand for a period of time,
5 based on projected costs. However, the costs change
6 throughout the year, which impacts the cost price, and the
7 volume is set based on NWAU and an approximation of
8 separations and ED attendance, et cetera, which does --
9
10 Q. Efficiency?
11 A. Yeah, so efficiency plays a part in all of that.
12
13 THE COMMISSIONER: Q. But it is one part, right?
14 A. Yes.
15
16 Q. There is also what kind of service?
17 A. Yep.
18
19 Q. And also where?
20 A. Correct.
21
22 Q. So just picking up on the fact that you spent some
23 time at St Vincent's, one of the things that St Vincent's
24 people say to us is that ABF doesn't necessarily work very
25 well for them in relation to some of their services, in
26 particular heart and lung transplants?
27 A. Yes, yes, correct.
28
29 Q. That cost more than they're funded?
30 A. That's correct. And the reason for that, to some
31 extent, is that it is a specialised service.
32
33 Q. Yes.
34 A. There is only one or two of those in Australia.
35
36 Q. Yes.
37 A. So it's a very small NWAU population for want of a
38 better term.
39
40 Q. Low volume?
41 A. Low volume.
42
43 Q. But highly complex?
44 A. But highly complex. And the NWAU calculation only
45 provides for when you do something. It doesn't provide for
46 you've got a grade one team sitting around ready to do an
47 EVAC to pick up a heart or something. Those costs aren't

1 calculated. The transport costs aren't calculated. In
2 fact, we did - when I was there, we did a reconciliation
3 and did a submission and demonstrated that a lot of the
4 costs associated with the harvesting were in fact in the
5 NWAU price, which drove their price out. So that was
6 another compounding issue. So there's lots of associated
7 issues. NWAU needs to be the right price for the job and
8 it needs to be paid in such a way that you are given
9 recognition of being ready to provide a service as well,
10 which we do do in block funding in ED to some extent and
11 also in ICUs.
12
13 MR FULLER: Q. If we just have a look at paragraph 10 of
14 your statement, please, you told us that the nature of ABF
15 is the funding is based on historical information. Can you
16 just explain what you mean by that?
17 A. Yes. So the set - obviously, it is quite complex
18 and - but this set - the key components are that we provide
19 activity in the community. We're given a budgeted NWAU for
20 the activity, but we're not necessarily sure exactly what
21 activity comes in. By and large, the hospital
22 statistically gets more standardised, but we've had
23 significant growth, for instance, in our port-based ED over
24 the last 12 to 18 months, significant growth which is not
25 calculated in the NWAU we've been provided. So - and the
26 cost of doing the service can change over that period of
27 time based on changes in procurement process, changes in
28 the medical model, locums, agency, and some of the other
29 costs associated with doing this.
30
31 THE COMMISSIONER: Q. And then-current NWAU may not
32 reflect that change in cost?
33 A. And it gets worse, because we submit - if we do the
34 costs FY24, they are submitted in our costing as a State to
35 FY25 to the government, the NHRA doesn't get around
36 providing adjustments until FY26.
37
38 Q. It is two years?
39 A. It is two years. And that is the real challenge that
40 we have as an LHD, that we provide service in good faith
41 but aren't always remunerated for it or get - have to play
42 catch-up in this case.
43
44 Q. Particularly if employment costs go up and
45 particularly if there is inflation?
46 A. Correct, and we've had both. And also we've had the
47 challenge of coming out of COVID where we were provided

1 with additional costs and to tease out and go back to
2 normal is really challenging. Like most of health, our
3 cadence have slowed down so our activity per FT has dropped
4 but costs per FT have gone up. So it's a double whammy.
5
6 Q. And for some very large sites, this - because we're
7 talking about averages it might all come out in the wash,
8 but for sites that either, because of their size or
9 location, there might be a greater impact and also those
10 sites, St Vincent's being an example, of doing quite a lot
11 of low volume but highly complex work, they get - for want
12 of a better expression, it might sting them more, what
13 we're talking about?
14 A. Absolutely. Well, the challenge we've had is that if
15 you take our NWAU and compare it to 18-19 and then look at
16 our FT, if you - the FTE in 18-19 produced 9 per cent per
17 FTE more. While our costs went up 11 per cent, they went
18 up 35 per cent in medical, and our medical NWAU went down
19 17 per cent per FTE. So you had a price increase and a
20 volume reduction, so the efficiency and the cost to both
21 have both been impacted, which has - as I say, it is a
22 double whammy on the cost structure and then takes two
23 years for that to catch up with the NWAU.
24
25 MR FULLER: Q. Mr Slaven, in one of your earlier
26 answers, you said, "We're given a budgeted NWAU for
27 activity." That's given to you by the ministry; is that
28 right?
29 A. That's correct.
30
31 Q. And is that escalated in any way to take into account
32 the fact that it's two years old? Is there any mechanism
33 for doing that?
34 A. So the ministry can only provide the funding they've
35 been provided by the Commonwealth. So there is always
36 going to be a lag in the price. There is within the State,
37 we do get incremental increase in the NWAU price.
38 I haven't ever seen it go down, but the way the model
39 works, it's based on the costs from two years ago. So
40 we're constantly playing catch-up in the NWAU price.
41
42 THE COMMISSIONER: Q. When you say the ministry can only
43 providing the funding they have been provided by the
44 Commonwealth, of course New South Wales Treasury could make
45 a different decision if it wanted to; it's not --
46 A. Absolutely, but we are talking about the NWAU price
47 terms. 45 per cent paid by the Commonwealth. So I guess

1 they are doing an inclined contribution to - sorry,
2 matching it. Matching it.
3
4 MR FULLER: Q. You tell us near the end of your
5 statement that your district currently had a budget
6 shortfall for the 2024 financial year; that's right?
7 A. That's correct.
8
9 Q. What was the amount of that shortfall?
10 A. That cost of service, approximately $50 million.
11
12 Q. And are the causes of that shortfall from , based on
13 your knowledge, the sorts of issues that you told us about
14 already or are they --
15 A. Yes, they are, but I guess the other issue that
16 I just touched on is the cadence on which we do work.
17 Throughout COVID, our systems and processes were required
18 to be changed. You know, we changed our red zones and
19 green zones and blue zones. We changed our pathways. And
20 unfortunately with Health, it is a highly FTE-driven model,
21 with almost 80 per cent of our costs in FTE. So any of
22 those changes are fine, we can address them, but, if you
23 like, they are a manual-type process. So during COVID, we
24 had quite a lot of - and this is around the world, to be
25 frank. Throughout COVID, we had quite a bit of change in
26 staffing. So a lot of those processes were in place prior
27 to COVID were ceased and then they perhaps, you know,
28 potentially even disappeared as a result of the staff that
29 were providing those services, providing those procedures.
30 So now it's about re-establishing that.
31
32 Q. What sorts of procedures are you talking about?
33 A. Just, like, the way we discharge patients or the way -
34 the interfaces. Some of the interfaces are human-to-human;
35 they're not all machine-based. So those interfaces were
36 lost during that. And the way we triage and the way we do
37 things have changed over a period of time with COVID, and
38 now we are reestablishing a lot of those processes, which
39 means we have to speak and we have to catch up again to
40 where we were.
41
42 Q. For the most part, the - if not entirely - well,
43 sorry, I'll start that again. To what extent were the
44 causes of the district's budget shortfall things within the
45 district's control?
46 A. That's a really, really good question. We couldn't
47 control the increasing costs in labour. Certainly in the

1 medical workforce that was a particularly difficult one.
2 We are more fortunate in our --
3
4 THE COMMISSIONER: Q. Just on that topic, though, is that
5 a large part of the reason for the budget shortfall that
6 you just described?
7 A. Quite a few million dollars, yeah. Yeah. There's
8 quite a few million dollars.
9
10 Q. What was the budget shortfall in FY-24; do you know?
11 A. 50 million.
12
13 Q. Sorry, yes, you did say that.
14
15 MR FULLER: Q. And in terms of other factors that
16 impacted on that or that caused there to be a budget
17 shortfall, would you say any of those were within the
18 district's control, really?
19 A. Our recovery plan has got two components to it. One
20 component is getting back and re-establishing those
21 processes and businesses which maybe haven't been ideal
22 over those last couple of years. So certainly some of that
23 is what we can do in our control.
24
25 THE COMMISSIONER: Q. What are examples of those?
26 A. Minimising our overtime. Looking at criteria to get
27 the patients out on time. We have dropped our length of
28 stay quite considerably over the last six to 12 months,
29 when we started to focus on it. Specials, controlling
30 specials on the ward. Again, putting policy back in place
31 that may have fallen over during that period. We have
32 lifted the delegation so that it's a lot more robust system
33 in maintaining - in approving specials. So, overtime,
34 specials. Leave management - again, leave has crept up
35 during the time and that's unfortunate because in some of
36 our rosters leave is actually budgeted into our roster, so
37 the opportunity was lost, so perhaps staffing above levels
38 we didn't necessarily need to do, so we are now bringing
39 back down to the appropriate nursing hour per patient day
40 ratios throughout the facility. So lots of back to basic.
41 Better roster optimisation. We are actually looking at our
42 rostering practices. What we found was a lot of our cost
43 centre managers in fact had moved on, and so a lot of the
44 training disappeared. So when they came back, then we are
45 introducing that training through the system. And then the
46 other part, of course, is that with the cost pressure, we
47 are starting to look at our way we're doing business. So

1 we are looking more at a one LHD process. We have two
2 large hospitals and they have differing models in some
3 areas, they have differing processes. And to be able to
4 transfer our staff from one facility to another would be
5 really advantageous. We also have similar services at two
6 facilities, doing - in fact, we need to actually provide
7 those sub-specialty services at both. That's a decision, a
8 piece of work we are currently doing trying to bring our
9 cost structure down as well.
10
11 THE COMMISSIONER: Q. Presumably that's not just based
12 on - a decision like that wouldn't be based on budget
13 repair, if I can call it that?
14 A. That's best practice. It's best practice.
15
16 Q. It's about clinical need as well?
17 A. Yeah. Yeah. A shorter stay is a better stay.
18
19 Q. Yes. We're told that, yes. And you mentioned your
20 length of stay issue. I mean, a lot of the evidence we
21 have about length of stay, particularly in regional
22 hospitals, is that maybe there's different models of care
23 that might result in shorter length of stay, but what seems
24 to be beyond the control of - let's use Tamworth Hospital
25 as an example - is beds being occupied by people that could
26 be discharged to aged care that aren't. That seems to be
27 an actually universal story around --
28 A. Absolutely, it is one of our challenges, particularly
29 in our Coffs Basin.
30
31 Q. Yes. I've heard all that. Yep.
32 A. It is worse than it is in our port.
33
34 Q. I am not sure that there is a regional hospital that
35 does not have that problem.
36 A. Yeah.
37
38 Q. So it is a mix of things. It'd be, you know,
39 inflation, various things. Cost of locums where locums are
40 absolutely necessary to provide the service. They're out
41 of the LHD control, they're out of the site's control, but
42 you've mentioned some things that maybe there are some
43 efficiencies whilst still providing the services that are
44 needed that could be done.
45 A. Yeah. We are trying to optimise our position any way
46 we can but by still maintaining a patient-centred care. We
47 are not moving away from that. Some of the challenges are,

1 I guess, also with the medical model, the VMO versus staff
2 specialists. That is creating more challenge as we go
3 forward. You know, doctors are fantastic and we need them,
4 but we probably need more staff specialists than VMOs to be
5 frank. We lose some control of our workforce in a VMO
6 model.
7
8 Q. Current awards? Is that a problem in relation to
9 staff specialists?
10 A. Absolutely. We're due for a significant review of all
11 medical and nursing awards, to be frank. I think, you
12 know, the awards were written many years ago. They're not
13 fit to today's environment, and I think that's well
14 overdue. That would make a big difference, streamlining
15 them. The rostering is quite problematic because of the
16 complexity of the awards. So you've got to be Einstein in
17 some cases to understand how to roster in the best way.
18 And we actually have these conversations of what's a great
19 medical roster and it is really hard to find someone who
20 can articulate a great response in that space and then
21 maintain it. You bring an actuary in and do the
22 calculation, of course, it's - a roster has to be flexible,
23 so it is only a point in time that it's great unless you
24 are constantly working on it. And I believe that's partly
25 because of the medical model, the rostering system, the
26 rostering of the awards. It is a combination of all of
27 that is creating a lot of more challenges to bring an LHD
28 up in value.
29
30 MR FULLER: Q. Have you done any sort of modelling as
31 to how much you expect the optimisations we've been talking
32 about to save or recover out of your budget shortfall?
33 A. We're hoping for 10-plus million this year in just the
34 back to basics, you know, doing better business.
35 Optimisation is our stage 2. We haven't yet - we've got
36 ideas but we haven't actually finalised those plans in any
37 form; haven't consulted. So we've done no real work in
38 that, other than we have got some plans in that space. And
39 obviously they had to fit with the ministry as well in
40 consultation with the unions.
41
42 Q. Those further optimisations are part of stage two
43 financial enquiries?
44 A. Stage two, yeah. Yeah, so we have broken it into two
45 stages: those that we can do as better business and those
46 at stage two is through consultation and redesign.
47

1 Q. Is the financial recovery plan something that you
2 developed at the district level, or was it developed by the
3 ministry?
4 A. So there was a review done of LHD back in November.
5 It was an invitation by the board, by the ministry, to come
6 in and have a review for us. They conducted a review and
7 came up with approximately 40-plus recommendations. I'd
8 done a similar piece of work at St Vincent's, so I actually
9 added another 30 or 40 recommendations to that and we
10 synthesised that down to a recovery plan, which we are now
11 working through.
12
13 Q. So your recovery plan was developed by the district
14 based on a combination of recommendations and --
15 A. From the ministry.
16
17 Q. -- there were ideas that you had and some from the
18 ministry; is that right?
19 A. Yeah, yeah. The ministry has a good team in that
20 space, so we invited them in and they gave us some - you
21 know, they also have access to the data across the states.
22 They have a got better understanding of where we may be out
23 of step with others across the networks.
24
25 Q. In terms of funding and budgeting for your district,
26 is there an issue with the fact that, as you tell us in
27 paragraphs 13 and 14, your district provides some community
28 health services as well? Does that cause a budgeting
29 problem for your district?
30 A. So from a materiality perspective it doesn't, but from
31 a perspective of needing to step in and provide a last
32 resort the refugee one, there's not a lot of dollars in
33 that, but I guess it is just demonstrating what we have to
34 do to ensure that the community is provided with a service.
35 You know, we have a language problem with the refugee.
36 They don't have any Medicare cards, they can't go to the
37 GP, so there's a real gap in providing service to these
38 guys while they're actually registered for Medicare and
39 while the language barrier is overcome.
40
41 Q. Do you have get any specific funding from either the
42 ministry or the Commonwealth for the community health
43 initiatives that your district implements?
44 A. Well - sorry. So the refugee one, yes, we had some
45 funding but it's probably not enough to meet the demand.
46 As you know, we've had immigration has been increased. The
47 space - there's refugee placements in Coffs Harbour, and

1 that then is not necessarily reflected in the funding for
2 that. So, yeah, we get some relief but not enough, and
3 then it is a matter of the - it is a catch-up. So we will
4 have negotiations with the ministry and at some stage we
5 will redefine the service or move it on into a
6 community-based one where we can get someone else to take
7 it on. But in the meantime we still have to fill that gap,
8 otherwise it comes back at our ED.
9
10 Q. Are we right in understanding that some of the
11 community health initiatives are also funded, effectively,
12 through the MBS through the section 19(2) exemption; is
13 that right?
14 A. Yes, the section 19(2) MBS, we had that at Wauchope.
15 We do provide that, and then we have an urgent care centre
16 there that works really well. So they're a good model, but
17 the community - that community is only 40 minutes from Port
18 Base. So while it works well, that particular facility
19 hasn't been provided with a lot of capital injection over
20 the last 70 years. Si it has had some bits and pieces, but
21 there are things that aren't almost fit-for purpose in that
22 facility, so - which is a problem.
23
24 Q. If we just go back to paragraph 7 of your statement,
25 you have given us a list of community health centres that
26 are operated by the district --
27 A. Yes.
28
29 Q. -- if I understood that correctly. And to what extent
30 are those funded by MBS contributions through a
31 section 19(2) exemption?
32 A. Not a lot, to be frank. We're not strong on that. It
33 is more community-based programs, Commonwealth funding for
34 programs of work. There is a whole myriad of stuff. The
35 community stuff makes up about 10 per cent of our overall
36 budget, so $70 million-plus. So it is not a huge amount in
37 the scheme of things, but it does have separate
38 program-based funding in quite a number of those. And
39 that's a challenge in itself, because you have to maintain
40 the costs. So you might have overlapping services with
41 funding from two different sources providing the same
42 thing. You have - somehow, you have to maximise the
43 service without distorting your costs.
44
45 Q. That $70 million or so that you just told us, is that
46 money that the district is kicking in on top of anything
47 that the Commonwealth is providing or is part of that --

1 A. It is part of the Commonwealth subsidies, yeah.
2
3 Q. But do you have a sense of what proportion of that is
4 fully funded by, for example, Commonwealth grants or
5 funding of various kinds versus --
6 A. I'm sorry, I couldn't give you a number. I could
7 provide that if you require it, but I don't have that to
8 hand.
9
10 Q. Yes. In paragraph 16, if you can just have a look at
11 that, please, you tell us about locum medical expenditure.
12 Do you have that?
13 A. Yes.
14
15 Q. You have distinguished between focusing on the first
16 sentence medical agency costs and then medical locum
17 visiting medical officer costs. Do you see that?
18 A. Yes, I do.
19
20 Q. Can you just explain that distinction?
21 A. Yeah, the 3.8 million is medical agency fees. That's
22 the fee we pay on top to the agency itself for the
23 provision of the service.
24
25 Q. Just before we come to that, you see you have got
26 17.8 million on medical agency costs?
27 A. Yeah.
28
29 Q. And then you've got, after the brackets,
30 21.7-odd million on medical locum visiting medical officer
31 costs; do you see that?
32 A. Yes, yes.
33
34 Q. So just that, starting with that distinction, what is
35 that distinction?
36 A. So the first one is 17.8, is the locums, so the
37 absolute locum costs, including the eight - the costs of
38 placing them, which is 3.8. But on top of that we have
39 VMOs, which is an additional 21.7.
40
41 Q. Okay. So the 21.7 is VMOs?
42 A. Yes.
43
44 Q. Is that right? And then you've got an additional
45 amount presumably for staff specialists of employees?
46 A. Yeah.
47

1 Q. Do you have a sense of how these figures compare with
2 the district spend on staff specialists?
3 A. Not off the top of my head, but the challenge is that
4 the expenditure in medical has gone up approximately
5 35 per cent since 18-19, yet the activity has gone down
6 17 per cent if you look at the NWAU. So there's a real - a
7 significant increase which hasn't been matched by increases
8 in NWAU over that period, which has caused certainly some
9 of the financial challenges we face.
10
11 Q. Do you perceive that a lot of that increase has been
12 down to an increasing proportion of locums and VMOs
13 compared with staff specialists?
14 A. Yeah, we find we're getting more doctors opting out
15 into a VMO model rather than a staff specialist model. It
16 is a dollar-based decision for them. They make more money,
17 generally speaking, as a VMO. They have more flexibility
18 in their workforce. They essentially are contracted and
19 they're not a staff member, so they're not - they just have
20 more flexibility and more ability to earn more money going
21 forward, so --
22
23 Q. I think you told us this, but just to be clear, the
24 3.8 million that you have identified in brackets --
25 A. Yeah.
26
27 Q. -- that's on top of - that's money that is going to
28 the agency --
29 A. Yeah.
30
31 Q. -- not to the doctors?
32 A. Absolutely, yeah.
33
34 Q. Similarly, if we look at paragraph 17, you tell us
35 about agency nursing expenditure.
36 A. Yes.
37
38 Q. We see that that has increased from 2022-23 to
39 2023-24.
40 A. Yeah.
41
42 Q. Do you have a sense of reasons for that increase?
43 A. I wasn't at the LHD during that period of time of
44 those increases, but there was certainly more money
45 provided for, say, for nursing and there was certainly a
46 big push in that time to put on more nursing staff during
47 that period, supported by COVID, some of it.

1
2 THE COMMISSIONER: Q. Am I reading this right, that the
3 agency fee is more than the wages?
4 A. I did see that just then, too. I don't think that is
5 correct.
6
7 Q. Do you want to - you can take it on notice. You might
8 just double-check paragraph 17, because it might be right,
9 but it would seem astonishing that the agency fee can -
10 anyway, we'll take on notice those figures in 17. If you
11 could get back to us about that, yes, thanks.
12 A. We have done a lot of work, thought, on the agency
13 costs and we have brought them down. We have brought in
14 overseas nurses and we are down quite considerably, so
15 that's a piece of work we have achieved good success over
16 the last 12 months and will continue to get that down.
17
18 Why we bring down our length of stay, we will be able
19 to free up more nursing staff and reduce our demand on
20 overtime and also agency staff. So it's about back to
21 basics, back to good business practice, you know, getting
22 your length of stay down, getting them working together,
23 and those costs will be the first ones that will be driven
24 out of the cost structure.
25
26 MR FULLER: Q. How do you say that reducing length of
27 stay will reduce overtime?
28 A. So the length of stays is a patient comes in, they
29 might stay for four days, they might stay for five days.
30 If you multiply that by 400 or 500 beds, that's a bed
31 saving that is quite significant. If you can close a bed -
32 a bed is worth approximately $300,000 a year, 300-350,
33 depending what the bed is. So just by reducing your number
34 of beds that you have open, you reduce your costs
35 associated with that. So it's a direct relationship with
36 length of stay and reducing your costing structure, and the
37 first thing, it would eliminate the issue of casual labour,
38 your overtime and your agency staff, because they're
39 positions that you can work on, they're (indistinct).
40
41 Q. That assumes, does it, that if you reduce length of
42 stay, you'll be able to close beds? Is that --
43 A. Absolutely, yeah. Yeah.
44
45 Q. And do you have a sense of whether that is actually
46 practically what will happen or whether the beds will just
47 be filled up in any event?

1 A. It's a really good decision - a really good question,
2 because it depends on how well we manage our bed stock. We
3 should - what we have done is - it's more around
4 controlling the bed stock so that we don't surge beds when
5 we don't need to, so we have more controls in place to
6 ensure that the bed does bona fide need to be open. So it
7 is not about closing our regular beds, it is more reducing
8 our surge beds where we haven't got the staff that have
9 been rostered for it, so straight away it goes onto an
10 overtime type of shift.
11
12 Q. Can I ask you about paragraph 21 of your statement,
13 please. You say in the first sentence there that you
14 consider the health system in New South Wales would benefit
15 from more statewide clarity and consistency in the
16 standards regarding service delivery. Can you just explain
17 what you mean by that?
18 A. Yeah. Look, I guess this is a little bit of a passion
19 of mine, but the way the system works is that each LHD
20 provides - it does its own clinical services plan. And
21 I don't necessarily believe that the guidance around that,
22 or the collation of those plans, is done to the best of the
23 opportunity that we have in front of us. So what I mean by
24 that is that we go out and we consult with the doctors, we
25 consult with the community, consult with the clinicians,
26 and everybody, which raises expectations of everybody. We
27 don't often always close that loop out properly so their
28 expectations have raised and they haven't been lowered
29 again. So that's the first thing we do wrong.
30
31 The second thing is when they go out in that
32 consultation without a framework of what's the imperative
33 or what's the platform for the State, like, what are the
34 key services that are non-negotiable across the State? So
35 surely the clinical services plan should actually focus on
36 back to basics, the actual key stuff that we need to be
37 doing, and all the other stuff then, if we have the money
38 and have the time, it should come.
39
40 Also, the clinical services plans across the state are
41 done in kind of a rolling program, but they're done in
42 isolation. If you were to do them consistently across the
43 State and say, "Okay, they are all going to be done. So
44 year one we're all going to do ED. Year two, we're going
45 to do surgery across the state to determine what our total
46 surgical need is, what is the gaps in surgery that aren't
47 be addressed," because often surgical clinical service

1 plans don't always identify all the gaps to standard the
2 State should be operating at. So identify them as a state
3 process and then put in the minimum standards, then step
4 back and look at how we are going to service that, which
5 may actually mean a change in the model of how the service
6 is provided across the State. So when finances are tight,
7 you need to minimise your wastes. So you need to look at
8 what you are providing to ensure you provide the basics so
9 you don't miss anything, but you then maybe look at your
10 models to optimise. Because we all know that
11 New South Wales is financially challenged. We also know
12 that Health has been growing for many years and as a
13 percentage of the State budget, it just can't keep growing
14 at the same rate. So we have to put some controls in
15 place. So by bringing together a clinical services plan
16 for the State which is actually costed, it would provide a
17 strong framework so that service is consistent across the
18 State, but then costed, so that perhaps some of the other
19 projects that we do get up at the moment maybe have less
20 weight put on them going forward while we're financially
21 constrained.
22
23 Q. Presumably no such thing as a central costed clinical
24 services plan exists at the moment?
25 A. No, there's nothing like that that I'm aware of.
26
27 THE COMMISSIONER: Q. What about in other states? Do
28 you know?
29 A. I haven't actually seen one. In Queensland, for my -
30 since I obviously worked in Queensland for a period, and we
31 did try and do a five-year rolling model. The problem with
32 it was it identified to government that the gap was getting
33 bigger, and so that didn't help the situation.
34
35 Q. They didn't want to hear that?
36 A. Sorry?
37
38 Q. They didn't want to hear that?
39 A. No, they didn't want to hear that. So that was the
40 problem. But I think, you know, just because you don't
41 want to hear it doesn't mean you shouldn't be, perhaps,
42 doing the work. And there is also a disconnect in the
43 clinical services plan. As I alluded to earlier, a lot of
44 it is about what the community and the medical workforce
45 perceive is needed doesn't necessarily fit with maybe what
46 is affordable within the State at the time as we go
47 forward. So it could be a better model if we did it at a

1 statewide level. But we're starting to do it with
2 procurement. Like we're doing the single digit patient
3 record, actually getting it together and getting the
4 economies across the state.
5
6 MR FULLER: Q. Would you agree that in such a model
7 there would still be a need to take into account local
8 issues and community demands?
9 A. Yeah, but I think the work could be done better
10 upfront, identifying where the gaps are before we actually
11 start the actual talking to the community. I think there
12 is so much data we have in our system, statistically you
13 should be able to see whether the level of service of a
14 particular type of health issue relates in all communities.
15 So I think we could do more with the data to determine how
16 we should be pushing forward with our clinical services
17 plans. We do do some of that, but it's not great at this
18 stage.
19
20 THE COMMISSIONER: Q. That data includes, you know, like
21 population health?
22 A. NWAU, the cost of doing business; the direction for
23 the State in, you know, where are we going with AI for
24 instance. The clinical services plans that were done
25 locally, they'd have no idea what the State is doing with
26 AI.
27
28 Q. And maybe also where the borders are for a public
29 health - or boundaries are, for a public health system? By
30 that, I mean something akin to the discussion some of the
31 clinicians raised in Port Macquarie about how much is spent
32 on patients who are really in end-of-life situation and
33 whether a public system should always be offering expensive
34 interventions to people that are in the process of dying
35 anyway. Family pressures, I mean, that is a difficult
36 awkward conversation, but it's possibly one that the State
37 will ultimately have to have just for cost reasons?
38 A. I 100 per cent agree with you. And I guess that's
39 what I was talking about/, the policy that we live in is
40 not potentially strong enough for what we need to do. And
41 in LHD we get a lot of pressure --
42
43 Q. Yes.
44 A. -- it would be great if there was a policy that
45 supported hip replacements over a certain age or
46 end-of-life heroics, or all those type of things which are
47 great, but, as you know, they cost a lot of money for a

1 very short period of time and do they add any quality of
2 life?
3
4 Q. All of this would have to be done obviously within
5 ethical boundaries, and a whole range of things --
6 A. Not by accountants.
7
8 Q. But - yeah.
9 A. But again, if that was part of a statewide costed
10 clinical services plan, you could actually start to put a
11 cost on that saving or that service as a statewide and make
12 a decision as a State whether we support or don't support
13 it. Because at the moment, it is a little bit haphazard as
14 to how that does occur.
15
16 Q. That would be - I mean, this is not part of this
17 inquiry and certainly not inviting you to give evidence
18 about it, but there is a huge amount of political
19 ramifications tied up with that. But that's not a reason
20 for at least not having the discussion about it involving
21 everyone in that health system network?
22 A. So that's why I think an overall costed clinical
23 services plan would start to provide the framework for
24 those decisions, which is just not there at the moment.
25
26 Q. Yeah. Because you might actually get a really stark -
27 perhaps this data exists anyway, but you might get a really
28 stark picture of how much we are spending on people that
29 don't have much quality of life anyway, but still doing
30 some expensive and perhaps unpleasant intervention because
31 of various pressures?
32 A. Absolutely.
33
34 THE COMMISSIONER: Yes.
35
36 MR FULLER: Those are my questions for this witness.
37 Thank you.
38
39 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
40 questions?
41
42 MR CHENEY: Commissioner, we may have to clarify that
43 paragraph 17.
44
45 THE COMMISSIONER: Yeah, no. I have already sent a
46 message on Teams to have that happen. No doubt that will
47 happen, because someone gave me a thumbs up. So thank you

1 very much for your time. We are very grateful. You are
2 excused.
3
4 THE WITNESS: Thank you very much.
5
6 **<THE WITNESS WAS RELEASED**
7
8 THE COMMISSIONER: That is probably a convenient time, is
9 it, to take the morning break and come back at 12 when the
10 witness was due? I mean, I was going to say 11.55, but the
11 witness is listed at 12 so shall we make it 12 or do you
12 want me to make it 11.55?
13
14 MR FULLER: I think 12 is fine.
15
16 THE COMMISSIONER: We will adjourn until 12. Thank you.
17
18 **SHORT ADJOURNMENT**
19
20 THE COMMISSIONER: Good afternoon. Dr Davies, can you
21 hear me? You might be on mute.
22
23 THE WITNESS: Is that better?
24
25 THE COMMISSIONER: Yeah, we can hear you now.
26
27 THE WITNESS: Cool.
28
29 THE COMMISSIONER: Doctor, would you like to give your
30 evidence by way of oath or affirmation?
31
32 THE WITNESS: Oath, please.
33
34 **<ROBERT JOHN DAVIES, VIA VIDEO-CONFERENCE, SWORN [12.02 pm]**
35
36 **<EXAMINATION BY MR FULLER**
37
38 THE COMMISSIONER: Yes, Mr Fuller.
39
40 MR FULLER: Thank you, Commissioner.
41
42 Q. Dr Davies, my name is Dan Fuller. I am one of the
43 counsel assisting the Commissioner. We met the other week.
44 Can you see and hear me okay?
45 A. Yes, I can see and hear you.
46
47 Q. Can you state your full name, please?

1 A. It's Robert John Davies.
2
3 Q. Your professional address is the Tweed Valley Hospital
4 at 771 Cudgen Road, Cudgen; is that right?
5 A. Correct.
6
7 Q. You are the director of emergency medicine
8 Tweed Valley Hospital Northern New South Wales Local Health
9 District?
10 A. Correct.
11
12 Q. You have given a statement to assist the inquiry; is
13 that right?
14 A. Yes.
15
16 Q. Do you have a copy of the statement with you?
17 A. Yes, right here.
18
19 Q. Have you had the opportunity to look over it recently,
20 noting you signed it yesterday?
21 A. Ten minutes ago, yes.
22
23 Q. And is everything in the statement true and correct to
24 the best of your knowledge and belief?
25 A. It is, yes.
26
27 Q. Thank you. You have been director of emergency
28 medicine at Tweed Valley Hospital since 2011; is that
29 right?
30 A. Correct, yes.
31
32 Q. And in your role, you oversee not only the Tweed
33 emergency department, but also the emergency departments at
34 Byron and Murwillumbah hospitals; that is right?
35 A. Yes.
36
37 Q. How far is the Tweed Valley Hospital, the new
38 hospital, from the Queensland border?
39 A. It's about 10 minutes.
40
41 Q. Are there doctors that you are --
42 A. Sorry, correction. If you - straight up the freeway
43 just to the border, it's about six or seven minutes on the
44 highway. So, yeah, it's very close. 10 kilometres.
45
46 Q. Are there doctors who you are aware of at the
47 Tweed Valley Hospital who live in Queensland?

1 A. Yes. Many, many of our doctors do. Probably close to
2 50 per cent.
3
4 Q. What about doctors who went to university in
5 Queensland; do you have a sense of that?
6 A. No. That's a harder one across the spectrum, yeah.
7 That's harder for me to comment.
8
9 Q. Okay. Can you have a look at paragraph 12 of your
10 statement, please. Starting with medical students, you
11 tell us that Tweed Valley Hospital supports medical
12 students from Bond and Griffith universities in Queensland,
13 but most of them accept positions in South East Queensland
14 once they finish training. Do you have any observations as
15 to why that is?
16 A. I think there's a couple of things. One, they spend
17 probably a lot more of their rotations in Queensland, so
18 they become more familiar with those hospitals and they
19 only do some of their rotations across the Tweed. And, you
20 know, there are bigger hospitals than the Tweed with more
21 services, especially the Gold Coast University Hospital but
22 also hospitals across Brisbane, the PA, Royal Brisbane
23 hospitals, and so they have more tertiary services so there
24 is more opportunities for training. The junior doctors
25 often, obviously, are concerned with their future career
26 progression and want to, you know, start on pathways, you
27 know, that may lead them into opportunities for different
28 specialist training. So it's always - has been known
29 within the professions that it is harder to recruit in
30 regional and smaller hospitals when you compete with
31 tertiary hospitals because of that.
32
33 Q. Do you have any views as to anything that could be
34 done to improve the situation of medical students who train
35 in Tweed Valley Hospital staying or coming back to
36 Tweed Valley Hospital?
37 A. So there's various things that have been done over the
38 years to improve the recruitment. So the systems, there
39 are interim places in Queensland and New South Wales which
40 are controlled, obviously, by those states, and there are
41 specific pathways that the medical students have to use to
42 be able to apply to those positions in another State from
43 where they trained, and those have been a little bit more
44 aligned. I think there is only two days between
45 New South Wales and Queensland this time, so that the
46 intern positions all came out very close together. So
47 that's one thing, is obviously keeping those dates, because

1 if you have been offered a position in Queensland a month
2 before you get offered a position in New South Wales, you
3 probably won't be taking up your position in
4 New South Wales, if that makes sense. So keeping --
5
6 Q. And just --
7 A. Yep, go on.
8
9 Q. Just pausing there, are we right in thinking that
10 previously there was about six weeks' gap between --
11 A. Not in the intern - the intern position has always
12 been closer, but there has been, you know, a week, two
13 weeks before in difference. And then there is priorities
14 and how they're listed priority-wise and processes and how
15 they apply to various states. And so, that's been worked
16 on over the years to try and improve and to produce a bit
17 of equity or more parity between the students.
18
19 Q. I think you tell us about some of the challenges for
20 recruiting interns at the hospital in paragraph 15 of your
21 statement; is that right?
22 A. Yeah, it is. When I started making the statement and
23 towards the end, it's almost been nullified by what's
24 happened this year. So last year we had this big deficit
25 of interns. We were in the old hospital of course, the old
26 Tweed Hospital then. We have moved to this lovely new
27 shiny building here at Cudgen. And HETI at the time told
28 us that there was a shortage of interns across the State,
29 and at the time we were allowed to IMGs to fill those
30 intern positions with permission from HETI. This year, we
31 were actually told - my GMO manager told me the other day
32 we were the only hospital, or one of only a couple of
33 hospitals in the State that have actually filled all their
34 intern positions this year. So I don't know, that sort of
35 makes it hard with some of the issues I've written in the
36 statement which, of course, are historical and also before
37 we had the shiny new hospital, which we certainly think has
38 been an effect but also, as I said, some of those changes
39 in priority that we've made into how we rank students
40 between Queensland and New South Wales, which the GMO
41 office here has tried to manage to improve, which, for our
42 first year ever has resulted in us having actually all of
43 our intern positions filled. So yes, I don't know --
44
45 Q. Just going through those one-by-one, those factors
46 that you think have contributed to you having a full
47 complement of interns this year, one is the new hospital;

1 is that right?
2 A. Yeah. We think so. Certainly across the board, right
3 through all of our positions, our RMO positions, our
4 registrar positions, we've had, you know, an increase in
5 applicants across those positions. So, which nothing else
6 really has changed, you know, in the RMO and registrar sort
7 of application positions to change what we've done. We've
8 done the same. It's only the hospital that is the
9 difference in those settings. The interns, our GMO office
10 certainly did apply certain slightly different criteria and
11 were allowed to apply slightly different criteria in terms
12 of ranking the applicants, which this year seems to have --
13
14 Q. I'm sorry to interrupt you.
15 A. No, no. You're okay.
16
17 Q. Can you just elaborate on that change, the change in
18 the ranking of priority process?
19 A. That might be better to - I don't want to say
20 something that's not correct here. So, you know, that's
21 obviously information they have told me that they've
22 changed the way they rank the priorities. Yeah, I think
23 I would have to probably leave it at that. The depth of my
24 knowledge is a little bit reliant on the information I've
25 been given.
26
27 Q. Just as a matter of background, when you say "rank the
28 priorities", what does that actually mean?
29 A. So if you've got 20 positions, then the top - after
30 interviews and selection, the top 20 candidates will be
31 offered a position but there may be other suitable
32 candidates that are put on an eligibility list. Hopefully,
33 that makes sense. So where you put those doctors, where
34 you rank them on, you know, for offers and on the
35 eligibility list, then as doctors decline, offers depends
36 on, you know, the subsequent doctors on eligibility lists
37 may or may not get offers depending on if they have
38 selected jobs elsewhere. And so, if you - you know, for
39 example, rank a doctor in Sydney, you know, say, I don't
40 know, in third or fourth spot for a position behind, you
41 know, someone that's more a doctor who has actually been
42 born and bred on the Tweed, you know, they might have
43 family on the Tweed, they might have done their education,
44 their high school education, on the Tweed and then may have
45 done their medical school in Queensland or Victoria or
46 something else, those doctors are more likely to come back
47 to Tweed. Does that make sense? And those rankings are -

1 it is a ranking system that gives priorities to, you know,
2 if you trained in high school in New South Wales, have you
3 done your medical degree in New South Wales, do you live in
4 New South Wales versus, you know, a training/medical school
5 in New South Wales but high school in Queensland, you know,
6 live in Queensland sort of thing. So how you select those
7 priorities actually changes - can change quite considerably
8 the number of people that you are - actually finally accept
9 your jobs and take the positions. I hope that's not -
10 I haven't confused everyone.
11
12 Q. That makes sense. So as you understand it, there was
13 some change in the methodology for ranking or prioritising
14 over the last year which seems to have contributed to
15 improvement in your numbers?
16 A. That's the only other thing we have done other than
17 the shiny new hospital, so --
18
19 Q. In your statement, paragraph 15(b), you told us that -
20 and appreciating this may be historical - that Queensland
21 medical graduates are prioritised lower than
22 New South Wales graduates. Do you know if that is
23 something that has changed this year, or do you not know?
24 A. I don't know, because as I say, it is multi-faceted
25 depending on high school, where they live, and medical
26 school and where they've graduated, so, yeah.
27
28 Q. One of the other things in (c) that you tell us is
29 there are more favourable pay conditions in Queensland.
30 I take it that's not something that's changed in the past
31 year; is that right?
32 A. No. No. So these gaps can come and go over years,
33 you know, and over decades. So the states sort of leapfrog
34 each other in various settings at the moment.
35 New South Wales was sort of at the bottom when I started in
36 New South Wales 20 years ago. I actually had a pay
37 increase coming from Queensland, you know. So, you know,
38 those things change over time. But at the moment, yes, the
39 RMOs and interns get more and registrars get more money in
40 Queensland and they also get the incentives which, you
41 know, are freely available. I think if you put into Google
42 search "Queensland incentives".
43
44 Q. Those are things like sign-on bonuses and that sort of
45 thing?
46 A. Yeah. So there is rural and regional ones and metro
47 ones. So --

1
2 Q. Yes.
3 A. And they're considerable. For a junior doctor's pay,
4 you are talking - there is a $10,000 bonus sign-on if you
5 come from interstate and a $10,000 if you finish your
6 contract. It is an extra $50,000 if you go to a rural
7 regional area, to certain rural areas, on top of that
8 $20,000. That's a considerable amount of money for junior
9 doctors.
10
11 Q. Leaving aside the bonuses that you can get in
12 Queensland, do you know roughly what the difference in pay
13 is for, say, an intern from New South Wales versus
14 Queensland?
15 A. The intern, I'm not so sure about. The last time
16 I looked for an RMO PGY-2 to 3, it was about $15,000
17 per annum.
18
19 Q. Yes, all right.
20 A. That was about six - six to nine months ago so, as
21 I said, they do change.
22
23 Q. Then in 15(d), you tell us that New South Wales
24 medical graduates applying for a rural or regional intern
25 position have to complete an essay. Is that still the
26 case, to your knowledge?
27 A. It is still to my knowledge, yes. Certainly it was
28 current last year and one of our interns actually
29 presented, you know, at the round table on this and I had a
30 chat with him afterwards and it's - yeah, I'm actually
31 surprised. I was astounded to hear about it, but surprised
32 we get as many applicants as we do under that setting.
33 It's, you know, you must really, really want to come if you
34 have to do that sort of process.
35
36 Q. It's the case, isn't it, that Tweed Valley Hospital is
37 classified as MM1 under the modified Monash model? MM1?
38 A. Yes, that's quite right now. So for years, you know,
39 we've always been classed as a regional hospital, but Tweed
40 is a city now and under the MMR, modified Monash scale, a
41 city is actually an MM1. So we are sort of looked on often
42 as regional because we are so far from Sydney, yet we sit
43 right on the bottom of the Gold Coast. So on the MMR scale
44 we are looked at as outer metro.
45
46 Q. And you told us in your statement that the same is for
47 Murwillumbah now, that it is also classified as an MM1

1 locality?
2 A. Yeah.
3
4 Q. Do you have any knowledge why Tweed Hospital is
5 nevertheless treated as a rural or regional intern position
6 for the purpose of applicants having to --
7 A. I can only assume because it's so far from Sydney.
8 So, like, you know, your Coffs and Tamworth where you're
9 sat, you know, Port Macquaries and Lismores and things.
10 You know, so - and that's traditionally, as I said, how it
11 was, you know, was looked upon. Yeah.
12
13 Q. As someone who has practiced in the region for a long
14 time, can you think of any good reason why an intern
15 applicant needs to complete a 4,000-word essay to make
16 their application?
17 A. No. As I said, I was astounded and, you know, for me
18 I personally think as an intern, you know, with lots of
19 other things to be doing at the time, I'd probably groan if
20 I had to do that for every regional hospital. And, you
21 know, obviously, you know, we have a lot of doctors that
22 have grown up in the region, especially across the Gold
23 Coast and the Southern Tweed, you know, that want to come
24 back here. And we hear this all the time, they'd love to
25 come back and train at the Tweed Hospital. And I think
26 those two things, one, you know, as an intern as we talked
27 about, these sorts of barriers, you know, and the ranking
28 systems and things that have made it hard for some of them,
29 and then, you know, the opportunity for training, you know,
30 which is lower down in my statement about, you know,
31 registrar and training positions. You know, that they'll
32 choose, you know, tertiary hospitals across the border if
33 they're returning to the area. So --
34
35 Q. I'll come to that now, since you've raised it. If you
36 just go to paragraph 34 of your statement, please.
37 A. Yep.
38
39 Q. You see there in the first sentence, you say:
40
41 *Some specialty training programs are*
42 *integrated into Queensland while others are*
43 *from New South Wales.*
44
45 Can you just explain what you mean by that?
46 A. So a lot of training programs are often linked to
47 networks. So if you want to train as an anaesthetist, you

1 will train across the network and you will move between
2 various hospitals at various stages of that training
3 program. And so, those networks obviously involve, as
4 I said, lots of - various hospitals. Some of those
5 networks, you know, Tweed is linked with Queensland
6 hospitals. The majority were linked with other hospitals
7 in New South Wales, so, for instance --
8
9 Q. Do you --
10 A. Go on.
11
12 Q. No, no. Please continue.
13 A. You go. You go.
14
15 Q. Just focusing on emergency medicine, for example,
16 which is your area, there is an emergency medicine training
17 network that sits under HETI?
18 A. Correct, correct. So we're network 5 and we're linked
19 to Westmead and other hospitals in Sydney, which again, you
20 know, is a good example of how that doesn't work for us,
21 because we have managed to get one trainee from Sydney who
22 spent six months with us in the 15 years that network has
23 been running. We're too far away.
24
25 Q. Is it your view that, at least for emergency medicine,
26 it would be better in terms of attracting trainees if you
27 had a network that was integrated with Queensland?
28 A. Absolutely.
29
30 Q. Can you just explain why that's the case?
31 A. So because of - well, one is distance. So doctors, if
32 they can do most of their training, you know, in one place
33 and they don't have to move themselves and their families
34 from hospital to hospital from, you know, location to
35 location across the State, that makes life a lot easier
36 whilst you're training. And so obviously, you know, in
37 terms of distances, we're very close to Queensland
38 hospitals. But it depends, you know, on the training
39 network and - sorry, the training program. So, for
40 example, in emergency medicine, you actually can't do all
41 your training in one hospital. You know, the college
42 actually has built the program so you actually have to work
43 in different emergency departments across different
44 hospitals to gain different experiences. You have to do at
45 least six months in a tertiary hospital, you have to do at
46 least six months in a regional hospital, you know, as parts
47 of the program, and that's been built in to try and make

1 sure everybody gets a diverse experience and different
2 experience across. So those things are built into the
3 training program, but we can't actually offer, or it is a
4 lot harder for us to offer or compete as an alternative to
5 some of the outer metros or the hospitals, you know, that
6 doctors need to rotate through, because our hospitals that
7 rotate through us are 700 kilometres away in Sydney versus
8 1,500 kilometres away in Brisbane and Gold Coast. Does
9 that make sense?
10
11 Q. Yes. How long would a doctor's rotation through Tweed
12 Hospital be?
13 A. It absolutely depends on the doctor, often where they
14 are in their training program, and it's very flexible.
15 They could do at least a minimum of six months is a
16 minimum, but with our department is accredited for up to
17 36 months of the 48 months of training that you have to do.
18 So they can spend - you know, especially if they start as a
19 junior, they can spend three, four years here quite easily.
20
21 Q. Would we be right in thinking - and tell me if you
22 don't know the answer to this - that the longer a trainee
23 spends in either your hospital or in the region, the more
24 likely it is that they'll stay in the region to work as a
25 specialist?
26 A. Yes, absolutely that is the case. And, you know, most
27 of my consultants, you know, that we have in the
28 department - there's 28 consultants, you know, that we
29 employ in various parts of part-time but 28 bodies, but the
30 vast majority of those have had training in the Tweed
31 Hospital, either part or a considerable portion or most of
32 their training.
33
34 Q. Just going back to paragraph 34 of your statement, you
35 tell us about other specialties where you have, for
36 example, in orthopaedics one accredited and six
37 unaccredited positions and medicine eight accredited, four
38 unaccredited.
39 A. Mmm.
40
41 Q. Does having those unaccredited positions make a
42 practical difference to the delivery of patient care either
43 now or in the future?
44 A. It's - I'll think about this one. So the unaccredited
45 positions basically are there to fulfil the workforce
46 requirements, if that makes sense. So, you know, we - for
47 example, with our orthopaedics department, we have seven

1 registrars that we need to actually look after that
2 volume of patients that come through our orthopaedic
3 department, through the fracture clinics, through the
4 theatres, through the emergency department. So we couldn't
5 run on just one position. For the orthopaedic training
6 program - sorry, for the accredited trainee, the numbers of
7 those are decided by the orthopaedic college. So we don't
8 get to decide, you know, "Oh, well, we'd like to make all
9 seven of those as training positions." As for the - you
10 know, to become an orthopaedic surgeon, their college
11 decides that and they decide the numbers across the State,
12 and I won't go - and across the country, and I won't go
13 into the politics of that. I'm sure you may or may not
14 have had some representations or be aware of some of the
15 limitations of numbers of trainees across the country in
16 various specialties that don't match the workforce need
17 across Australia. But I'm not going to go into that for,
18 you know, in this, but it suffices to say, you know, there
19 are, you know, discrepancies between, you know, the numbers
20 of accredited positions and the unaccredited positions;
21 therefore, might fulfil the workforce requirement for those
22 areas.
23
24 Q. Do you have a view as to whether it would be
25 preferable if all of those positions could be accredited
26 training positions rather than having a significant
27 proportion of unaccredited positions?
28 A. I am very sure that there are lots of doctors who want
29 to train in orthopaedics that would be very grateful if
30 there were more orthopaedic training positions, accredited
31 training positions, across the country. But, yeah, would
32 it be beneficial? Yes, I think that helps recruit, you
33 know, helps us with our recruitment if we had, you know, an
34 extra couple of advanced trainee positions. Orthopaedics
35 is a very competitive program to get on, and there's, you
36 know, many years are spent trying to get onto the program.
37 So it's not an area that we usually have difficulty filling
38 with unaccredited trainees. They're usually trying to get
39 orthopaedic experience to get on into an accredited
40 position.
41
42 Q. In your area of emergency medicine, are you also
43 deficient in accredited positions, or not?
44 A. So we - the colleges are - they actually have
45 different systems. So my college, for example, doesn't
46 limit or it hasn't got a limit on - well, there is, but it
47 is based on the numbers of consultants. So if I have

1 10 consultants, I may be actually able to actually take 15
2 trainees. You know, if I only have five consultants, I may
3 only be able to have five trainees. So as long as the
4 emergency department has enough patients going through it
5 and has enough consultants to supervise, then those
6 training numbers are a lot more flexible. Did I answer
7 your question?
8
9 Q. So this - sorry, go on.
10 A. No, no. You go on. What was your question again,
11 might help me rephrase?
12
13 Q. This issue with accredited positions or a lack of
14 accredited positions is not an issue that affects emergency
15 medicine at Tweed Hospital; is that right?
16 A. No, it's - no, we have enough accredited positions.
17 Our issue is getting enough doctors to fill them.
18
19 Q. Can we just go back to international medical
20 graduates, which you talk about in the section above. And
21 you tell us about some challenges with international
22 medical graduates which makes sense. Can I just ask you
23 about paragraph 23, where you propose a possible solution
24 to this problem. Can I just ask you to elaborate on what
25 you envisage this would look like?
26 A. Yes. So I suppose I'm very passionate in supporting
27 IMGs. We've had a lot for decades and so, you know, we
28 have a lot of experience in supporting and bringing doctors
29 on, and they actually form quite a critical part of the
30 workforce, and have done for us. So, you know, over the
31 years, you know, these are my observations and opinions
32 over many, many years of, you know, the issues with trying
33 to support, you know, them into becoming, you know,
34 functional doctors in the system whilst not harming them
35 and not harming patients. And so, the process of, you
36 know, putting, just slotting them into a vacant position as
37 an international medical graduate to fill a position that
38 would normally be filled by, you know, a fully trained
39 Australian doctor with, you know, either, obviously not as
40 an intern but in particular usually as a second or
41 third-year doctor, just slotting them in is setting them up
42 to fail. They're trying to - you know, even if their
43 conversational English is good, they're trying to work in a
44 language that they've not been trained medically, or
45 sometimes even if they have, it's not at the same level of
46 use of the English language. And so, they have to - and
47 you can see this when you work with them, and I talk about

1 the cognitive load, you can see them trying to decipher all
2 the information they're given. And these are very bright
3 and capable people, and with support, they can make that
4 transition to that efficiency where they can actually work
5 in medical English and they can therefore free up a bit of
6 bandwidth I talk about to then be actually able to learn
7 the system and understand the system more. But that takes
8 that time, and so the problem is that we just slot them
9 into the system on day one and we expect them to function,
10 and that is detrimental to the system and detrimental to
11 the doctor and detrimental to the patients.
12
13 So the recognition - and I suppose that's what I'm
14 trying to just outline here, is the recognition for the
15 system that you can't just slot these doctors in without
16 causing problems in efficiency, in throughput, but in
17 particular, safety for them and for patients, and that this
18 ability - and there are lots of different ways to do it.
19 I just have just put a solution there of being able to
20 bring them on so that positions are actually supernumerary
21 for a period of time so they're not expected to be slotted
22 straight into a role and perform at the level of an
23 Australian doctor for that period of time, but they are
24 supported with supervision to be able to learn the system
25 alongside other doctors so that they can then function
26 more.
27
28 As I said, it's hard to get into specifics because
29 there's lots of different ways of doing it, but it is
30 recognition in the system that you just can't slot them
31 into an Australian doctor's position and expect them to do
32 the same thing. I don't know if any of that makes sense or
33 is helpful.
34
35 THE COMMISSIONER: Q. Can I just ask you a question or
36 two about the paragraphs before the paragraph Mr Fuller
37 just directed you to. Back in paragraph 18, you talk about
38 UK, Canada, USA, Ireland and New Zealand IMGs and their
39 pathway, and then in paragraph 19 you talk about IMGs who
40 are medically qualified in countries other than those?
41 A. Yes.
42
43 Q. And you tell me about the AMC exam, and you've told me
44 that it has a 20 per cent pass rate. Is that pass rate
45 historical? Ie, is it consistently only 20 per cent?
46 A. So for the last few years, yes. Is it the
47 Commissioner I am talking to there?

1
2 Q. You are, yes. Sorry, you can't see me.
3 A. Yes, Commissioner. No, it's all good. So, yes, the
4 last couple of years, that is, and the AMC actually changed
5 it about six - changed the pass rate about six months ago.
6 So they used to have to get - I think it was 11 out of 14
7 or 10 out of 14 sections correct, pass 10 or 11 out of 14
8 sections, and they have just lowered it by one section. So
9 if it was 10, it's now nine; if it was 11, it's now 10.
10
11 Q. Was that in recognition that a 20 per cent pass -
12 I mean, I'm not suggesting this exam should be easy --
13 A. No.
14
15 Q. -- but was that recognition that a 20 per cent pass
16 rate might mean that the test was harder than was
17 appropriate, is the words I've got for that, or not?
18 A. I suppose - I don't know that I can answer that,
19 Commissioner, as to the AMC's reasons for changing, but all
20 of my AMC candidate doctors here were all very, very happy
21 with the change. But yeah, I couldn't answer the reasons
22 for the AMC. One would hope that that was part of the
23 reason, but they may have had other reasons as well, so --
24
25 Q. Okay.
26 A. I think the important part with the exam to me is that
27 it actually doesn't reflect whether the doctor can do the
28 job or not.
29
30 Q. Well, that's what I was about to ask you. The
31 candidates you were talking about, how would you describe
32 their level of competence to actually be medical clinicians
33 in the Australian health system?
34 A. So it depends when they've come to us and what they've
35 done. Sometimes they actually start - they try to do the
36 AMC before they've even got a clinical job or right at the
37 start of the clinical job. Sometimes they may wait six
38 months, sometimes they may wait 18 months, and so I have
39 doctors at various stages, you know, of integration into
40 the Australian system.
41
42 Q. Sure.
43 A. You know, I know of multiple doctors that we are very
44 happy with their level of competence and, you know, their
45 level of practice that fail the exam and, you know, so -
46 and that's - passing an exam tells you you can pass an
47 exam. It doesn't tell you anything else. It's like an

1 interview tells you somebody's good at an interview. It
2 doesn't actually tell you that they can do the job. And
3 so, you know, that's the problem with any exam. And that
4 doesn't - whether it is just the AMC exam or any fellowship
5 exam or anything else. So --
6
7 THE COMMISSIONER: Yes. Thank you.
8
9 MR FULLER: .
10
11 Q. You have told us, Dr Davies, that Northern
12 New South Wales LHD is in the process of establishing -
13 this is paragraph 25 - a workplace-based investment
14 pathway.
15 A. Yes.
16
17 Q. Do you think that will be beneficial for some of those
18 IMGs?
19 A. I have - this can get complex now. But it - it can do
20 for those that may not be or may not feel as confident
21 about passing an exam, but there's - I mean, we have
22 probably, I don't know - we probably have about 30 IMGs
23 across the hospital and I know two of them are going to get
24 a potential WBA space next year. Even if we had six at
25 Lismore, what happens in these hospitals is that doctors
26 can actually be put on a wait list where they do six or
27 12 months or 18 months in the hospital as an IMG before
28 they actually get put on the WBA pathway, which is then
29 another 12 months. So it is a way that hospitals can use
30 to hold the IMGs in the hospital for a longer period of
31 time, if that makes sense. So the hardest part of, you
32 know, working with an IMG, for them and for us, is the
33 first six months. It is incredibly stressful for them. It
34 requires a lot of supervision and then over that six to
35 12 months, their confidence and efficiency builds. So
36 everybody wants to take an IMG if they are a standard
37 pathway doctor after they've done the first six to
38 12 months in the Australian system; does that make sense?
39 So unfortunately, the WBA pathways can actually mean that
40 they are attracting doctors who have done six or 12 months
41 or more in other hospitals, and they'll take them, select
42 them at interview to be the ones that can go on their WBA
43 pathway next year. Does that make sense? So it can
44 actually be used in this - well, quite - I think in a quite
45 unethical way, but of course the IMGs if they don't want to
46 do the exam, they will head towards that pathway. But the
47 hospitals who have put in all the hard yards and have taken

1 all the risk and the time for supervision, you know, are
2 being used as a pathway into WBA for other hospitals. So
3 I have mixed feelings about the WBA system. Personally,
4 I think, you know, these hospitals also charge candidates
5 about anywhere from 10 to 15,000 a year to actually
6 undertake the WBA program. So that's a big hit on doctors
7 that come from overseas that are trying to establish
8 themselves in, you know, a new country like Australia.
9 And, to me, you know, I think there could be actually
10 emphasis put more on helping the IMGs either through a -
11 actually through the clinical exam and more focus on
12 supporting them, and that's what I've actually - I'm trying
13 to actually, you know, institute at our hospital alongside
14 the WBA program, because I think, you know, it's
15 potentially quicker and better for them. It is certainly a
16 lot cheaper for them financially and they, you know, have
17 more freedom then in the system if, you know, we can get
18 them - support them over six months to pass an exam.
19 Overall what I would like to see? I think it would be very
20 easy to actually have a hospital-based system very akin to
21 a swap them into an intern-type, you know, process that we
22 already have well set up in Australia. But this all gets
23 controlled by the AMC for international graduates or by the
24 AMC for international graduates, and it's sort of outside
25 those other systems. So yeah, sorry, I hope I didn't -
26 yeah. I have mixed feelings for it and I think WBA, whilst
27 it is a good process, it can be used, I think, to exploit
28 IMGs. I'm not into that.
29
30 Q. You have told us in paragraph 24, just above, that
31 recruitment of IMGs reduces your reliance on locums.
32 I take it you see that as a positive?
33 A. Absolutely. I hate using locums, because they charge
34 me twice as much as a doctor at the same stage of training.
35 They come for two weeks, you know, and they go. So, you
36 know, they're not really overly interested in, you know,
37 whether they're part of the system. It's very mercenary,
38 you know. Yes, you can have longer term locums and things
39 like that, but most hop and skip, you know, for a reason,
40 you know, because then, you know, there's less
41 responsibility is the term I'm looking for them. And so,
42 yes, all care no responsibility sort of term, you know. As
43 I said, I find that mercenary. I don't think that buys
44 into the hospital, into the community, into the service,
45 which is what we should be providing. And so, I would -
46 I far prefer, and always have done, to have taken on IMGs
47 to fill those vacancies and work with them to fill our

1 vacancy gaps so we don't have a reliance on locums.
2
3 Q. In relation to both IMGs and JMOs, junior medical
4 officers, after the intern stage, you tell us that there is
5 a gap in the timeframe for recruitment between Queensland
6 and New South Wales. Have I understood that correctly?
7 That's a six-week gap?
8 A. Yeah, it's at least six weeks. It sort of drives us
9 mad because we don't understand why it exists and being on
10 a border region, but being behind everybody anyway -
11 I mean, we're the last state of the states, we're the last
12 cab off the rank, which means everyone else has already got
13 offers all around us, be it the Victorian side or
14 Queensland side, before we've started our recruitment
15 campaign. And so, you know, doctors will accept positions
16 that they've been offered in other places and we won't even
17 get a look-in. So there has to be - you have to have a
18 very specific and strong reason to come to us to apply to
19 us, if that makes sense.
20
21 Q. And is that the case even for doctors who have been
22 working as interns in your hospital; that is, you may lose
23 some of them to Queensland because Queensland has an
24 earlier recruitment round?
25 A. Yep, absolutely. They can have a job offered, signed,
26 letter of offer, you know, for their $20,000 bonus if they
27 skip across the border and they're higher pay, you know,
28 before we've, you know, put the advert up.
29
30 Q. And I take it from your earlier --
31 A. It makes it nice and safe for them to apply for
32 Queensland.
33
34 Q. I take it from your earlier answer that you don't see
35 any good reason for the gap in the approval?
36 A. Well, I don't - I don't know why New South Wales
37 system does that. They may have very good reasons, but I'm
38 not aware of it and I think it's - you know, you're moving
39 a time, you're picking a time, you know, in a year to start
40 off with, just pick a time six weeks earlier or two months
41 earlier.
42
43 Q. Can I ask you now about senior medical staff, which
44 you deal with from paragraph 36 of your statement. You
45 have told us that the ED at Tweed Valley Hospital is
46 staffed only by visiting medical officers; that's right?
47 A. Yeah, correct.

1
2 Q. What is the reason for that, do you know?
3 A. Historic, in a way, and again because we sit very
4 close to the Queensland border. And so, you may or may not
5 be aware - I would assume the Commission is aware - that
6 the staff specialist award in Queensland is a lot higher
7 rate than New South Wales' staff specialist award.
8
9 THE COMMISSIONER: Q. We have heard that once or twice
10 now.
11 A. Just once or twice? I thought you might be aware,
12 Commissioner.
13
14 Q. I've forgotten a few, yes.
15 A. I think it is probably the lowest - you have probably
16 heard that a little while - the lowest of the staff
17 specialist awards. Look, again I might sit outside some of
18 my colleagues in this, but I actually like a VMO system for
19 not purely based on numerical reasons. You know, it was
20 put in historically when the department in 2001 became
21 accredited with the emergency college and started - we were
22 trying to attract specialists, FACEMs, in emergency
23 medicine. The positions were initially, and I myself
24 started, as a staff specialist. And over the first
25 18 months people were just walking back across the border
26 into Queensland and taking staff specialist positions for a
27 lot more money. So the LHD executive decided at the time
28 to offer us VMO rates which, you know, on a numerical basis
29 was a closer match to the Queensland rates. We, of course,
30 lost, you know - don't have any, you know, sick leave,
31 annual leave, you know, paternity leave, all those long
32 service leave, all those sorts of things; it is just purely
33 the numerical rate. And since that time, we've always
34 advertised positions for consultants as either VMO or staff
35 specialists. To be honest, I haven't bothered the last
36 couple of years because in the 20-something-years we've
37 been doing this now, two people have taken staff - a staff
38 specialist over a VMO contract and they've both left within
39 a year. So it just is where we sit in the setup. I also
40 actually think, you know, the VMO system works well in
41 emergency medicine. You know, we have a lot of flexibility
42 around the way we work. My consultants tend to work eight
43 to 8.5-hour shifts, not 10-hour shifts. It makes a
44 difference when you get older and when you get stuck for an
45 hour or two at the end of your shift. They tend to work
46 three clinical shifts a week, which is 24 hours. And so -
47 and earn a good rate of pay for that. So from a balance -

1 emergency medicine is tough. You know, it is a very
2 chaotic environment, a very stimulating environment. And
3 so, you know, you sort of - burnout and all those sorts of
4 things are a risk. So our system here, I've always felt,
5 was very conducive to having a good work/life balance, to
6 having shorter shifts, having, you know, a limited number
7 of shifts or only needing a limited number of shifts to
8 earn, and it seems to have stood the test of time over the
9 20-years or so and, yeah. So I - yeah.
10
11 MR FULLER: Q. In terms of pay, do you know what the
12 difference in pay for yourself, for example, as an ED staff
13 specialist in New South Wales versus Queensland would be?
14 A. So it's hard because it depends on what year, it
15 depends on if you get any managerial loading and things,
16 which is, again, is higher in Queensland. And so, yeah, it
17 all depends on when - when we were looking at this, you
18 know, it will - if you look at it and you try and compare
19 it as like-with-like as much as you can, depending on where
20 they sit, you know, the gap again gets smaller. A bit like
21 nurses, the gap gets smaller the more senior you get in New
22 South Wales to Queensland, but it can be 100 to 150,000
23 when you're in the first few years as a staff specialist,
24 so --
25
26 Q. Yes.
27 A. Depending on how you work and weekend rates of pay and
28 remuneration and the packages and - yeah.
29
30 Q. Have you, at your hospital or in the district, done
31 any sort of analysis, documented analysis, of the
32 disparities? Or it is something you have just looked at
33 generally?
34 A. Not for a while, no. Intermittently. Sometimes when
35 we get a new director of medical services, they come along
36 and cost the department and run the figures. The DMS,
37 about two years ago, did the costing and said we were still
38 a lot cheaper than a staff specialist department. And the
39 reason for that is even though we get paid more as a VMO
40 per hour, is you're not paying us whilst we're not here.
41 So staff specialists get a lot of additives on the award
42 for annual leave, long service leave, study leave, TESL, as
43 you might have heard of, which is about 25 days a year of
44 study leave and a $30,000 or something bonus. So all that
45 time if you have a department fully staffed with staff
46 specialists, you have to employ a lot more people to come
47 to work whilst they're on all their leave.

1
2 Q. I see
3 A. You look like I'd confused you; does that make sense?
4 So for every five staff specialists you employ, you have
5 got to employ another full-time specialist to cover all
6 their leave.
7
8 Q. And based on the calculations that were done, when
9 that was last done, it would be more expensive to do that
10 than to just have the current cohort of VMOs; is that
11 right?
12 A. To cover the rostered hours and on the - to cover all
13 the hours on the roster, yes, you would need a lot more
14 staff specialists and a lot more bodies to cover all the
15 leave. And they also get the non-clinical time or clinical
16 support time. So 25 per cent of their time, at least, is
17 spent in a non-clinical capacity, so not seeing patients.
18
19 Q. If you and your colleagues had access to a staff
20 specialists award that gave you something close to parity
21 of pay with Queensland and the flexibility to work the sort
22 of fractional or shorter hours that some of your colleagues
23 want to work, do you think you or your colleagues would
24 become staff specialists?
25 A. I think so. I think mainly that's, you know, then
26 around, especially as you become older, you know, having
27 things like sick leave and, you know, paid annual leave.
28 You know, on a VMO award, we have our own annual leave
29 fund. You know, we put money aside if you want to go on
30 holiday. You know, all of that is built into the award.
31 For female doctors, of course, you know, maternity leave,
32 you know, those sorts of assurances built into the award.
33 You know, I think that yes, I think the majority of doctors
34 would elect to change over to a staff specialist award if
35 we were on par to Queensland, yeah.
36
37 Q. And what if you're on par to just the VMO rates in
38 New South Wales versus - so, rather than being on par with
39 Queensland, if you had a staff specialist award that put
40 you on par with the VMO rates that you currently receive
41 and built in a flexibility that you are talking about,
42 would that still be attractive because of, for example,
43 sick leave, do you think?
44 A. Yes, but you'd probably be paying quite a lot.
45
46 Q. Are you getting paid more as a VMO than you would get
47 paid as a staff specialist in Queensland, do you know?

1 A. No. We're still a little bit behind, but we're - from
2 the last time I looked at it, but I haven't looked for
3 probably five years or more. But, yeah.
4
5 Q. So the reason why it would cost more is for the
6 reasons you've told us earlier; that is, you would have to
7 employ an additional FTE to account for --
8 A. For all the leave.
9
10 Q. Okay.
11 A. Or the non-productive hours, I think, is the correct
12 term.
13
14 Q. Can I ask you briefly about the clinical interaction
15 with Queensland. You told us in paragraph 6 of your
16 statement that approximately 20 per cent of ED
17 presentations to the Tweed Valley Hospital are currently
18 from Queensland, but that figure has declined over the
19 years. Do you know why that decline has happened?
20 A. Yes. So, again, various reasons over a long span. So
21 when I first started at Tweed, which is 2001, and I came
22 from Queensland at that time from the Gold Coast Hospital,
23 about 40 per cent, just over 40 per cent, of presentations
24 to the Tweed Hospital were Queensland. At that stage,
25 there was only the Gold Coast Hospital in the north end of
26 the Gold Coast and Tweed in the southern end, just across
27 the border. As you might know, the old Tweed hospital was
28 right on the border with Queensland. So the thing is in
29 2007 Robina Hospital got built, and so traditionally our
30 catchment area used to be from Burleigh Heads south for the
31 Tweed Hospital, and ambulances, Queensland ambulances,
32 would bring patients from Tallebudgera Creek south to the
33 Tweed Hospital. When the Robina Hospital, which is right
34 in the middle of the Gold Coast, opened, then obviously
35 their catchment area encroached on that traditional Tweed
36 area, so that reduced patients' numbers to us and probably
37 took off - well, we went from 45,000 to 40,000, you know,
38 in a year of Robina Hospital opening, so - and the majority
39 of those, of course, virtually all of those, were
40 Queensland patients at the time. So our numbers, we sort
41 of dropped from 40 per cent to 30 per cent at that time, or
42 just below 30 per cent Queensland patients. So that was
43 the first hit.
44
45 And then over time as Robina has grown and they've
46 built more services in, there has been more ambulance
47 diversions there, various things like paramedics on the

1 Gold Coast. Intensive care paramedics, they tend to take
2 the patients north because of the tertiary services at Gold
3 Coast; that's diverted more. And then for many, many, many
4 years, we've been on Queensland ambulance bypass almost
5 constantly for the last two or three years because Tweed
6 Hospital has been at capacity. In the middle of there is
7 COVID as well, when the border was shut. And so, all of
8 these things have trained patients to go north into the
9 Queensland hospitals, if that makes sense.
10
11 Q. Yes. So Robina Hospital is a different hospital from
12 the Gold Coast University Hospital; is that right?
13 A. Yep. Yep.
14
15 Q. You've told us at the end of your statement in
16 paragraph 39 of Queensland hospitals being increasingly
17 reluctant to take New South Wales patients, including Gold
18 Coast University Hospital, and you've referred to some
19 standing orders that you're aware of at that hospital to
20 certain specialties. Are you able to identify, for
21 example, which specialties that has affected?
22 A. Dermatology. Dermatology is one. I am trying to
23 think - I was trying to remember which - who was the other
24 who had it, and it was on - I think it was - I'll try and
25 remember. If it was vascular surgery or - but, anyway,
26 I can't remember. So I was trying to think which was the
27 other one that had strict instructions from the - on the
28 switchboard, and still does. Dermatology, and that was
29 only from a couple of weeks ago. They're emphatic that
30 they're --
31
32 Q. How are you aware of that?
33 A. The switchboard will tell you. If you ring Gold Coast
34 University Hospital switchboard now and say you are a
35 doctor from the Tweed Hospital and you'd like to speak to
36 the dermatologist, you'll be told by the switchboard,
37 "Sorry, I have a standing order. I can't put you through
38 to those doctors."
39
40 Q. In paragraph 39 --
41 A. It's not hidden.
42
43 Q. -- you have also told us about spinal injury patients
44 refused care at Princess Alexandra Hospital, and you were
45 told or someone at your hospital was told, to send them to
46 Sydney for tertiary assessment?
47 A. For tertiary care.

1
2 Q. Can you just explain from your perspective the problem
3 with that?
4 A. Well, you've got a patient who has had a trauma, has
5 got a broken neck. This is the example. And so this
6 patient is going to be in hospital for at least six months.
7 Potentially 12, but between six and 12 as a quad, a new
8 quadriplegic patient. And so you can imagine from a
9 resource usage cost, that's hundreds of thousands if not,
10 you know, millions of dollars to pay for that patient. So
11 we were told, you know, with this particular patient - and
12 obviously it was quite a stir at the time because we've
13 never had this before that, you know, you needed to arrange
14 transport to Sydney, to North Shore, which was a referral
15 spinal hospital, network hospital, to have care for that
16 patient there and arrange care for that patient, which of
17 course is a massive displacement for that family and for
18 all the carers that actually lived, you know, in the Tweed
19 area. So we had, you know, discussions around that
20 patient, who finally did get accepted at the Princess
21 Alexandra Hospital. Executives had to be involved and this
22 took, obviously, many, many, many hours to arrange and
23 quite considerable pressure to arrange for this patient.
24 And, you know, these - this is obviously - I've tried to
25 give specific examples. You know, this is a quite
26 concerning example of the level of pushback that we get now
27 across various specialties for patients and the
28 difficulties that we have trying to get patients,
29 New South Wales patients, into tertiary care in Queensland.
30
31 Q. You have told us in paragraph 39 that with Gold Coast
32 University Hospital, you think that it is a capacity issue
33 with that hospital. That - sorry, I'll let you answer
34 that.
35 A. No, you keep answering your question, because I think
36 you are going to ask me what I was going to say anyway, so.
37
38 Q. In relation to the spinal injury example, do you
39 perceive that as a cost issue rather than a capacity?
40 A. Yes, yes. So I should have - so when Gold Coast
41 University first got built, we actually used to get
42 specialists from there would come down to the Tweed
43 Hospital and let us know of the new services that we've put
44 on board and certainly invite us to make sure that we
45 contacted them and, you know, referred patients to them,
46 for example. A good example of that is their angio service
47 that they put on, the cardiac cath lab service that was put

1 in when they moved to the university hospital and they had
2 lots of cardiologists, you know, that were wanting to build
3 the service. Whereas now, you know, trying to get a
4 patient that may need an angiogram done is very, very
5 difficult. And that's just a capacity issue, you know. So
6 if we have a patient, say, in our coronary care unit that
7 might need an angiogram in the next day or two, they might
8 actually wait in our coronary care for four or five days.
9 And some have been discharged, you know, to have an angio
10 done as an - that is, an angiogram - done as an outpatient.
11 And that is just capacity. You know, they're just full.
12 You know?
13
14 The other side, as you quite rightly identified, the
15 PA is one that comes down to funding. And we get this
16 comment - we get two other comments. One is a funding
17 comment and the other is a medicolegal comment that "I'm
18 not covered to look after patients in New South Wales and
19 provide advice for New South Wales patients." And that's
20 typically around, you know, advice on care as opposed to
21 accepting the patient. You know, once obviously they're in
22 Queensland, then they're covered, but - so they don't even
23 want to give us any advice about the patient that may need
24 to come to them in - go to them in Queensland, but the
25 patient is in New South Wales, which we find absurd. But
26 the other - as you have quite rightly identified - is
27 funding. So we get specialists constantly sort of saying,
28 "Well, I am not funded to look after New South Wales
29 patients", and, "I'm not funded to look after this patient
30 that's not from Queensland", which, of course, is - you
31 know, in particular units you get these mantras that are
32 passed down when you ring particular units, which obviously
33 may be through from heads of department or from executives
34 above, or whatever. And so, then there is this pushback to
35 care for New South Wales patients. That is one of the
36 things that, you know, I talk about the cross-border
37 committee that we used to have was very helpful in dealing
38 with when we had those levels of, you know, resistance to
39 moving patients across the border.
40
41 Q. And you've told us that that committee is now starting
42 up again; is that right?
43 A. That is what I've been told. That is, the chief
44 executive has said that, yes, she very much wants to start
45 that up again, to try and, you know, I suppose improve some
46 of the workings and the functions of the links across the
47 border. These are key links. You know, these - and, you

1 know, these links have existed for decades. You know,
2 these aren't - it's not - you know, we're not suddenly just
3 sending patients to Queensland hospitals. You know, these
4 have been our tertiary hospitals for as long as, you know,
5 hospitals like Tweed have existed, so --
6
7 Q. The other solution that you have identified is to
8 increase funding for Tweed Valley Hospital to develop its
9 own tertiary services, and you have given some examples in
10 paragraph 41. With those examples, do you have a sense of
11 whether there is sufficient demand in your region to
12 justify those services?
13 A. So those services that I put on are specifically - and
14 this is my - as I sort of said in my statement, my work as
15 one of the former chairs of the medical staff council.
16 These things are all in the clinical service plan for the
17 Tween Valley Hospital. These were the things that were
18 developed. They have been built. The interventional
19 cardiology lab, interventional radiology lab, theatres,
20 they're built. These things, vascular surgery, you know,
21 theatre for vascular surgery, they are built. You know, so
22 they have been built in this building at Tweed Valley, and
23 so they were put in and developed in the clinical services
24 plan to develop those services at the Tweed Valley Hospital
25 for New South Wales patients. How they come online and the
26 funding, you know, to allow them to come online, of course,
27 is always, you know, the real problem that either
28 facilitates them or, you know, holds them back. And so,
29 obviously, you know, our reliance on Queensland hospitals
30 for some of these services can be significantly reduced by
31 bringing those services online. Did I answer your
32 question?
33
34 THE COMMISSIONER: Q. The question, I think, was demand,
35 though, for those services?
36 A. Yeah. So when the clinical services plan is built,
37 Commissioner, it's done on population planning and
38 demographics and numbers. So those all feed into the
39 clinical services plan. And so, those services wouldn't
40 have been signed off by the LHD and by the ministry, had
41 those figures not been done and provided and the evidence
42 for them to build those services. So my answer is, yes,
43 the demand should be there.
44
45 THE COMMISSIONER: Thank you.
46
47 MR FULLER: The other advantage you have identified of

1 developing Tweed Hospital's tertiary services is in your
2 last sentence:
3
4 *Helping to retain junior doctors due to the*
5 *associated increased availability of*
6 *training.*
7
8 Can you just elaborate briefly on what you meant by that?
9 A. Yes. So that comes back to those training networks we
10 were talking about before, you know, for trainees. So, you
11 know, if you have vascular surgery here, for example, you
12 can have a vascular surgical training program. If you have
13 interventional cardiology, you can have cardiology
14 trainees, advanced cardiology trainees. So there are
15 certainly components of opportunities, you know, certain
16 services, you know, that a hospital has to be able to
17 provide so that a training network can operate in that
18 space. You know, so for an advanced trainee, for example,
19 they need to be able to spend some time in the cath lab.
20 You know, so if we don't have a cath lab, we can't get an
21 advanced cardiology trainee. Does that make sense? So
22 those things open up those networks, those training
23 networks, which means more doctors then actually want to
24 apply and to stay here.
25
26 Q. Are you aware of any junior doctors in recent times
27 who have decided not to come to or stay at the hospital
28 because of inadequate or not inadequate but a lack of
29 variety and complexity in some of those services that are
30 offered?
31 A. Yes. So I know of two of our RMOs that are currently
32 in the hospital that are second years, that are going to
33 Victoria next year for opportunities in - one is in
34 obstetrics. I think there's a doctor, obviously, who
35 presented at the round table. Another one for radiology
36 training, you know, which again, you know, if we do more
37 interventional sort of radiology, that again opens up
38 potential to have, you know, registrars here for radiology
39 and interventional radiology.
40
41 MR FULLER: Thank you, Doctor. Those are my questions for
42 this witness.
43
44 THE COMMISSIONER: Thank you. Mr Cheney, do you have any
45 questions?
46
47 MR CHENEY: No, Commissioner.

1
2 THE COMMISSIONER: Doctor, thank you very much for your
3 time. We are very grateful. And you are excused.
4
5 THE WITNESS: Thank you. Thank you for the opportunity to
6 talk.
7
8 THE COMMISSIONER: Sure. Thanks.
9
10 **<THE WITNESS WAS RELEASED**
11
12 THE COMMISSIONER: On the witness list there is just
13 Ms Richter.
14
15 MR FULLER: Yes.
16
17 THE COMMISSIONER: How long will she take?
18
19 MR FULLER: 45 minutes.
20
21 THE COMMISSIONER: The reason I am asking is - and I am in
22 your hands - would there be any point in starting Ms Wong?
23
24 MR FULLER: I think probably not, Commissioner. I think
25 I'll be going close to time with Ms Richter.
26
27 THE COMMISSIONER: Okay. We will adjourn till ten past
28 two.
29
30 **LUNCHEON ADJOURNMENT**
31
32 THE COMMISSIONER: Yes, good afternoon. Ms Richter, can
33 you hear me?
34
35 THE WITNESS: I can, yes.
36
37 **<JENNIFER RICHTER, VIA VIDEO-CONFERENCE, AFFIRMED [2.12 pm]**
38
39 **<EXAMINATION BY MR FULLER**
40
41 THE COMMISSIONER: Yes, Mr Fuller.
42
43 MR FULLER: Thank you, Commissioner.
44
45 Q. Ms Richter, my name is Dan Fuller. I am one of the
46 counsel assisting the Commissioner. Can you hear me okay?
47 A. I can hear you okay, yes.

1
2 Q. I think you can't see me at the moment but you will
3 shortly, hopefully. Can you state your full name, please?
4 A. Jennifer Richter.
5
6 Q. Your business or your professional address is 51 Tamar
7 Street, Ballina, is that right?
8 A. That's right.
9
10 Q. You're a nurse manager, a nursing and midwifery
11 workforce, for the northern New South Wales local health
12 district?
13 A. Yes, that's correct.
14
15 Q. You have given a statement to assist the Inquiry. Do
16 you have a copy of that with you there?
17 A. I do, yes.
18
19 Q. The number is [MOH.0011.0056.0001] and it's tab K-36.
20 Ms Richter, have you had the opportunity to review your
21 statement recently?
22 A. I have. I've reviewed it again today.
23
24 Q. Thank you. Is it true and correct to the best of your
25 knowledge and belief?
26 A. I would just like to make one change to paragraph 8.
27
28 Q. Yes.
29 A. Where I have said that there were 150 nurses, I'd just
30 like to change that to 133.
31
32 Q. So that should say:
33
34 *The local health district successfully*
35 *recruited over 133 nurses.*
36
37 A. You can take out "over" and just "successfully
38 recruited 133 nurses".
39
40 Q. Thank you. With that change, is the statement true
41 and correct to the best of your knowledge and belief?
42 A. Yes, the rest of it is true and correct, yes.
43
44 Q. Thank you. In your role, Ms Richter, are you
45 responsible for a nursing workforce across the northern
46 New South Wales local health district?
47 A. Yeah, that's right. I look after all nursing and

1 midwifery workforce from Tweed Heads down to Grafton and
2 out Urbenville, yes.
3
4 Q. In paragraph 5 of your statement, you told us that
5 that there has been an increase in nursing and midwifery
6 workforce shortages in recent years for a number of reasons
7 which you set out there. Do you see that?
8 A. I do, yes.
9
10 Q. One of the factors you refer to is environmental
11 factors such as bush fires and floods. Can I ask you just
12 to tell us about how the recent environmental events have
13 affected your nursing and midwifery workforce.
14 A. Because I didn't actually live in the district during
15 the bush fires so I can't comment on that, but I did take
16 over this role not long after the floods and the way it
17 affected our workforce was that there were quite a number
18 of staff who lost their homes and lost all their
19 possessions and had to stop working during that period, or
20 else we saw it in a reduction in their hours. So maybe
21 they, you know, might have worked full-time and now they
22 wanted to work part-time whilst they were able to look
23 after what was going on personally in their lives.
24
25 Q. Were there nurses and midwives who were permanently
26 lost to your workforce because of the floods?
27 A. I would say yes, although it's difficult for us to get
28 that data to be able to say exactly what that looked like
29 at the time.
30
31 Q. In terms of the reduction in hours, is that something
32 you're still feeling the effect of?
33 A. Northern New South Wales typically has a workforce
34 that likes to work part-time anyway. It's very common for
35 us - for nurses and midwives to want to work part-time up
36 here, so, yes, we still do see that.
37
38 THE COMMISSIONER: Q. One of the things the Commission
39 has noticed about bush fires and floods not being
40 tremendous for recruitment purposes for any location,
41 I guess it's more what has been any particular change in
42 that? You talk in paragraph 5 about current FTE vacancies,
43 both permanent and temporary, as at July 2024.
44 A. That's right, yes.
45
46 Q. Have those numbers shifted significantly from July '23
47 and July '22 across --

1 A. So when I came into the role, we did not have a
2 vacancy reporting --
3
4 Q. I see.
5 A. -- that was accurate. So we really changed over to
6 that in May 2023.
7
8 Q. Right.
9 A. Probably since then we've been able to monitor.
10
11 Q. All right. Then in terms of at least better data,
12 what about in the last 12 months, is the position getting
13 worse? Is it stable or is it better?
14 A. It's about the same, yeah. It's not getting any
15 significantly worse or any significantly better.
16
17 Q. Okay.
18
19 MR FULLER: Q. You have told us in paragraph 5 that you
20 currently have vacancies of over 300 FTE, and that's been
21 the case since May 2023, is that right?
22 A. Yeah, that's right.
23
24 Q. How has that level of vacancies affected the clinical
25 operations of the facilities in your district, based on
26 your observations?
27 A. We have still been able to provide clinical
28 operations, as far as I am aware, in my experience.
29 However, we do that via using agency nurses, overtime;
30 part-time staff picking up extra hours.
31
32 Q. Do you have a view about whether that is an effective
33 and sustainable way of providing nursing and midwifery
34 services in your district?
35 A. It's certainly not sustainable and it's not effective.
36 The agency cost is high to our district and the increase in
37 overtime can fatigue our staff.
38
39 Q. Do you --
40 A. So there is --
41
42 Q. Sorry, please continue.
43 A. No, no.
44
45 Q. Do you have a sense of the overall cost of the agency
46 staff to your district relative to the cost of your
47 permanent workforce, your employed workforce?

1 A. I don't know the cost of it, no.
2
3 Q. On a per nurse basis, do you know how much more an
4 agency nurse costs than an employed nurse, for example, on
5 average?
6 A. I don't know that on average. I do know that once the
7 floods came and we started to see an increase in agency,
8 I don't know the exact numbers, but I do know at that time
9 the contract that we were using, the agency cost was higher
10 than what a part-time or full-time nurse would earn in our
11 district.
12
13 Q. From paragraph 22 of your statement, you've told us
14 about challenges with the cross-border pay disparity with
15 Queensland. Do you see that?
16 A. Yes.
17
18 Q. Can you just elaborate on that issue for the
19 Commissioner, please?
20 A. Because we are so close to that Queensland border, the
21 difference per annum that a nurse can earn in Queensland
22 compared to New South Wales is significant, and if you look
23 at our assistant in nursing classification here in
24 New South Wales, they can earn up to $15,000 to $17,000
25 more a year by going over to Queensland. Same with the
26 enrolled nurse classification, they can earn $8,000 more a
27 year and registered nurses can earn anywhere between
28 $11,000 to $13,000 more a year.
29
30 Q. Just going through each of those. So an assistant in
31 nursing would be overall the lowest paid of those three
32 groups that you have identified.
33 A. That's right, yeah.
34
35 Q. And so $15,000 to $17,000 would be a substantial
36 proportion of their salary, wouldn't it?
37 A. That's right, and they are nurses - usually, they are
38 nurses that are studying so there are undergraduate nurses
39 who are studying, so that difference in pay can make a real
40 difference to them whilst they're at university.
41
42 THE COMMISSIONER: Q. That is because they're living
43 paycheck to paycheck, so any increase is really helpful?
44 A. Yes, that's right.
45
46 MR FULLER: Q. Enrolled nurses are the next level up in
47 terms of pay for comparative years of experience?

1 A. Yes.
2
3 Q. And then registered and midwives, is it --
4 A. And midwives, yes.
5
6 Q. -- earn $11,000 to $13,000 per annum.
7 A. Depending on what grade year they are, yes.
8
9 Q. Am I right in thinking that if you compare that amount
10 to the New South Wales salary, it would be about 10 to
11 15 per cent at base level; do you know whether that's
12 right?
13 A. I'm not sure of that to be honest, that percentage.
14
15 Q. It is a significant proportion of their salary?
16 A. It is significant.
17
18 Q. You have identified as well in paragraph 24 some other
19 conditions of work offered by Queensland Health that you
20 say are attractive. Do we understand that as meaning more
21 attractive than conditions that are available, the
22 corresponding conditions that are available, in
23 New South Wales?
24 A. Yes, more attractive than New South Wales.
25
26 Q. Can I ask you about 24(d) where you say:
27
28 *Staff receive 100 per cent of their salary*
29 *packaging.*
30
31 Can you just explain that to the Commissioner, please.
32 A. I am no salary packaging expert, but I know the nurses
33 and midwives in New South Wales only receive 50 per cent of
34 their salary packaging, but I'm not - I'm not sure past
35 that. I'm not - I'm not sure what that means, but, yeah.
36
37 Q. The practical effect of that is that the staff who
38 choose to salary package, they get more of their salary in
39 their pocket--
40 A. That's right.
41
42 Q. -- in Queensland compared with New South Wales?
43 A. That's right, yes.
44
45 Q. And depending on the amount of their salary, it could
46 be substantially more because there is the 50 per cent
47 difference that you have identified?

1 A. That's right, yes.
2
3 Q. Are you aware of nurses or midwives who have not
4 come - either not come to work in your district or have
5 left work in your district because of the more attractive
6 Queensland paying conditions?
7 A. I am certainly aware that, anecdotally, it's difficult
8 for us here to get exact numbers on that, but I certainly
9 hear that that is what happens and has happened. Yeah.
10 But the actual numbers, I don't have.
11
12 Q. Based on what you've heard anecdotally, are you able
13 to say whether it is common or uncommon? How common is it
14 for someone to leave for that reason?
15 A. It is - it is discussed in our organisation like it's
16 very common and certainly the chatter, I guess, you would
17 say, around it makes out like it's very common. I think it
18 does happen but as to how often, I'm not sure.
19
20 Q. You have mentioned only recently having data on
21 vacancies to start with and that's because you have
22 implemented a tracking mechanism, is that right?
23 A. That's remote, yes.
24
25 Q. You tell us about that in paragraph 6. It is a manual
26 system with an Excel spreadsheet, is that right?
27 A. That's right.
28
29 Q. Would it assist you to have a better system or a
30 less-manual or - sorry, would it assist you to have a
31 different kind of system for tracking vacancies?
32 A. Absolutely, yes.
33
34 Q. What sort of system would assist you?
35 A. Any system that easily allows me to go in there and
36 see what is my funded FTE for nurses and midwives, so what
37 have I been funded for and what I am allowed to recruit to,
38 and then what does that particular unit currently have.
39 And, then, where are all the people that work in that unit,
40 so, are they working at the hours that they should? So
41 just really a simple system that actually tells me what is
42 my funded FTE, how many nurses and midwives am I meant to
43 have, how many have I got, and what are my permanent and
44 temporary vacancies. Yes.
45
46 Q. Is that a system that you envisage being developed and
47 implemented at a district level or at a central ministry or

1 statewide kind of level?
2 A. I would expect it to be developed at a statewide
3 level.
4
5 Q. Would it assist you to have statewide or broader than
6 your district data about vacancies?
7 A. I don't understand what that means, sorry. What are
8 you asking?
9
10 Q. Why do you think it is a system that would be
11 appropriate to develop at a statewide level?
12 A. Because I think that the district - sorry, the State
13 would want a system that they can globally see what the
14 vacancies are across the State.
15
16 Q. The other data issue that you have identified is data
17 or information about why staff are leaving, have
18 I understood that correctly? You have told us a bit about
19 that in paragraphs 28 and 29 of your statement and you have
20 gone on to tell us some ways that you think that might be
21 able to be addressed. But if you had more information
22 about why staff were leaving, what difference would that
23 make to your work?
24 A. It would make - there'd be a number of things that
25 we'd be able to use that for.
26
27 Firstly, we'd be able to use it in the district to
28 fact check what is being said by the staff. So, in terms
29 of when we hear that conversation around, "Oh, all our
30 nurses are leaving to go to Queensland", we could actually
31 say, "Well, here is our data and, in fact, this is exactly
32 how many nurses have gone to take positions in Queensland";
33 and I think it could be used that way. And then the other
34 way we could use it is to then do workforce strategic
35 planning and look at the trends around why people are
36 leaving, look at the areas for where people are leaving
37 from, and then decide whether or not we need to implement
38 actions into that from a workforce point of view.
39
40 Q. Am I right in thinking, based on your statement, that
41 the main challenge you have with getting that sort of
42 information is with staff who are leaving, feeling
43 comfortable to tell someone, in some way, why they're
44 leaving?
45 A. Yeah. And the way that the staff currently advise us
46 of their resignations is that they will write a letter or
47 an email to their line manager and say, "I'm resigning",

1 and it might have the reason why or it might not, and then
2 it is up to the line manager then to put it into a
3 StaffLink system and it is up to the line manager to pick
4 the reason why that person has resigned, and the StaffLink,
5 the actual application, only has a number of generic
6 reasons and so I think that it would be more beneficial if
7 the staff member was actually the one to fill in that
8 particular application first.
9
10 Q. Could that be done in an anonymous or confidential way
11 that doesn't disclose their identity but still be helpful
12 to you?
13 A. I think that you would have to do it in two ways.
14 I think there would have to be the official, "I'm resigning
15 and here is my resignation", and then I think you could
16 also provide them the opportunity at that time to do an
17 anonymous exit interview, and they can choose to take that
18 up or they can choose to ignore it.
19
20 Q. Coming back to your vacancies, have you attempted to
21 recruit, to fill those vacancies, locally; that is, within
22 your --
23 A. All the time.
24
25 Q. Can you just briefly explain what you have done since
26 you started in your role to try to recruit locally.
27 A. So each nursing unit manager, or nurse manager, or
28 midwife unit manager is responsible for reviewing their
29 staffing whenever there is a change to it. So say someone
30 suddenly resigned, or someone goes on secondment, they
31 review that at that time and then they make a decision with
32 their director of nursing whether recruitment is required
33 and they put out the recruitment. So they manage
34 recruitment locally on their own.
35
36 What I do in my role is I manage the larger campaigns
37 such as Grad Start where we recruit to the graduate program
38 and I was also - I also currently look after the overseas
39 recruitment that we've done from a district point of view.
40
41 Q. Just sticking with local recruitment other than
42 graduates --
43 A. Yeah.
44
45 Q. -- do we take it that has not been particularly
46 successful in the time that you've been in the district
47 because your vacancy rates have stayed basically the same?

1 A. Yes, that's right. We generally find that we do not
2 get enough applicants to fill the vacant FTE that we have.
3
4 Q. You have mentioned that you have turned to
5 international recruitment and you talk about this from
6 paragraph 8 of your statement. You tell us that your
7 district conducted a large-scale overseas recruitment
8 campaign in 2023. Can you just tell us a bit about that
9 process?
10 A. Yes. So at the end of 2022, it was identified that we
11 did have a large-scale vacancy rate and so approval was
12 given for us to recruit from overseas. So we sent a team,
13 which included this position - I was not in it at the time,
14 but it did include this position, plus two directors of
15 nursing, and we sent that team in January and in April of
16 2023 and we used the recruitment agency to help us
17 advertise and recruit those nurses, and we offered
18 sponsorship via a 186 visa.
19
20 Q. Was that a process that was conducted by the district
21 itself; that is, there wasn't ministry involvement in that
22 process?
23 A. That's right.
24
25 Q. Would you say, based on your knowledge and
26 observations, that it was successful?
27 A. Yes. I think it was very successful, actually. The
28 people that we recruited work full-time, so that's been a
29 good injection of full-time workers into our district. We
30 also know that a large portion of those nurses that we
31 recruited were born in India and were working in the UK at
32 the time, so we have increased that diversity in our
33 district which has been very good, and we have also a large
34 portion of those nurses, again, that were recruited, were
35 at a registered nurse year rate or thereafter level. So,
36 experienced nurses.
37
38 Q. What are the key reasons why you think the
39 international recruitment campaign was successful?
40 A. I think that the nurses who we recruited work hard,
41 that is the feedback that I've heard. I also know that
42 we've seen - because a lot of them come from communities
43 overseas, we've seen that flow-on effect and the example
44 I can give is: we hired a nurse for Kyogle MPS who came
45 out and she was sponsored on a 186 visa and then she went
46 back to her friends in the UK and said, "I really love
47 working here, it's really great", and we've since had two

1 more nurses apply and move to Australia from there. So
2 I think- it is early days yet, but I think there will be a
3 bigger flow-on effect whence people get out here and then
4 they go back and tell their friends overseas that it's a
5 nice place to work; so I think there's that. And I do
6 think the fact that they work full-time has been very
7 helpful.
8
9 Q. What do you think, to the extent you have a sense of
10 this, what do you think made working in your district
11 attractive for the international recruits who ultimately
12 came here?
13 A. I think we provided a very good benefits package for
14 them. So we paid for their visa costs, including their
15 visa nomination and then their visa application for
16 themselves and for their partner and any children they may
17 have had, so that was enticing for them. We also then
18 provided a relocation benefit of $10,000 and we also
19 provided accommodation support for when they moved out here
20 for 12 weeks.
21
22 Q. You have told us in paragraph 11 of your statement
23 that, in general, the cost would be around $40,000 to
24 $55,000 per nurse to go through that process.
25 A. Yes.
26
27 Q. That is approximately, but am I right in thinking that
28 that is still more financially effective than relying on
29 agency nursing?
30 A. Yes, that's right, and these people actually become
31 part of that team that they are joining.
32
33 Q. You told us, although the process was successful, it
34 involved a lot of time and effort on the part of people in
35 your district, is that right?
36 A. Sorry, I just had technicality difficulty then, so
37 I missed that question.
38
39 Q. I will just repeat the question. You told us that
40 despite the process being successful, there was a lot of
41 time and effort involved on the part of people in your
42 district to undertake the visa application process, and so
43 on. Have I understood that correctly?
44 A. That's right, yes.
45
46 Q. Would it assist you if there was a centralised process
47 for international recruitment?

1 A. I think so, yes. I think that it would be much more
2 beneficial for that process to sit at a State level because
3 they have a global view of the State and whose need is
4 greater. We have found - not many cases, but there were
5 some cases where we found that the applicants took a
6 position in other health districts because they were just
7 being offered more there than what we were currently
8 offering them here. It wasn't many, it was one or two,
9 from my memory, but still, I think, run from a State level,
10 the State would have more oversight around whose need was
11 greater for those nurses.
12
13 Q. Are those other districts doing basically the same as
14 your district; that is, sending people overseas to engage
15 with a recruitment agency to try and find nurses for their
16 district?
17 A. That's right. It's my understanding that there were a
18 number of districts that did that.
19
20 Q. And there was no coordination of that from the
21 ministry level, is that right?
22 A. Not from our - for our district, no.
23
24 Q. Have you raised the possibility of centralised or
25 statewide recruitment with anyone in the ministry?
26 A. I personally have not, no.
27
28 Q. Are you aware whether anyone has raised that today
29 with the ministry?
30 A. I'm not sure.
31
32 Q. Just turning then to graduates and cadetships, in
33 paragraph 14 of your statement, you describe some issues
34 around recruiting to graduate positions in the Clarence and
35 Richmond areas and also in mental health. Do you see that?
36 A. Yeah, that's right. Yes.
37
38 Q. Do you have any knowledge of the causes of those
39 recruitment issues in those areas?
40 A. No, I don't.
41
42 Q. Is there any way that you can think of, of working out
43 what the causes of those issues were from your level?
44 A. I think the only way we'd be able to work it out is if
45 we were in discussions with, say, the local university
46 around whether or not their enrolments for that particular
47 year were low. There is a - I mean, I don't see the

1 other - what - what the other districts have been given.
2 So for someone like Clarence, it could be that maybe people
3 have decided to work in Mid North Coast, but I don't see
4 that.
5
6 Q. What about mental health? Do you have any sense of
7 what has made that a difficult field to recruit nurses
8 into?
9 A. No, I don't know. I can't answer that at all.
10
11 Q. Do you have any views from your position of anything
12 that can be done to address the particular difficulties
13 faced in those areas and that field?
14 A. I think that one of the things we're going to start
15 looking at up in this district is how do we work closer
16 with the local high schools to get those high school
17 students interested in nursing and hopefully see an
18 increase in enrolment to university that way. Yeah. I'm
19 not sure otherwise. It's a difficult one.
20
21 Q. Why do you think approaching local high schools is
22 something that might be helpful?
23 A. I think it's just about getting nursing and midwifery
24 out there and letting the school-aged children know the
25 type of career you can have with nursing. I guess if I
26 look over the last four to five years, and COVID hit, and
27 there was a lot of media coverage about nurses working
28 hard, there was a lot of media coverage about nurses being
29 underpaid, and so I do think there is probably some
30 negativity out there around what nursing and midwifery is.
31 What I'd like to do is go out there and let them know the
32 positives around nursing and midwifery.
33
34 Q. Do you have any observations from your position about
35 whether nurses and midwives who have gone to schooling or
36 lived in the local area are more likely to stay, be
37 retained in positions in the local area?
38 A. We do see that here. We do see with our graduate
39 program that if we hire people who live locally, they're
40 more likely to stay. As part of the graduate program, you
41 do have the option of using what they call the "eligibility
42 applicant bank", and so that's a bank of nurses who don't
43 have a position yet that you can contact and say, "Oh,
44 I have a position here, would you like it?" Now, those
45 people can live anywhere across the State and we have found
46 that if we pull people from, say, Sydney to come and work
47 up here, they don't have longevity up here without that

1 family support.
2
3 Q. In paragraph 16, you have told us about another issue
4 that may be experienced by graduate nurses which is that
5 they might be in leadership roles, found in leadership
6 roles early in their career. Do you have any views about
7 anything that might be done to address that issue?
8 A. So we're already working on something up here in
9 northern New South Wales to - we already have a senior
10 nurse in charge program up here in the district, but what
11 we want to do is work with those early career nurses, so
12 those registered nurses, year one and two, and support them
13 through some leadership training.
14
15 For me it's not about, "You are an RN1 so you can only
16 do this". For me it's about: "You're a nurse, what
17 capabilities do you have? How can I support you and how
18 can I move you forward?", and I guess that's what we're
19 trying to change up here in this district. The way that
20 that's perceived up here is everyone has to wait their turn
21 to come into leadership roles, but it's really about
22 supporting people who have the capabilities to do the role.
23
24 Q. Finally, in paragraph 21, you have told us about
25 Aboriginal nursing and midwifery cadetships in your
26 district, do you see that?
27
28 THE COMMISSIONER: Just before you go 21, can I just ask a
29 question about paragraph 19, please.
30
31 MR FULLER: Of course.
32
33 THE COMMISSIONER: Thanks.
34
35 Q. Can you help me with a couple of things in
36 paragraph 19 relating to agency staff. The first matter,
37 you tell me about a challenge of agency staff is they may
38 not be aware of the team systems and processes which can
39 impede them contributing to team culture. At a general
40 level, I understand that, but I'm just wondering at a more
41 specific level, how do systems and processes differ from
42 site to site for similar health services that might impede
43 an agency nurse from contributing to team culture? Can you
44 give me something concrete or specific?
45 A. Yeah. Well, I think it's more - I mean, models of
46 care differ from unit to unit anyway.
47

1 Q. Right.
2 A. And then, of course, you've got just the general setup
3 of wards would also differ from unit to unit.
4
5 Q. You mean practical things, like, where things are?
6 A. Practical things where things are, and then what we
7 find with the agency - because they are on short-term
8 contracts - if there is a quality project happening on the
9 unit, they're unlikely to want to be involved in that.
10
11 Q. Explain a quality project to me. What might be an
12 example of that?
13 A. Oh, at the moment we've got a wonderful program called
14 "Enhanced Care" up here in northern New South Wales and
15 that's really about how we provide individual care to
16 people who might be suffering from, say, a delirium.
17
18 Q. I see.
19 A. And it's about just faction techniques and supporting
20 them, assessments of them, so that is currently being
21 rolled out across our district, so that's a quality
22 project.
23
24 Q. So you are either trialling a model of care or you are
25 implementing a new way of doing things, the agency nurse
26 comes in, and he or she has got no idea about that project?
27 A. That's right.
28
29 Q. And may not have the same commitment to it as a
30 permanent member of staff, that's the sort of thing you're
31 trying to talk about there?
32 A. That's right, yes.
33
34 Q. Okay. The next concept is - you've said:
35
36 *We do not fully understand the skill set of*
37 *agency nurses. For instance, we might*
38 *anticipate high level expertise and then*
39 *discover their skills fall short of the*
40 *expectation.*
41
42 Can I just ask - again, I understand that as a general
43 concept, but what do you get from the agencies? I assume
44 you get some form of CV with a list of the work experience
45 of the particular agency nurse that should, in theory, be a
46 guide about their skill set, but I'm gathering, or I am
47 drawing the implication from what you have said here,

1 that's not always the case. Can you help explain that to
2 me?
3 A. Yeah. We definitely get resumes or CVs from the
4 agency on any agency nurse we do get in the district. It
5 would be things like, "I'm an ED nurse; I tell you I can
6 triage". However, when I get to your ED, maybe I've been
7 taught to triage differently to how you have taught your
8 staff up here. So we would have been expecting a competent
9 triage nurse but actually now what has to happen is we need
10 to support that nurse and get them up to speed to how we
11 would triage here.
12
13 Q. And that's, for perfectly understandable reasons,
14 imposing your own standards, based on how you think things
15 should be done and how you address medical risks, and all
16 those sorts of things?
17 A. That's right, yes.
18
19 Q. Okay. Thank you.
20
21 MR FULLER: Q. Just on paragraph 19, when you said
22 "short-term contracts", what sort of range? Typically,
23 what sort of period of time, typically, would an agency
24 nurse be working in a facility in your district?
25 A. Oh, anywhere from one week to 12 weeks.
26
27 Q. So, 12 weeks is at the higher end, is that right?
28 A. Yeah, 12 weeks would be the maximum. There are
29 occasions where we might extend past that 12 weeks and that
30 is in cases - maybe at our MPS sites who require nurses
31 that are ED and medical ward trained, and if we find that
32 with a particular nurse with an agency, we might extend
33 their contracts but, generally, we keep it to that 90-days,
34 12 weeks.
35
36 Q. Do you get many repeat agency nurses, so the same
37 nurse coming back to the same facility?
38 A. I've seen it, yes. I don't know the exact numbers but
39 I've seen it.
40
41 Q. When you say you've seen it, is it uncommon for that
42 to happen?
43 A. It's not uncommon, but it's not really common. What
44 we usually find, that those nurses might - I know of one
45 particular nurse who worked with us for - she did the
46 90-days, so 12 weeks, and then she went on holiday to the
47 UK and then, when she came back, she picked up another

1 contract with us.
2
3 Q. Does the short-term nature of the agency contracts
4 affect the ability of agency nurses to develop
5 relationships in the team that they're placed in? Do you
6 observe that?
7 A. Yeah, I think so.
8
9 Q. Just finally on agency, do you have a sense of how
10 much your district pays to the agency itself in the way of
11 fees in comparison with what you actually pay the nurses?
12 A. I'm not sure of those numbers exactly, but the
13 Ministry of Health have implemented the statewide agency
14 contract that began this week. So all local health
15 districts are now on the same contract.
16
17 Q. Does that mean that all local health districts are now
18 paying the same amount for a given agency nurse?
19 A. That's right.
20
21 Q. Just coming back to the Aboriginal nursing and
22 midwifery cadetships, you have told us that it is a great
23 pathway to improve representation in your workforce, but
24 you don't see many people applying for it. Do you have a
25 sense of the reason why you don't see many applicants?
26 A. I don't have a reason as to why, no. It's well -
27 I think it's well advertised by the Ministry of Health.
28 Yeah. I do know that with our graduate program this year -
29 sorry, for next year - some of the Aboriginal applicants
30 from that already work for us as enrolled nurses, so they
31 wouldn't then do a cadet.
32
33 Q. Do you have any views on how to improve the number of
34 applicants for those cadetships?
35 A. I don't, but, again, it'll be - it will form part of
36 our going into those high schools and letting them know
37 what's available for those cadetships.
38
39 MR FULLER: Thank you, Ms Richter. Those are my questions
40 for this witness.
41
42 THE COMMISSIONER: Mr Cheney, do you have any questions
43 for the witness?
44
45 MR CHENEY: No, Commissioner.
46
47 THE COMMISSIONER: Thank you very much for your time.

1 We're very grateful.
2 A. Thank you.
3
4 Q. And you are excused.
5 A. Great. Thank you very much.
6
7 **<THE WITNESS WAS RELEASED**
8
9 THE COMMISSIONER: All right. Now, I understand we are
10 starting at 9.30 tomorrow morning now, is that right?
11
12 MR GLOVER: Arrangements are in train to see if Dr Awad
13 can come at 9.30 to deliver that very useful presentation.
14
15 THE COMMISSIONER: I thought he was confirmed. Is that
16 still --
17
18 MR GLOVER: No, it hasn't reached - you are ahead of me.
19
20 THE COMMISSIONER: I am ahead of you, yes.
21
22 MR GLOVER: As always, as it should be.
23
24 THE COMMISSIONER: So we are going to have Dr Ramsey Awad
25 at 9.30 tomorrow, then the witnesses Ms Wong and then
26 Ms Maisey.
27
28 MR GLOVER: Yes.
29
30 THE COMMISSIONER: Then that's the day.
31
32 MR GLOVER: That's the day.
33
34 THE COMMISSIONER: But then we are also going to start at
35 9.30 on Thursday for Dr Grotowski at 9.30.
36
37 MR GLOVER: Yes.
38
39 THE COMMISSIONER: And we have excused for the time being
40 the CE of Mid North Coast and we will then have Ms McCosker
41 and the other witnesses listed.
42
43 MR GLOVER: Yes.
44
45 THE COMMISSIONER: I won't say anymore now in case it
46 changes, but that's the plan. So we are adjourned until
47 9.30 tomorrow morning. We will adjourned until then.

1
2
3 AT 2.58 PM THE INQUIRY WAS ADJOURNED TO 9.30 AM ON
4 WEDNESDAY, 18 SEPTEMBER 2024
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