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

Thursday, 19 September 2024 at 9.19am

(Day 52)

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 Pintos-Lopez for NSW Health

THE COMMISSIONER: Yes, good morning, Mr Glover.

MR GLOVER: Thank you, Commissioner. The first witness this morning is Dr Grotowski, and she is in the witness box.

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

THE WITNESS: Oath, please.

<MIRIAM EDITH GROTOWSKI, SWORN [9.20 am]

<EXAMINATION BY MR GLOVER

MR GLOVER: Q. Doctor, could you tell us your full name please?
A. Dr Miriam Edith Grotowski.

Q. And you are a general practitioner in practice here in Tamworth?
A. I am.

Q. And been a fellow of the Royal Australian College of General Practitioners since about 1995?
A. Correct.

Q. Have you always practiced in Tamworth?
A. I have. I practiced in Newcastle for a year beforehand.

Q. Do you operate a general practice here in Tamworth?
A. Yes, so up until February I was a practice owner for over 20 years of a general practice and I now work in a general practice owned by a corporate.

Q. You also have a role with the University of Newcastle Department of Rural Health here in Tamworth; is that right?
A. Yes. I am a senior lecturer in medical education at the royal clinical school university Department of Rural Health, but I am also the clinical dean at the moment.

Q. Just tell a little about your role as clinical dean; what does that involve?
A. So clinical dean is in charge of ensuring the medical curriculum and the medical program is produced and supported for the students that come and study in our area.

So we have up to 50 students from the second-last and final year of their medical degree come and live in Tamworth and do all their training up at our hospital and in our facilities.

Q. I'll just explore that a little bit. What sort of education and training is conducted through the department here in Tamworth?
A. So in their - the students I was just talking about, the year-long students, it is the entirety of their course. So we currently - the course, which is a joint medical program between the University of New England and the University of Newcastle, we have students that are doing subjects such as medicine, psychiatry, women and children's health, critical care and palliative care, surgery, general practice and an elective placement that all take place within our clinical school.

Q. And they'll be here for a year?
A. So they'll be here for a year. There are a few students who get to stay for two years as well.

Q. They are medical students?
A. I am talking about medical students in the rural clinical school, but in the University of Newcastle's Department of Rural Health we have allied health and nursing students as well.

Q. What allied health disciplines?
A. There are allied health students from speech pathology, nutrition and dietetics, from OT, from medication - sorry, medical radiation services, physiotherapy. Who have I forgotten? Someone.

Q. A broad spectrum?
A. Pharmacy, sorry. Yes.

Q. No, that's all right. Nursing?
A. Yeah, so there are nursing students as well.

Q. And when they come to spend time at the --

THE COMMISSIONER: Q. What are the numbers of the allied health and the nursing compared to the medical students?
A. So the medical students, we have currently 50 students between years four and five and we have a rotating group of

third year students that are - number about four. So my understanding - sorry, and I am not as au fait because I look after the rural clinical school, which is the medicine side, but I believe that at any point in time we could have up to another 40 students present with us.

Q. From?
A. From their various disciplines.

Q. This is allied health and nursing?
A. Yes, and a few would be year-long.

Q. In terms of their accommodation, they are all mixed together in the accommodation we were shown on --
A. Yes.

Q. -- Monday?
A. Monday.

Q. And part of the purpose of that, as I understood it, was so that medical students mixed with allied health students mixed with nursing students, so that they form some bonds to ultimately, hopefully, in the longer term, they might learn things from each other and assist in working in a multidisciplinary-type integrated way?
A. Yep, absolutely. So I think it is a lived example of interprofessional education that occurs both in the educational sphere, if you like, in what do we teach our students? We teach our works to work together collaboratively because we know that learning from and with each other makes for a more collaborative workforce. And that absolutely occurs in formal ways within our curriculum in this rural clinical school, but we also know that co-locating students in accommodation encourages a shared understanding of what it means to be a physio student or what it means to be a medical student, but they learn about - a lot more about much each other informally in that space as well.

Q. What I was describing was the informal aspect of it. You have added that there is a formal aspect of that "mixing", for want of a better expression?
A. Yes.

MR GLOVER: Q. How long has that approach to education and living arrangements been implemented at the department?
A. So in our own department, we have got a strong history

of inter-professional education, and 15 years we've been doing it. We have actually won state and national awards for that work that happens in the formal space.

Q. And over that time, have you observed the benefits of the kind that you were just discussing with the Commissioner about students coming out with a better appreciation of what their colleagues in other disciplines do?
A. Absolutely. So I guess in my medical education hat, I'm conscious that there is a lot of evidence about inter-professional education having benefits for a collaborative workplace, but I have actually seen it in practice. And I have heard those light bulb moments from students where they understand a bit more about what each profession does, how better to communicate and how to respect each profession.

Q. And you have been a VMO to some of the services here in the district, haven't you?
A. I am, yeah.

Q. And you have seen the benefits first-hand of that type of approach to delivering care?
A. Oh, absolutely. And in my general practice, absolutely. So we work collaboratively with nurses, we've had psychologists within the practice. As a VMO, absolutely that collaborative approach is huge.

Q. Does the department partner with the district in terms of clinical placements and the like?
A. The department - sorry, which department?

THE COMMISSIONER: You are talking about rural health?

MR GLOVER: The Department of Rural Health. Yes, sorry.
A. That's all right. Yeah, the Department of Rural Health absolutely collaborates with our local hospital because that's where our clinical placements take place.

MR GLOVER: Q. What sort of engagement between the school and the - I'll use "school" instead of "department" - and the LHD?
A. Yeah, so I think we have an excellent engagement and I think locally, in particular, we have been able to form long and strong bonds, so we work with the - I'll go get the right title but, sorry, the director of training at the

hospital. We also work with all the clinicians at the hospital where our students are placed and we provide, I guess, a quid pro quo, so we also provide some education for the junior medical officers around how to educate and how to teach in clinical spaces. We provide the same sort of education and support for clinicians, including conduent appointments with the university.

Q. We have heard a little bit of evidence in the inquiry about the benefits of medical students, nursing students, allied health students being exposed to rural settings during their training. Do you have a view as to whether that exposure at that early stage can lead to benefits in retaining those same students when they become clinicians?
A. I absolutely do have a view, and I think it's based both on my own experience, but also on the evidence that I know to be true. So we know that the biggest predictor of return to rural is - currently still stands as a rural origin student, and we do get rural origin students coming to rural clinical placements.

Q. Pausing there, by "rural origin", you mean people who grew up in rural areas?
A. Sorry, yes, students who grew up in rural areas. But the second biggest predictor, and the University of Queensland recently published on this, is the positive rural exposure, so the experience being a positive one. And that is something our rural clinical school and the University Department of Rural Health takes very seriously, and it is something that I think we work very well at doing. And as a result of that, we do see some of the gaining students, training students and retaining students in rural areas.

THE COMMISSIONER: Just so we get it right for the transcript, when we are talking about - there were two concepts there. One is the students come from rural areas; the other is the concept of having a positive rural experience regardless of where they come from?
A. Yes.

Q. By "rural areas", do you mean nearby to the school itself or from anywhere that's rural going to a rural training facility?
A. It could be anywhere that's rural.

THE COMMISSIONER: Right, okay. Yes.

MR GLOVER: Q. Just before I forget --

THE COMMISSIONER: Q. And I'm just wondering, also - this is me being very pedantic about the question, but the question was: we've heard a little bit of evidence in the inquiry, blah, blah, blah - I don't mean that critically. I would actually say we have heard a lot of evidence consistently that --

MR GLOVER: I underpromised, overdelivered.

THE COMMISSIONER: Yes.

MR GLOVER: Q. In that earlier answer, you mentioned some work done by the University of Queensland on this topic. Was there a study that they did on this issue?
A. Yes, there is.

Q. And there is a published paper?
A. Yes.

Q. We might have someone follow up with you, if you wouldn't mind, sharing that with us. So rural origin, positive experiences. What about length of time studying in rural areas?
A. Yes. So the length of time does make a difference, but we understand in more recent evidence that the length of time is not as integral as we originally thought. So we thought that a minimum of a year, although we do know that that has impact, and significant impact. But we do know that periods of time such as six to eight weeks of positive exposure can have as well an impact. And when we are talking about impact, I need to clarify. Whilst I would love all our students to return and work rurally, and preferably in our region, (a) there is no expectation of that, but (b), we also hope even if they don't, that they are informed about what it means to live and work in a rural area because of their rural exposure.

THE COMMISSIONER: Q. Can I just explore. When you say, for example, "But we do know periods of time such as six to eight weeks of positive exposure can have as well an impact", I take that to mean can also have a positive impact?
A. Yes.

Q. Is that - my assumption would be that the opinion you're expressing there is - and you are using "we", not "I" - is that it's, (a), the opinion of you and your colleagues based on your own observations, but equally supported by literature, including peer-reviewed literature on this subject that you have obviously read and considered; is that right?
A. Yes.

MR GLOVER: Q. Is there something that can be done at a systemic level to encourage more training in rural locations like this?
A. So I think we talked about that gain for students, so we get them to come to rural placements. We train them in place. But that training has to include the post-graduate training as well. So anything that can encourage continued ability to train and remain in the rural space throughout your career development is something that's going to make a huge difference to rural retention. So when we - what we know is that we lose students - sorry, we lose possible rural doctors, and I'll speak to doctors because that's what I am most familiar with, when they go away to train because they may meet partners, because they have other obligations in other areas, and then it is very hard to relocate back to a rural area again.

THE COMMISSIONER: Q. Because they are at a time of life where they are forming --
A. That's it.

Q. -- sort of connections with other people getting into debt, buying things? Houses?
A. Yeah, and then there are impediments to returning, yes.

MR GLOVER: Q. When you are referring to doctors who go away to train, are you talking about doctors undertaking specialist training?
A. Any training. So general practice being a specialist training as well.

Q. Yes.
A. Many of the doctors have to return to a major centre for a large proportion of their training. And that is something that is being looked at, and I'm aware of that, but I think that is a huge factor in our loss of that pipeline of clinicians remaining in rural areas.

Q. Can I ask you a little about general practice in the area. About 25 years in practice in Tamworth; is that right?
A. I started practising as a GP in training in 1991, so a bit longer than that.

Q. And you have seen some changes to the state of general practice in the region over that time, I take it?
A. Absolutely.

Q. Just in general terms can you tell the Commissioner what they are?
A. So I think one of the biggest changes that I've seen has been the chronicity of the cases, the complexity of the cases, that we are dealing with. And I was reflecting that when I first started, treating patients at the age of 75 was considered an older patient and many of my own patients and my colleagues' patients are well over 90 now. So we're dealing with an ageing population, a more complex set of presentations, and the complexity of the work that we do has significantly changed in that 30 years.

Q. Increased prevalence of chronic disease over that time?
A. Absolutely. And increased means and expectations of treatment in those spaces as well.

Q. What do you mean by that comment?
A. So, for example, the medications that we have available to treat heart failure or to treat diabetes and detect and the expectations around care have absolutely changed over those 30 years, as they should, as we have become more informed, as we have more information. But that relates to complexity and to management decisions that impact the way that I practice as a GP.

Q. What about the numbers of general practitioners in this region?
A. So I was also reflecting when I came to Tamworth in 1991, there was a dearth of general practitioners in the regional centre which was, I guess, hoped to be improved, but my experience is as our population - even though the number of GPs has increased since I came here, two factors impact the actual ability for that to change the ratio of GPs to patients, because I believe it has not improved significantly, and that is that a lot of the GPs work

part-time. That's male and female general practitioners. So part-time equivalence affects the bottom line. And the other one is our population has grown, but the GP numbers haven't grown to the extent that that makes a big difference to the ratio.

Q. Are there practices in the region that are closed books, for example?
A. There are practices with closed books, yes.

THE COMMISSIONER: Q. That includes your own?
A. Absolutely. So several practitioners in our practice have closed books.

MR GLOVER: Q. And does that - are there sometimes long wait times to be able to get in?
A. There are very long wait times. We know in urban centres that wait times - usually, sorry, patients can get appointments that are non-urgent within one to two weeks and we would have about a six- to eight-week wait for some of our doctors, for three months for some of our doctors. Non-urgent cases, that is. That doesn't mean there aren't appointments on the day.

Q. Does that have an effect on the ability to deliver healthcare to the region?
A. Yes. I think it has an effect on patients and I think it has an effect on the clinicians.

Q. We will start with the patients.

THE COMMISSIONER: Q. Just before you do, what should I - "non-urgent", what should I understand by that?
A. So if a patient has an illness that requires care in the immediate sense or they require medication or something - a certificate, that would be considered urgent care. So it needs to be seen within a day or so. Non-urgent care would be what we would call a routine appointment or a follow-up appointment or something that can wait.

MR GLOVER: Q. We'll start with the effect on patients. What's your observation there?
A. So I think there is frustration in patients that would like to see their practitioner more regularly. I think there is also, for new patients coming to town, the inability to secure regular doctor is also of concern. So

that affects someone's decision to stay in a rural area as well, if you can't access services.

Q. What about on their health generally?
A. So, I would suggest that the reason that we limit our books, for example, in our practice, is that the number of patients that we have, we can provide good care to, and that's why we have to limit it, because if we take everyone who wants to come, we will have to spread ourselves too thinly and the patient care would be sub-optimal. But the current status is patients will be seen at a regular enough space, but the patients themselves may want a bit more care than we're actually able to provide.

Q. Are you aware of examples where that situation in terms of either not being able to access a GP or not being able to access a GP for some time might lead some in the community just not to seek treatment at all?
A. Oh, I think COVID was a perfect example of what happened in that space where general practitioners in this region and other regions had to be very careful with their appointments and restructure appointments related to a pandemic response and related to illness within their own profession. And patients, we noticed, once the face-to-face appointments were more routine, that we saw patients presenting with chronic illnesses such as cardiac failure that we would normally have caught much earlier, as well as later presentations of cancers.

THE COMMISSIONER: Q. Were any of the practices to your knowledge able to bulk bill either entirely or in part?
A. Locally?

Q. Yes.
A. So there is one practice that does bulk - so we all bulk bill in part, that I am aware of, but there is one practice that I know of that does bulk bill.

MR GLOVER: Q. We have also heard of the lower numbers of new GPs coming through the system. Is that also a feature of this area?
A. It's a feature across New South Wales and across Australia. So our colleges, so the RACGP and the Australian College of Remote and Rural Medicine are very aware that we have significantly lower numbers coming in to the beginning of our pipeline for general practice training than we had 10-15 years ago.

Q. With both your educator and GP hat on, you think there are some strategies that might be deployed to reverse that trend?
A. So, I'm seeing a strategy at the moment that I think makes a difference, and that's the single-employer model. That is happening with a general practice training, and I think that that is huge. But I think the other strategy is the push for generalism, so having doctors who have the skills to practice in rural areas that are equipped to feel comfortable practising with the broad scope of practice, and the improvement in the community and the government, I guess, is the perspective of the skills that those GPs have.

Q. Why do you see the single employer model as having a huge impact in the space?
A. Yeah, so at the moment I hear - so this is just my opinion - that many of the younger doctors that we train don't want to leave the hospital system with its security of employment, its maternity leave and its, you know - all the other components that come with an employer - to go out and train in general practice where you are suddenly a contractor. So under a single employer model, they can continue to be employed by the hospital system, maintaining all those benefits, which their colleagues who train in, for example, physicians' training or surgical training, have and they can continue to do their training as a GP.

THE COMMISSIONER: Q. I think when we were speaking on Monday, I think I asked you, if you had unlimited power, what you might change about the health system generally, and my recollection is you told me a greater emphasis on primary care and, in particular, its role in prevention. First of all, is my recollection correct? And if it is, why is that your view?
A. Absolutely. So I think at the moment that a lot of the state-funded healthcare system is based on the acute services. And that's not just an opinion; that's based on the dollars that are spent in that area. But I think that's also an Australian-wide issue. So GPs see 90 per cent of the population but receive 7 per cent of the health budget, so there's a mismatch. I also know, and also am aware, that my colleges also support the fact that primary care is the most cost-effective component of the healthcare system. With good primary prevention, you can reduce a lot of the use of that acute end and pointy end.

But we also can improve a patient's quality of life, and it is not just about extending length of life but quality of life during that time.

Q. I think we also discussed your view about what had become the limitations of the Medicare system in relation to primary care and how the health demographics aren't suited to - I think we used the expression "six-minute medicine". Do you want to expand on that for us?
A. I think that currently to rely solely on the Medicare funding for general practice, as a practice owner for many years, it is no longer viable. And I think one of the reasons for that is, as I mentioned before, the complexity of cases that we see within primary care. To do justice to the patient and to also do justice to the practitioner, six minutes is nowhere near long enough to manage those complex cases, and the funding doesn't allow for benefits, I guess, of the longer consultation. So the other area I work quite a lot in is in mental health, and that is also certainly not supported under the current Medicare structure because those consultations are (a) very complex, but, (b), quite lengthy.

MR GLOVER: Q. In an earlier answer, the second of the strategies that you saw as being beneficial to attracting generalist practitioners is the move to rural generalism?
A. Mm.

Q. Can you just expand why you see that being advantageous to getting more clinicians into rural areas?
A. So I think for two reasons. One, I think rural generalism equips a doctor to have the skills that they need to practice in the smaller rural and regional centres. And by that I mean extended skills in emergency practice, but then it could also be obstetrics, anaesthetics, surgery, mental health, Aboriginal health. Having those services means you can serve your community safely and effectively, and currently the rural generalist training program equips a doctor with that skill set. What New South Wales might like to look at is currently across the border, Queensland does a better job of marketing, attracting, and keeping rural generalist trainees than New South Wales does.

Q. Why do you say that?
A. Because of the dollars that the trainees are paid. It's more attractive to go across the border.

Q. Thank you. What about the availability of access to specialist clinicians in the region? Is there ready access across the spectrum or lack of?
A. A few subspecialist paediatrics, subspecialist psychiatrists, subspecialist - many subspecialties, there is absolutely an dearth of access. And that has a huge impacts on our patient population. If I can use the example of paediatrics, for example. The current wait to see a general paediatrician for a developmental assessment, and we are talking particularly currently with assessments regarding attention deficit disorder or ASD - autism spectrum disorder - we have patients that are waiting years for those consultations within the public system.

THE COMMISSIONER: Q. That, I think we discussed this also on Monday, about (a) - tell me if I get this wrong -- (a), the importance of as-early-as-possible intervention for the conditions that you have just described, but, (b), the costs, including the long-term costs, of not having that early intervention both for the patient's development but probably for their productivity as an adult later on.
A. Absolutely and for their family unit during the time that that's happening, and from an educational perspective as well. So I think it has huge ramifications.

The other area is mental health, and currently we have a fly in/fly out psychiatry workforce in our region, so I am talking about the Tamworth region, and when I first moved to this town we had live-in psychiatry services with around four full-time psychiatrist equivalent. And the difference in service provision and access is significant, and it impacts me as a practitioner trying to get that subspecialty support, but it also impacts my patients significantly.

MR GLOVER: Q. Aside from the numbers, what impacts to service provision --
A. It's access.

Q. -- flow from that model?
A. So it's access to diagnostics; it's access to, for me as a clinician, support for the increased acuity of - or change in medication, change in therapeutics that I need. It is also working as a team. So under a model where live-in psychiatrists are here, as a medical community we tend to coordinate much better, we tend to collaborate much

better, and that has certainly been missing.

Q. What you are pointing to there is the benefits of multidisciplinary care wrapping around a patient, correct?
A. Absolutely.

Q. Does that require coordination between both the primary and the acute care sectors?
A. Absolutely.

Q. How well does that function at the moment?
A. Not as well as I would like. Not as well as it could.

Q. What improvements could be made to it, in your view?
A. I think we need to be mindful that in order to provide a service to the region, the option of fly in/fly out subspecialties has occurred, but I think we're almost in a trapped position where because we have got incumbent fly in/fly outs, we're unable to accommodate new practitioners that come that have that same skill set. So I'm conscious of a current psychiatrist who has moved to live in this area but cannot find work in the public system because there is no work, because it's full of VMO fly in/fly out.

Q. What about the integration between general practices in this area and the acute care setting? Could there be improvements in that space?
A. So as we spoke on Monday, I think my biggest point there would be around shared IT platforms. And I don't know what they look like; I'm sorry, that's not my remit. But at the moment, there is an incredible duplication of services for a patient at times. So I might see a patient on a Monday, they have some bloods, they get reviewed on a Wednesday and get sent to hospital because their condition has deteriorated. If those bloods have occurred currently in the community, in the private system, the hospital doesn't have access to those bloods and the patient often gets a whole redo of all those bloods. So that has an impact on the patient, it is another set of bloods that they may not need, it is also a cost to our broader community that is unnecessary.

Q. And I take it that the same operates in reverse?
A. Oh, absolutely.

Q. If a patient had had tests done at the hospital and attended on you in your rooms, you would not necessarily be

able to see those results?
A. Not necessarily, although that has improved. That is something that has improved of late. So we do have coordination of the bloods and the discharge summaries that come from the hospital in a timely manner, so that is something that I have seen in this region.

Q. Really, what you are pointing to is the need to share the patient's medical record across the spectrum of treating practitioners, correct?
A. Absolutely, and I think that that would make a huge difference to the patient's experience as well as the clinician's.

THE COMMISSIONER: Q. I think you have told us you have been involved in some discussions, I'm not sure whether it was at the ministry level or where, in relation to GP access to the single digital patient record when it comes out?
A. So it was local health district and ministry.

Q. Right, okay. And tell us what you think the benefit would be if GPs were involved in that?
A. So, again, I believe it is around the care for that patient being able - the timely care for that patient is able to be seen and accessed by the clinician that's treating them at the time, be that in primary care or be that in the acute setting. I think that has huge advantages.

MR GLOVER: Q. Do you consider that the primary health network that covers this region has a role to play in integrating both services and data-sharing between the primary care system and the acute care setting?
A. I believe it could.

Q. Does it at the moment?
A. I guess my experience in working with the primary health network has been that their current remit has not actually enabled increased provision of services in the primary care sector in the way that is responsive to our sub-local community, if you like. So I think one of the things is the primary health network is quite big and it services a large area, just as our local health district services a large area, and being responsive locally seems to be something that has gone a little bit by the wayside with the PHN over the time.

Q. Can you give us some practical examples of how that manifests?
A. Yep. So I mentioned before that as a practice, in general practice, we have a large mental health load, as many practitioners do, but our practice has a subspecialty in mental health with many of us with extra skills. We previously employed a mental health nurse, and she left the region. So we were trying, and tried unsuccessfully, to recruit a mental health nurse to our practice in a part-time capacity. And so we went to the primary health network to ask them to consider a model where they employed the mental health nurse, because we had also been to other practices who were happy to say - we were happy to employ her for two and a half days, someone else one day, someone else one another half day, so that this practitioner could be employed, and that was something that they were unable to assist us. Now, when I - and I'm going back in history and I know that's not helpful, but when divisions of practice existed, that was something that they would have actually taken on board.

MR GLOVER: Thank you, doctor. I have no further questions.

THE COMMISSIONER: Can I just ask, before I invite Mr Cheney whether he's got - we didn't cover some things like when the clinical school started, et cetera. I can remember Professor May's evidence in general terms, but those specifics, I assume, were - I just can't remember. They were covered in her evidence, were they?

MR GLOVER: There are and there are some documents as well.

THE COMMISSIONER: I will leave that alone. Mr Cheney - sorry, you were no doubt provided with this outline of evidence, were you? Yes. Do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: This should be tendered, shouldn't it? I think it is better if it is.

MR GLOVER: Then I'll tender it.

THE COMMISSIONER: Yes, assuming there is no objection.

MR CHENEY: No objection.

THE COMMISSIONER: Doctor, thank you very much for your time. We are very grateful. You are excused.

THE WITNESS WAS RELEASED

MR GLOVER: The next witness, Commissioner, is Tracey McCosker.

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

THE WITNESS: Affirmation.

<TRACEY LEE McCOSKER, AFFIRMED [9.52 am]

<EXAMINATION BY MR GLOVER

MR GLOVER: Q. Ms McCosker, can you tell us your full name, please?
A. Tracey Lee McCosker.

Q. You are the chief executive of the Hunter New England Local Health District?
A. I am.

Q. Prior to assuming that role in April 2023, you were the chief executive of NSW Health Pathology, correct?
A. That's correct.

Q. How long had you held that role?
A. Ten years, a bit more.

Q. To assist the Commission in its work, you made a statement dated the - sorry, I should have noted the date. It's on the last page - 13 September 2024, correct? Have you read it again before giving your evidence today?
A. I have.

Q. Are you satisfied that it is true and correct?
A. Yes.

THE COMMISSIONER: How come mine is dated 6 September? Mine is signed and has got the computer thing, which usually indicates it's final.

MR GLOVER: So does mine, and it has got a different date on it. I'll just get to the bottom of this.

THE COMMISSIONER: Have the paragraph numbers changed?

MR GLOVER: There is some formatting and a correction to part of it. I'm not sure whether the correction matters. I might, start, Commissioner --

THE COMMISSIONER: Yeah, yeah.

MR GLOVER: -- by sort of going to that particular paragraph, and if we run into trouble --

THE COMMISSIONER: If I can just be - don't stop for me, but eventually if someone can give me the absolutely most up-to-date version, I'll just compare it to what version I've got. But you start. Thank you.

MR GLOVER: I see. There might be some more significant changes than we thought. There are five less paragraphs in the one I am working on than the one you might have. Oh, yeah, 124 and 129, something went missing

MR GLOVER: I'll be working off the 124-13 version.

THE COMMISSIONER: Righto.

MR GLOVER: Q. Which version have you got there in the witness box?
A. I have got the 13 September version.

MR GLOVER: All right. Okay.

THE COMMISSIONER: I reckon I can cope.

MR GLOVER: I think so. I just want to make sure we have all got the same bits of paper and information.

Q. Ms McCosker, can I start on the topic of service planning within the district. Can you just run us through in general terms how the service planning function operates within your district?
A. Well, we have part of our organisation, one of our executives, looks after service planning. We have an overall strategic plan, obviously, that sets out over

this - ours finishes at 2026. So we also have the ministry's strategic plan that we're meeting - that we're in that direction as well. So when we identify areas of need, there is a whole process around consultation with community, with staff. It usually comes out of areas where either there is a deficit in a service or something has changed, or, for example, we are sort of moving more to more virtual health, so there would be some service planning around how we plan to do that, and we can talk about what the outcomes we want from that and then, you know, put a plan together. Often it involves capital planning, so there is capital planning and service planning are done in alignment. Yeah.

Q. Do I take it from that answer that the district strategic plan is a centrepiece of that process?
A. It is, but the longer it goes, the sort of more you have to tweak things. And also the ministry's direction also influences that, so it is a little bit - you know, we sort of steer it a little bit, I guess.

Q. I might just bring the strategic plan up on the screen. It is [SCI.0011.0416.0001]. It should come up on the screen there to your left. This is the strategic plan 2021 to 2026 that you were referring to in the answer a moment ago?
A. Yes.

Q. And it is updated on a regular basis?
A. Well, it is sort updated from an executive point of view. This document is not updated. And I wasn't involved in this document, because I only came in in 2023.

Q. Yes, although I think you might have a foreword to the most recent version of this document?
A. Yes.

Q. So there is some updating done along the way?
A. Yeah.

Q. Can we go to page --

THE COMMISSIONER: Q. At least to the extent of a new foreword?
A. Well, exactly. I think the new foreword just has --

Q. They haven't - you only updated the actual clinical

plans?
A. Yes. Because I - you set a strategic plan and then you sort of - you know? So, yes, the new chief executive is at the front of it, but not too much else would have changed.

MR GLOVER: Q. If we go to page 0024, please. On this page, there is a summary of the strategic priorities, correct?
A. Yes.

Q. And these are the core strategic priorities that drive the service planning process within the district?
A. Yes.

Q. And is the idea that these strategic priorities would align to the overall New South Wales strategic plan; is that the concept?
A. That's right.

Q. And one of the functions of the LHD is to promote - protect, promote and maintain the health of its community, correct?
A. Yes.

Q. And so in doing that, it would be important to understand, would it not, the health needs of the population within the district?
A. Yes.

Q. How does the district go about doing that?
A. Well, I'm not an expert in that field because we do have service planners that do that, but I know that, for example, we're having - we're talking to the Manning community around the rebuild of the Manning Hospital, so we get our team to look at the latest figures, the growth trends, the - you know, what diseases are prevalent, the socioeconomic issues, to try and determine - and the demands there and the presentations in the emergency department - to try and work out what the best response is to going to invest money to build a new hospital and add services, where is the best place to go and what's the best thing to do, and to plan and propose for that.

Q. So from that example, do I take it that you would agree that the starting point in service planning should be that identification of the needs of the population,

correct?
A. Yeah.

Q. Then an identification of the resources, both buildings, things that go beep, and people needed to meet those needs, correct?
A. Yes, but there is a whole capital planning process that you need to go through, through the ministry, because obviously we don't have the money to build a building, so we --

Q. Sure, but the capital planning process through the ministry ought be informed by what is needed in the districts throughout, should it not?
A. Yes, it would be.

Q. So in informing the capital planning process of the ministry, does the work of the districts in their own service planning process feed into that?
A. Yes.

Q. How?
A. Just through the normal processes that we have between the local health district and the ministry. There's regular meetings. Every year we have to submit our updated sort of capital plan and clinical services plan so that we're making sure it aligns, because a lot of time passes between when you submit, often, these capital plans and when they actually get approved and built.

Q. Using - I think you said Manning, was it, an example you gave earlier?
A. Yeah.

Q. How will that process play out? So there has been a need identified or an issue to respond to. Step us through how you see that process playing out, including to the extent that a submission needs to be made to the ministry?
A. So Manning has a capital works - had a capital works plan of $100 million to rebuild - there is already stage one has been rebuilt, so this is stage two and there is also a stage three. That was announced just before COVID. COVID stopped everything. When we came back to address, "Okay, what are we going to do?", that $100 million didn't go very far, given that Manning in particular is very landlocked, a very old building, so a lot needed to change.

And in the meantime there was a view that perhaps the needs of the community might have changed too, and so if we - what were we going to do with the $100 million? It was pretty difficult, because we felt that it actually wouldn't be a great way to spend the money because we'd get very little for it because of the way the building was. So we went back to the ministry and said, "These are the issues that we have. We don't want to go ahead like this." We had consultations with staff, and there's some very active community groups that were also concerned that Manning Hospital wasn't being refurbished and, you know, there was such a delay. So we talked to them about, you know, what they wanted, and it came back that we just didn't have enough money to do it.

So there was, you know, discussions. There were also some funding that had been promised, that treasury was aware of, for Foster, which was somewhere between $20 million and $80 million, or $20 million and then there was another $60 million. So eventually, we got together with the local MPs, the community groups, the ministry, and ourselves, and we said, "Why don't we try and create something that meets the needs of both the Manning community and the Foster community?" And so we've now gone back to say - so they have added the money together, we have now got $180 million, and we think we can build what we need to build on the Manning site but also create potentially an urgent care centre, or something like that, for the Foster community and they will work together. So iterative process that's taken a while, but I think we've come up with a really good outcome.

Q. The starting point to that process was identifying the particular need in those communities, correct?
A. Yeah. But that probably was in, a large way, already identified when the first, you know, plan went forward. Yeah.

Q. And part of that process might involve, as you have just referred to, adjustments to services that are being delivered, whether to alter their nature or cease them entirely, correct?
A. Yes.

Q. Can we go to your statement, please, paragraph 21.
A. Yes.

Q. There, you tell us that smaller facilities in regional and rural communities attract significant community interest when changes to service provision are proposed?
A. Yes.

Q. You give some examples?
A. Yes.

Q. Can we just start with Wee Waa. In paragraph 23, you tell us that:

Significant community concern arose out of the decision to reduce operations ...

A. Yes.

Q. How did that community concern manifest in a practical sense?
A. So with Wee Waa, we had - does it say how many? We had 18 inpatient beds. We were struggling to get the nursing staff recruited and rostered on to keep those inpatient beds open, to the point we decided it wasn't actually safe to open those inpatient beds anymore. This had been a conversation that we'd been having with the staff, the local - when I say the "local community", we had put out some media releases about the concerns about how many times we've tried to recruit for the nursing staff because we would have had intermittent, you know, closures of beds because we couldn't staff it on this day and then we couldn't staff it on that day. So we decided that, you know, we should make the difficult call to close those inpatient beds and then make the emergency department open certain hours a day for seven days. And that would be nurse-led care. The decision then was made to, if anybody presented at the emergency department that needed admission, that they would be then sent to Narrabri Hospital.

Q. So that was the decision --
A. Yeah.

Q. -- but how did the community response to that play out?
A. So the - yes, so local papers, local mayors - local mayor, MPs, everybody made it very clear that they were very unhappy that the inpatient services were closed, and I understand that. There's a hospital that's closing, and

that's not a great indication to the local community about, you know, do we care about their health and what are they going to do and Narrabri is, you know, an hour away, so --

Q. You mentioned media releases. Was there any community consultation done before the decision was made --
A. No formal --

Q. -- in relation to those services?
A. No formal communication. Like, no community forum. But the staff --

THE COMMISSIONER: Q. There were some media releases, though, before the decision was made to stop?
A. There was - I think there was - we've got one media release when it actually closes, but I think there was comments in local newspapers about, you know, us struggling to find the staff. So --

Q. How did those comments get in the paper?
A. They would just be local paper reported - oh, they would have asked us and we would have commented, yeah.

Q. Right. I see. So there was some enquiries made by journalists and some comments that we're having trouble staffing the ED?
A. And local managers live locally, staff live locally.

Q. The media release you are talking about is after the decision?
A. That's right. That was to make people aware. There were signs up around the hospital as well that there were concerns that - because some days this might be closed, so --

Q. You said Narrabri was an hour away. I thought it was a bit closer, to be more than that?
A. It might be. Sorry. It might be.

Q. I reckon it's - well, we can check. I reckon it's 40 minutes.
A. Yes. 40 minutes is probably right. I didn't want to underplay it, the concern of the community.

THE COMMISSIONER: Yeah. Yeah. I guess it depends how fast you drive.

MR GLOVER: Q. All right. But aside from reports in the press about difficulty staffing and signs that parts of the facility had closed, et cetera, there was no formal community consultation?
A. No, there wasn't.

THE COMMISSIONER: Q. Can I ask, the opposition that you mentioned, mayors, did you say the local MP?
A. Yeah, local MP.

Q. Was it - how can I phrase this? Was it evidence-based opposition or was it just, "We demand that you keep this open"?
A. They were very upset that it was closed and said that we needed to find the nursing staff to open it and they wanted it open. They wrote to the minister, and the minister arranged a meeting between the mayor, the local member, and community representatives.

Q. Is this in your time?
A. Yes.

Q. It is?
A. Just.

Q. Just as you are starting?
A. Yes. So we held the meeting. We've got a lot of local managers, but a senior local manager at the time, Susan Heyman, was very involved as well. And we just told them the process that we were going through to try and recruit, we told them how many times we tried to recruit, and all the failures that we've had to recruit and that we really were in a position that we couldn't open the hospital.

Q. And what was the response to that in general terms?
A. They were unhappy --

Q. Yes.
A. -- and just told us to keep trying, and we said we would keep trying. In the meantime, we had suggested that we could have this sort of collaborative care arrangement which has finally now come in that is led by the Rural Doctors Network. And I think originally they did not want to - it says here, you know, there was local meetings convened, and that the last one of that local working group met on 1 February 2024, and that was because they just got

tired of coming and being told the same thing, that we haven't been able to recruit nurses. So they said, well, there is no point in meeting.

They didn't want to accept new alternatives because, I guess, that was giving in to the fact that we weren't going to - they weren't going to have inpatient beds and a hospital open. But I think over time, we've met again with them, shown them, given them evidence that we can't staff the hospital, for the inpatient beds, at least. We can staff the emergency department, the nurse-led care there, and I think they're coming around now to thinking about what other things we can use that --

Q. I don't mean this critically, but were the people opposing the decision that was ultimately made, other than urging you to continue with efforts to find staff, did they offer any other solutions?
A. No.

Q. That you recall?
A. No, not that I recall. And I didn't go to all the meetings. The local people did. They may have, but --

Q. Okay. The 2.6 presentations per day that you talk about in paragraph 23, was that - you say "continues to have 2.6". Was that also historically about the figure in terms of presentations to the ED, or you don't know?
A. I don't know, but I do know that since we've had this new arrangement in place, Narrabri is quite a busy hospital, but we have looked at the post codes where people are presenting at Narrabri, and there is not a big movement from - like, there is not a big increase for people.

Q. From Wee Waa, -
A. Wee Waa.

Q. -- to Narrabri?
A. That's right.

MR GLOVER: Q. Looking back through what has occurred through this process, and I think in an answer a moment ago, you suggested people are now starting to understand the realities of the difficulties you face, do you think that perhaps some earlier consultation with those interested stakeholders about those difficulties might have, if not resolved the issues, at least smoothed the

process?
A. Yeah, I'm sure it would have, and we'll probably get to this, but a lot of the local health committees had fallen by the wayside at COVID and I guess the area, the local health district, was slow to reinvigorate a lot of those. So perhaps if there had been a local health community, we would have been talking to them already. But that wasn't established.

THE COMMISSIONER: The LHCs, local health committees --
A. Or reestablished.

Q. -- that you mention in paragraph 19 of your statement --
A. Yes.

Q. -- assuming it is 19 - I think it is 19 --
A. Yes, it is 19.

Q. -- in both. There wasn't one at Wee Waa, I take it?
A. No.

Q. Yeah, okay. The LHCs that do exist, you say that they play an important role in ensuring ongoing conversations are had regarding health service provision in the local communities, but by what means do they do that? Can you give me some examples?
A. Yes, so they have meetings, and the report that we commissioned, that Strengthening Local Health Communities report, we have committed to 70 recommendations, but we've committed to resourcing a person who looks after all of that engagement and an admin person so that we can have regular meetings, take regular minutes, give them feedback when those issues are escalated to the executive, and I think we potentially could have - it is a big district, so we could potentially have 43 local health committees. We've only got 18 up and running, so potentially 25, although some smaller communities might choose to join together as a local health committee, and we'll facilitate that, too. But, you know, these things, once they sort of stop, like they did in COVID, it's hard to reinvigorate unless you have got someone really strong in the community that wants to do that.

Q. Yes.
A. So I guess in the past we've been relying - waiting for that to happen. It's not happening, but things like

this happening at Wee Waa made us aware that we really need to ramp-up our consultation.

Q. That in part, I imagine, is - forget the Wee Waa example. Any time where a town, a decision might be made and a town might lose a service, regardless of the merits of the decision, it's highly likely there will be some local opposition?
A. Absolutely. And, you know, prior to NSW Health Pathology, I was 18 years in Hunter Health in Hunter New England, so I do know that. And so that's why I sort of said, "Let's get this going, do it better."

THE COMMISSIONER: Yes.

MR GLOVER: Q. And those opportunities for community consultation, whether through local health committees or other forums, as you tell us in paragraph 19, they are an important mechanism to discuss those proposed service changes, correct?
A. Yes.

Q. And that might include not necessarily just the closure of a service, but perhaps the redirection of resources in some cases, might it?
A. Yes, yes.

Q. So if you have an ED that might see 2.6 patients per day but there's a need for a dialysis service, for example, reallocation of resources might be of a greater benefit to the community?
A. Certainly that's where the conversation would start, absolutely.

Q. But that is a conversation that, to have the maximum impact, should be happening on an ongoing basis?
A. That's right, and that's why we have resourced that so we can have regular meetings.

Q. Can I take you to paragraph 24.

THE COMMISSIONER: I see. I've got two paragraph 24s. That partly explains why that statement got changed. Your 24 is:

> *To support local health services ....*

THE WITNESS: Yes.

MR GLOVER: Yes.

THE COMMISSIONER: Okay, got it.

MR GLOVER: Q. You mentioned this in an answer earlier. This is the collaborative care program in Wee Waa?
A. Yes.

Q. Can you tell us what it is?
A. It is led by the Rural Doctors Network, and it is about including primary healthcare providers and NGOs that offer services to coordinate those, hopefully, in our Wee Waa facility. Those are services that we don't necessarily offer through, you know, the state-funded services, but these are services that could be available and perhaps enhanced in Wee Waa.

Q. In the second sentence of that paragraph you tell us it is a "place-based planning initiative" --
A. Yes, so --

Q. -- and we mentioned those concepts before, but what do you mean by that when you use the phrase?
A. I guess I mean based in that facility to meet the needs of the people that are in place.

THE COMMISSIONER: Q. What services does it offer?
A. I'm sorry, I'm not across it, the detail of that.

Q. Is it - it says --
A. It says --

Q. I don't mean to --
A. Primary care --

Q. Please don't take this overly critically, but if you're not across the detail, I'm not suggesting you should be, but it's in your statement --
A. Yes.

Q. -- so you are inevitably going to get asked questions about it. And then - anyway, is it - tell me if you don't know. It says:

... aimed at developing community led

solutions to primary care ...

Do you know what that means?
A. I think it is other fund - like NGO-funded maybe allied health services or community health services that could be available and come to the area. Some of them would be in maybe towns nearby, that they then encourage to come to Wee Waa.

Q. Who is funding this collaborative care program? Has it got multiple funding sources or is it the LHD?
A. We are not funding it at this stage, because it's not - but there might be discussions. We are part of the working group, so there might be discussions of things that we could fund or perhaps services that we could --

Q. I see. Should I take from that that this is really still in the planning stage and --
A. Yes. Oh, very much so, yes.

Q. Okay, right. All right. This is - sorry. Then I should take from paragraph 24 that this idea is in planning stages involving some of your staff, people from the PHN, people from NGOs and the Rural Doctors Network, and it is to work out possibly a - I don't want to say "concepts of a plan" otherwise I will sound like Trump, but it is to work out possible potential services that might replace the ED at some stage --
A. Yes.

Q. --- that might better be directed at --
A. It may not replace the ED, we might still have that service, but there might be services being offered in towns that are close to Wee Waa, that there's no reason why they couldn't actually operate for a day in Wee Waa, and it just means that we are bringing services a bit closer to town.

THE COMMISSIONER: All right.

MR GLOVER: Q. Can I take you then to paragraph 25 and following where you tell us a little about the Wallsend Aged Care Facility.
A. Yes.

Q. Ultimately, a decision was made earlier this year to close the facility, correct?
A. Correct.

Q. In paragraph 28, you tell us that that decision was in line with the New South Wales Government decision to divest aged care facilities?
A. That's been a long-standing decision. I think you'll note that there's not too many aged care facilities that are run by LHDs.

Q. So they're MPS services?
A. That's right. There were big nursing homes run, but that's not the case any more.

Q. And that's in the context where there is declining private aged care across the State generally?
A. The decision was made a long time ago, like, when I was in Hunter New England the first time round. So it's a long-standing decision.

Q. But that decision stands now in the context where there is declining private aged care spaces across the State as a whole; you're aware of that?
A. Well, yes, but I'm - the state --

Q. I'm not --
A. The state doesn't have responsibility to provide that.

THE COMMISSIONER: Q. The national agreements you are referring to in relation to responsibility by the federal government, I assume you are referring to the addendum to the National Health Reform Agreement and what is stated to be federal government responsibilities?
A. That's right.

Q. One of which is, I think, funding of aged care?
A. That's right.

MR GLOVER: Funding, but not service delivery.

THE COMMISSIONER: Yes. What does it say? Keep going.

MR GLOVER: Q. In any event, I am not suggesting it was your decision to divest from aged care services, so don't take it that way, but it is the experience across the State, including in this local health district, that there are a declining number of aged care places compared to the needs of the community generally, correct?
A. Yes, that's correct.

THE COMMISSIONER: Q. The Commonwealth takes responsibility in the NRHA under clause 13(f) for the planning, funding, policy, management and delivery of the national aged care system, whatever that means. Anyway, that's what it says.

MR GLOVER: Q. I think the Commissioner has taken you to the issue that I wanted to, which is --

THE COMMISSIONER: It doesn't seem to have contractual force, this document. But anyway, keep going.

MR GLOVER: In some respects, perhaps.

Q. So the broader state and national agreements that you are referring to in paragraph 28 was the NRHA. Are there any others, when you refer to broader state and national agreements?
A. I'm not across the detail of those agreements. What I am across is the decision that we made to close Wallsend Aged Care Facility because it wasn't compliant with the latest aged care standards. It did not provide a home-like environment. The building - there was no private rooms in the organisation. And it was --

THE COMMISSIONER: Q. This was an old building, was it?
A. Very old building. Very old building.

Q. And you just said no private rooms? So, like, warding?
A. No en suites, nothing like that. It was an old hospital building that had been turned into a nursing home.

Q. I see. So it was originally a hospital?
A. Yeah, Wallsend Hospital.

Q. Did it have, like, a community area?
A. It had places that were made into community areas, but --

Q. Right.
A. -- nothing like you would see in a nursing home today.

Q. If a nursing home was built today, it would be built in an entirely different way to this?
A. And at the time I had already placed my mother into a

nursing home and I knew what the standard was, and I knew that we were well short of that, and it would have taken a lot of investment in capital to change that place to be compliant, and that actually was confirmed by accreditation standards that came through.

MR GLOVER: Q. The condition of that facility is probably a reason why there had been no new applications for people to come in since about 2020?
A. Yes. I spoke to the person that ran that Wallsend Aged Care Facility and they would talk to people that would ring up, and they say, "What is it like?" And they would come and have a look and they would say, "No, this is not where I want to put my" --

Q. In paragraph 29 of your statement, you tell us that:

> *[The] District consulted extensively with residents, their families and carers, staff, relevant unions and the [ministry] about the decision.*

A. Yes.

Q. What form did the consultation with each of those interested parties take?
A. So there were forums at the nursing home with residents, so residents were put on notice that we were considering this decision, particularly - we'd been considering it for a long time, but when the assessment went through that it was non-compliant, we spoke - we put out notices to the residents to let them know that we had to think about what the next steps were. For a lot of the family members - there were a number of residents that didn't have - they had guardians, not family members. But for those who did have family members, it was pretty distressing that they would have to think about moving. Many of those residents had been there a long time and they actually weren't concerned about the care; they thought it was great care. And I guess it's what you know and what you're used to.

And at least half of these - I think it says, yeah, 15 to 16 of the - it says 34 here but by the time we closed it, it was 25, I think - were NDIS eligible residents. Two were actually only in their 40s, but had had - you know, were paraplegics, quadriplegics. So, with ageing parents,

so it was concerning for them. So we talked to them a long time. We had a local member that was very against closing the Wallsend Aged Care Facility. But over time, we just felt that it was the right thing to do. So we continued to talk to residents and we had to get permission from the ministry and the minister to close it, but eventually the decision was made.

And then when we told the residents and their families, we said that we would do everything we can to help them get more appropriate accommodation. We had a team that resided at Wallsend Aged Care Facility, so we'd talk to the resident's family every time that they were there visiting. They were social workers and occupational therapists, the sort of people you needed to make sure they were making the right decisions for the residents, and they worked very closely with the NDIS people that were processing their applications and also with other aged care facilities when we were trying to find places for the residents that needed to move into aged care.

Q. In terms of the consultation that occurred, was that consultation commenced prior to the decision to close the facility?
A. Yes. Yes. A long time prior.

Q. And did it provide an opportunity for residents, their families, staff, local MPs, counsellors and the like to have input into that decision-making process?
A. They could tell us what they thought about that decision and tell us why they had concerns, yes, but ultimately someone has to make the decision.

THE COMMISSIONER: Q. They weren't the --
A. They're not the decision-makers; that's right.

Q. They were - there was an active consultation process?
A. Yes. I was over there. I walked around the nursing home many times with family members and heard their concerns.

MR GLOVER: Q. When I say "input into the decision-making", I mean their feedback and concerns were able to be taken into account as part of that process?
A. Absolutely, and it informed our response when we decided to close it. That's why we put people in situ for them to talk to and social workers to help the families

process it. And, yeah, there was a lot of care taken and we said that there was no timeframe, we wouldn't close it until the last resident had moved, and I think that might be happening this week.

Q. Can I go to paragraph 31, please.

THE COMMISSIONER: Q. This was February '24, the announcement that you would close it, and you've now only - your statement says there is only two, but they have both got places?
A. Yes, yes. So the process took six months.

Q. How many residents were left by the date of the decision to close? Less than 99, I take it?
A. Oh, 99 was a long time ago. 34. It had been sort of 34 residents or --

Q. Sorry, 34. Yes, you do say that. Sorry.
A. And I think by the time I think it was 25, because when people heard that we were considering it closing, some --

Q. They looked for alternatives?
A. -- of those proactively moved. Yeah. So it sort of went from 34 to 25, and so when the announcement was made it was probably closer to 25.

Q. Have the placements all been within the geographic vicinity?
A. Some of the people with guardians probably didn't matter.

Q. Yes.
A. But for those who had families - I'm pretty sure, and I'd have to check this, but - because I was getting regular feedback. I don't remember anybody having to travel a great distance. Like, there wasn't any - someone from Sydney or something like that, from Newcastle. And the two younger people that there was sort of most concern about, I think one of them is just around the corner.

MR GLOVER: Q. So part of that process involved looking at the location for potential --
A. Oh, all of it.

Q. -- relocation?

A. Yeah.

Q. Those who had family to ensure as best as one could they were within a reasonably close distance to them?
A. We were very proactive in offering them, taking them to nursing homes, letting them have a look, "Do you think this is the one? No? Okay, let's go back and try another one, why isn't that the one? Okay, now understand." So there was a long process, a very intense process, and I would say that the feedback is very positive about the new accommodation that those people have.

Q. And the two examples of changes to services that you give in your statement of Wee Waa and Wallsend are two examples where the services that were being provided either couldn't be staffed to appropriate levels or the conditions in which those services were being provided were not up to contemporary standards, correct?
A. Correct.

Q. And you would consider it would be in the better interests of the community and those patients to make a shift in those services or, in fact, to cease the service entirely?
A. Yes.

Q. Can we come to paragraph 31, please.

THE COMMISSIONER: Q. Sorry, just to close this off. The positive feedback you are talking about from residents and their families, that's something that's been reported to you by the transition team?
A. Yes.

Q. Or directly to you?
A. And I have seen emails and text messages.

THE COMMISSIONER: Okay.

MR GLOVER: Q. Paragraph 31. There, you tell us the district works closely with the PHN alongside the Central Coast LHD. You see that?
A. Yes.

Q. And that is because the PHN covers both this district and the Central Coast LHD. Do you consider that to be an important working relationship?

A. Yes, it is.

Q. Why?
A. We rely on our primary healthcare partners to provide services to our communities. There's lots of interaction between - well, PHN, but GPs. So, you know, the PHN's role is support GPs to be - have viable practices, and often they have - get money from the Commonwealth to commission particular services that they think will be helpful both to GPs and the communities they serve. So we're very involved in sort of talking through those, offering up, you know, places that we could pilot there. We also are in a partnership with the after hours GP, GP After Hours, where we host five of those GP After Hours services in our hospitals, which we don't charge rent for because, you know, it helps us that they're in our hospitals. So, yes, it is a pretty close partnership.

Q. You are a non-executive director of the PHN, with this new colleague from Central Coast, correct?
A. Yes.

Q. Do you see that as being beneficial to maintaining and strengthening that working relationship?
A. Yes, and we - yes, I do, and it's important, and we talk about the strategies in the board, but also there's quite a layer of my executive and probably tier 3 that also work very closely with the different layers in the PHN as well under different sort of - there is one integrated care working party and, you know, they all work together pretty closely.

Q. Is there scope for greater collaboration between the LHD on the one hand and primary care including the PHN on the other in conducting needs assessments of the communities you serve?
A. Yes. Yeah, I guess, yeah.

Q. Do you see a benefit in strengthening of that type of approach?
A. Yes, and the PHN doesn't represent or doesn't have all the GPs signed up, and I meet with other GPs regularly about the things that we're doing. We have got a few GPs that have indicated that they would be keen to be a part of our virtual care services. So we've got ongoing conversations with GPs.

Q. What about collaboration or coordination of service delivery across the sectors? Is there work done in that space?
A. Yes, and I think there are examples of where we employ our own GPs sometimes on site just so that we - you know, you - and Tomaree is an example of that. So we can make sure that that service can have that - you know, the triage 4 and 5s can go there, and then we can - the emergency department there can look after --

Q. Is there any strategic planning between the PHN and the LHD in that area; that is, to coordinate service delivery across the sectors?
A. Yeah. Strategically there is, but it's - how do I - we've got a lot to do. They have a lot to do; we have got a lot to do. So, you know, we do different tranches of work and different - we have different pilots for things that would work and then we try to roll that out. But it's an opportunity because we've already said that, you know, the lack of GPs has impacted our services. So anything we can do to recruit, retain, you know, make GPs viable, we'll help with. But I guess we've got a lot to do ourselves, too, so it's just part of, you know, how we divvy up our time.

Q. We have heard evidence in the inquiry about the need generally to invest more in preventative health measures and delivering care into the community. Is that also a feature of the needs of this district?
A. Yes.

Q. Is there work that is currently being done to try to identify those service needs within the LHD?
A. For preventative care?

Q. Yes, and for care being delivered into community.
A. Yes. I have recently restructured our clinical operations so that we've got sort of three main streams: acute services where we have got our sort of seven bigger acute services, so that they can work in a team. You know, they help each other out in regard to ED performance, trying to rationalise as best we can all the capacity we have in operating theatres so that we can make sure that we do as much surgery as we can. So they work together as a team, and I have actually given some coaching to the general managers and the directors of medical services so that they do work together as a team to solve some of the

big acute problems.

I've also got another stream with the smaller local rural and regional hospitals. So they have someone, two managers, that look after them to ensure that we cater for their needs. And often they're smaller hospitals; sometimes they have declining presentations or staff issues so we want to give them a lot of support. But also we want to give them the support along with the resourcing that we're doing of the local health communities to engage more with the community, because often they want, you know - they can't get a doctor, and so we'd like to work with the local councils to see how we can make that better. So there's another stream of work there.

And I guess the third stream is what we are calling integrated care partnerships and networks, and that is - that's where our virtual care services, we're trying to grow our virtual care services. One of the reasons for that is to avoid presentations and also facilitate earlier discharges from our acute services. We also have got all our community health services in that third stream so that we can marshall those resources to - and they have all - they have sort of been run as little fiefdoms and I'm trying to make sure that they're just all of our community health resources so that we can marshall those resources and allocate them as effectively as possible so that people don't have to leave their homes, we can visit them at home, but also they can come to our community health facilities and get the services that they need. And also coordinate that between sometimes they will be seen virtually and sometimes they will be seen in a community health centre, and hopefully we can get the best balance for the patients' particular needs.

Q. And is it in the - I'm sorry.

THE COMMISSIONER: Just in relation to that answer, so I understand it, when you were talking about the three streams and starting with acute services --
A. Yes.

Q. -- you said, "I have actually given some coaching to the general managers and the directors of medical services so they do work together as a team to solve some of the big acute problems." Can you give me some examples of what the big acute problems you are talking about, what would they

have been?
A. When I mean "acute", I mean the big problems in acute services?

Q. Yes.
A. Yes. So TOC, which is "transfer of care", which is offloading ambulances within 30 minutes. Sometimes we have a lot of ambulances arrive at one time. We can know that Maitland might be very busy but John Hunter has got capacity, so we put an ambulance matrix adjustment in, and John Hunter knows and is happy to take on those additional --

Q. Like system management?
A. That's right. That's right. And they used to - they did not used to operate as a team. You know, they had a lot of pressure to perform themselves, but they were trying very hard to perform just themselves, and allowing another ambulance to come to their ED might have actually hurt their performance. But now they are working much more as a team and saying, "Yes, I'll help you because in two days' time you might need to help me".

Q. Yes.
A. And just, you know, a lot of clinical staff don't have management skills. So I have given them a coach that helps them talk through their issues. How to have the difficult conversations with clinicians that don't want to do what it takes to get, you know, the performance indicators that we need. So just trying to help them out.

Q. So nothing to do with actually the way they deliver - well, directly deliver a clinical service, but more to do with how things are best coordinated --
A. That's right.

Q. -- through good communication?
A. That's right.

Q. Yes.
A. And that's the benefit of having - if we're going to have a big local health district, we might as well network and make the most of it.

Q. Sure. Then when you talked about the other stream with smaller local rural and regional hospitals, and you talked about engaging with the community, you talked about,

you know, "they can't get a doctor, so we'd like to work with the local councils to see how we can make that better." What does that engagement with the local councils involve?
A. Inverell is probably an example of that. They are always trying to get additional doctors into their service. Have a lot of locums, but sometimes they can't even get locums. The local council are very engaged in helping us find a doctor, but also if we did find one, providing accommodation, orientation to the town.

Q. This is getting support?
A. Support for --

Q. From the medical council in terms of things like accommodation?
A. Yes, yes. Introducing them to the schools, you know.

Q. Community support.
A. Yeah. Finding out what the partner does and seeing if there's something that they can do also to employ the partner.

THE COMMISSIONER: Yes, thank you.

MR GLOVER: Q. In mentioning the streams, you mentioned that the third of those streams was the community health services, and is it in that stream that preventative healthcare measures and services being delivered into the community sit?
A. We do have a population health part of our health service that actually reports in to our director of nursing and midwifery. They played a very strong role in COVID. And so, there's preventative work that is done there and population work that is done there. But, yes, a lot in the community health space is educating people about their health and how to look after their own health and how to take responsibility for their health. So there is a lot of that in community health.

Q. And is there collaboration in that space, in the community and preventative health space, between the LHD and, for example, the PHN?
A. Yes, there is.

Q. What form does that take?
A. As I said, there's some integrated working parties,

integrated care working parties. So they look at areas where they can assist each other in those spaces. I'm just trying to think of an example, but - and one of, I guess, the big examples, the very successful examples, is the diabetes plus program, the DAP+ program that we have mentioned here, is where the GPs - and we are - it is externally funded so we really can have ramped it up, so we are not just relying on PHN funding and local health district funding. That we have a medi-bus that goes around and diabetes testing in the rural and regional areas. They visits the GPs and educate the GPs on how to educate their patients better around diabetes, so it is a real - very successful collaboration, and that's preventative health as well as, you know, treating the problem.

Q. Do collaborations of that kind, include Aboriginal community services or Aboriginal community-controlled health organisations?
A. So this local health district hasn't had a close relationship with - formal relationship with Aboriginal medical services. Some of the community health services that we have do have close relationships, but we haven't had a formal one for a while.

THE COMMISSIONER: Q. Do you know why?
A. I think it is just a bit of a falling out there. But it was a while back.

Q. Sometimes these things are explained by one human being not getting on with another human being?
A. Yes, but we have got a new director of Aboriginal health and I have asked her to invigorate that relationship. We've already had one meeting where we had all the representatives or the leaders of all the Aboriginal medical services that we have in our district. It was a very successful meeting. We have restructured under the new director of Aboriginal health who reports directly to me.

Q. This is the meeting last month that you talk about in your statement?
A. Yes, and we have already got another one scheduled before the end of the year. Everyone was very happy with the direction we were talking with the restructure. They are quite excited about it, and I think we're going to have a much more collaborative relationship in the future.

Q. The plan is for quarterly meetings?
A. Yes.

MR GLOVER: Q. You refer to this in paragraph 38 of your statement, but one of the purposes of these partnership meetings is:

> *... to establish effective ways of working together and providing better support ...*

Do you see that?
A. Yes.

Q. I appreciate that this is at an early stage, but do you have any view at the moment about how those ways of working together and providing support might be implemented?
A. Yes. We're hopefully - we already do it with Armajun. But providing some of our clinicians to go to the Aboriginal medical services, because often Aboriginal people would prefer to present at an Aboriginal medical service than they would to a hospital. So the service that we provide at the hospital, we can move over and provide it at the Aboriginal medical service. So we're talking about the different opportunities that we have there, and our clinicians are very keen to do that.

Q. Can I come to the topic of workforce.
A. Yes.

Q. Can you go ahead in your statement, please, to paragraph 59.

THE COMMISSIONER: Q. Can I just ask a question before you get there. I have just got to find what paragraph. At paragraph 33 where you are talking about diabetes being a critical issue in your LHD and the statistics there and the cost to Australia's economy, have you sourced those figures from the Productivity Commission, or do you know exactly where those figures are sourced from?
A. I can't remember exactly where they are from, but --

Q. You can take that on notice. I am sure I've seen this in various sources, but I just want to make sure I understand where you're - the "one in eight" might your own LHD data, I imagine?
A. Yes.

Q. But you can take on notice to just let me know where that ratio is from and where that figure is from, but that can be done on notice.
A. No problem.

MR GLOVER: Q. Paragraph 59, please.
A. Yes.

Q. Here, you tell us about the challenges facing the LHD in relation to workforce.

THE COMMISSIONER: Q. You have skipped over funding. You are coming back to it, are you?

MR GLOVER: I am going to deal with it last, if that's convenient, Commissioner.

THE COMMISSIONER: Yes. Yes.

MR GLOVER: Q. And in paragraph 62, you give us some particular features of those challenges.
A. Yes.

Q. Can I just ask about the issue you raise in paragraph 62(b), that is the difference of remuneration and conditions that are available in Queensland to here.

THE COMMISSIONER: Sorry, which paragraph?

MR GLOVER: 62(b).

THE COMMISSIONER: 62(b), so for me that's 69(b). Okay.

MR GLOVER: It starts:

A key challenge ...

THE COMMISSIONER: "A key challenge", yes. Yes. (b) is, "NSW Awards".

MR GLOVER: Q. That's right. You're on the right page. Can you just tell us the extent to which that is an issue as you understand it for attracting workforce to your district?
A. Yes. We've had - a number of times had someone that we've been interested in has been interested, we're trying

to go through the process of recruiting them, they get an offer from Queensland, and they say, "I'm sorry, I really would have liked that job but the pay difference is too much." Now, I don't know - "too much to refuse," sorry. I don't know what the exact difference is, but it is a story we hear over and over again. And it also - some of the locums that we're getting to fill vacancies are coming from Queensland because a lot of the positions are full, because they're offering so much, such a better pay arrangement --

THE COMMISSIONER: Q. The full-time positions in Queensland are taken up?
A. The full-time positions are full, and so the people who want to do locums are actually coming to New South Wales and their story is that, "I can't get a job back in my own State because everybody wants the permanent jobs".

MR GLOVER: Q. The examples that you gave about trying to recruit people to positions, only to be effectively outbid by Queensland, are they positions across the --

THE COMMISSIONER: It's not "outbid", is it? It's just a - yeah, function of the awards, whatever they say.

MR GLOVER: Q. Quite right. To prefer to go to Queensland, is that a feature you are seeing across the length of your very long district, or is it more acute in the northern parts?
A. Well, it will be more acute in the northern parts because that's where the main vacancies are. You can - you know, people still want to come to Newcastle or Maitland to work and there is more support there and a community of doctors there, full-time doctors. We don't have too much of a locum issue in those areas, although we do still have to have locums, particularly outside of John Hunter, but not to the proportion that we have in the rural areas. So I guess it's more acute because the gap is bigger.

Q. Probably harder in those areas where you have already got challenges --
A. That's right.

Q. -- in filling those positions?
A. Yes.

Q. In paragraph 63, you describe some of the effects of

the workforce shortages, and in 63(b), you tell us one of those effects is that the district has not met its benchmark against many performance targets, and one of them being transfer of care. Can you just explain in practical ways why it is that the workforce challenges are impacting on the district's ability to meet that benchmark?
A. So processing people through the emergency department is quite dependent in a lot of ways on the medical staff. Very often we don't have the right number of medical staff in our EDs to process people quickly enough. So we have medical staff on so we can keep the ED open, but it means there is constant sort of triaging and if you get a resus in, then all of the resources go to the resus and people wait longer. So it just slows down the whole processing because we can't get enough staff in our emergency departments.

Often when I see what we call the TOC, which is the "transfer of care", KPI not going well, call and say, "What's happening?", and they've said, "We've had people call in sick and we can't find anyone to replace them, so we've had to slow down," or they've had to close the number of beds that they can offload people onto, which then also holds up the processing, and getting people off ambulances into the ED but also getting people admitted into beds in the ward to create the space that we need to process people.

THE COMMISSIONER: Q. The figure you have given of 72.7 per cent with a target of 90 per cent, I take it that those figures are across all sites with an ED?
A. Yes. So again we're looking at averages --

Q. So some are different than others?
A. Yes, so --

Q. Where are - is there any locations that are worse than others for particular reasons?
A. It's mainly in the big ones. So Armidale and Tamworth struggle often to get their staffing numbers. Having said that, Maitland is probably our worst performer, and that's probably not dependent as much on - well, it is on nursing staff, not so much medical staff. We've got the right number of medical staff in our emergency department, but we often don't have - we have gaps in the nursing staff at Maitland. But there's probably other issues. The ED performance is pretty complex; it's not just the number of

staff. But in our more rural areas it does bite more.

MR GLOVER: Q. If I can take you ahead to paragraph 63(c), please. There, you tell us about the difficulty maintaining medical coverage.
A. Yes.

Q. And then you tell us:

On any given day a number of our rural and regional have business continuity plans ... in place ...

Do you see that?
A. Yes.

Q. You tell us the purpose of a business continuity plan later in the paragraph, but can you give us some practical examples of the measures that might be implemented when a facility is subject to a business continuity plan?

THE COMMISSIONER: Which paragraph is that? 63?

MR GLOVER: 63(c), so immediately following.

THE COMMISSIONER: Yes. "Faces difficulty"?

MR GLOVER: Yes.

THE COMMISSIONER: Thanks.

MR GLOVER: I am drawing the witness's attention to the passage commencing in the second sentence.

THE COMMISSIONER: Yes.

THE WITNESS: Sorry. Yes. So what happens if, like what I said in Wee Waa, if we can't staff the beds, we have to close the beds. And therefore we can't accept patients. So often ambulances are told that we're on bypass, which means that you have to pass that hospital and go to the next closest hospital that is staffed appropriately to take patients. So that's the main thing that happens when something is on the BCP, it says that these conditions are to the point where we need to put this hospital on bypass.

MR GLOVER: Q. Can I come now to the topic of

international medical graduates. This starts at paragraph 70. It is a subheading, Commissioner:

> *(iv) International Medical Graduates*

A. Yes.

Q. In particular, I wanted to ask you about some of the initiatives you refer to in paragraph 71.
A. Yes.

Q. About halfway down that paragraph, you tell us the district has:

> *... implemented a workplace-based assessment program, which boosts a 99% pass rate - significantly higher than the 15-30% pass rate of the AMC examination-only approach.*

What is involved in that workplace-based assessment program?
A. So we have a number of - two clinicians that run that program who were IMGs themselves and understand the difficulties that IMGs face when they join the workforce. So there is an extensive orientation course that talks to them about what it is like to live in Australia, the sort of things that we say that they may not be used to, the sort of things that we like or think are funny that they may not be used to. So it is quite a practical orientation.

On their first day, I go down with Paul Craven, with our executive director of medical services. We welcome them to our local health district and tell them how much we appreciate them and how much we rely on their service, and encourage them to speak up if they've got issues because we're only too happy to hear them. We have in the past heard that, you know, it is a pretty scary time for them to turn up, so we want to make sure that they feel as welcome as possible.

Then, during the course of that orientation, different clinicians, different people in the hospital, the general manager of the hospital, say, "Hi, I'm the general manager of the hospital. If you see me around and you have got some concerns, please, you know, tell me what your issues

are." So there is that orientation.

And then when they're placed, they have senior clinicians that are qualified work-based assessors and they supervise them, give them advice, mentor them, and that's the way we get that, because they're very committed to that. And I think we host a dinner to thank them, because they do it for free, basically, to thank them for everything they do, but they find it is a very rewarding experience. So that's something that we've put in place and formalised, and now it has been taken up by a number of other hospitals.

Q. Hospitals in New South Wales or other in jurisdictions?
A. No, actually across the country and some across the world. I know that that's what I was told last time when I was there, that there's been other countries that have - hospitals in other countries that have also taken up the program.

Q. Have there been any formal evaluations of this model?
A. Not that I'm aware of. Probably been too busy doing it, but it is probably a good idea.

THE COMMISSIONER: Q. I should know this, but do the international medical graduates still have to do the AMC exam?
A. The AMC - I should know this too, probably.

Q. Are they given an exemption if you pass this particular program?
A. It says there is a significantly higher pass rate than the AMC examination-only approach. I think they would have to do it. Yeah, they would have to do it.

Q. They still have to do that? Right.
A. Yes, but it helps them pass.

Q. So a 99 per cent pass rate. It sounds like only one person failed, ever. I wonder who they are.
A. We've got a lot of them.

Q. Yes.
A. Could be more than one.

MR GLOVER: Commissioner, I am going to move to another

topic.

THE COMMISSIONER: Yeah, sure. We've been going since 9.15. Given the length of this particular session prelunch, if I said we'd adjourn till 11.30, would we still comfortably finish the evidence today with the witnesses we have?

MR GLOVER: Yes.

THE COMMISSIONER: In that case, I will adjourn until 11.30 then and give a slightly longer break.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner.

Q. Ms McCosker, if we can come now to the topic of specialist accreditation and training which you address in paragraph 76 and following of your statement. In those paragraphs, you give an example of training accreditation having been withdrawn by the RACP, but aside from that example, can you tell us about some of the challenges the district faces in maintaining specialist accreditation and providing appropriate supervision to trained specialists across the district?
A. Yeah, sure. I guess another example, other than this one, we haven't actually lost the accreditation but we often feel that it is a bit tenuous when it comes to, for example, orthopaedic surgery, and a lot of that can be they need the broad spectrum of training and there's a lot of trauma surgery and emergency surgery that happens particularly at John Hunter but because of the pressures that we're under with beds there can be some cancellation of elective surgery, and that means - and this happens in general surgery as well - the trainees don't get the same sort of breadth of experience because they just get this thing they get to look at and see, but they don't get to do elective surgery supervised because we cancel it.

Now, we do do it but probably not in the numbers that they would like to see. So sometimes that gets - you know, we have to sort of really make sure that we're allocating - thinking about their training requirements when we're allocating what we're doing, which is just another level of

complexity when you are trying to manage waiting lists. But yeah.

Q. Were you here when Dr Grotowski gave her evidence earlier?
A. I was.

Q. And you heard her describe the benefits of doctors at all levels of their training being trained in rural and regional areas?
A. Yes.

Q. And do I take it from the LHD perspective, there would be a benefit also in being able to provide those training opportunities in the region?
A. We do have those training opportunities, but, again, we then get - I don't always have the supervision, the senior people to supervise. Anaesthetics is one of those things. We are so short on anaesthetists that we struggle to provide sufficient supervision.

Q. Is that why in paragraph 79 of your statement you tell us that additional funding for supervision support would greatly benefit the district?
A. Yeah, that's - so this is for integrating overseas specialists particularly, because they need the extra supervision. There's a lot more that needs to be done to supervise IMGs than there are the usual trainees that come through that program.

Q. I'll come back to that aspect of the supervision requirements in a moment, but is there additional support, whether by funding or other means, that could be provided to the district to enhance its ability to provide specialist training opportunities?
A. I guess what happens when you're sort of under budget constraints, that you end up making decisions around the urgent over the important sometimes. So you allocate your funds to the gaps that we have, and that may not align with the supervision that we need for trainees. I know that makes it difficult sometimes to get it all coordinated. So maybe if we had additional funds, we could have the luxury of making sure we had good people employed to concentrate on the supervision as opposed to work, supervise on the go, and do everything else we are asking them to do.

Q. Providing those opportunities for training in the

system is an important part of the system itself, is it not?
A. Very much, yes.

Q. Important to workflow - workforce pipeline?
A. Yes.

Q. Important in trying to address some of the now distribution issues about which we've heard --
A. Yes.

Q. -- across the breadth of the inquiry, do you agree?
A. Yes, I do agree, and it's why I try to get involved in the visits from assessors when accreditation is happening, so I'm aware of what is happening and that they know that as best we can, we're supporting our trainees, trying to make sure that they've got the rosters that suit them, places to relax and sleep and, you know, there's more to it than just supervision, but supervision relies on the senior clinical staff; not what I can do.

Q. Do you see there being scope to engage with the colleges generally about the nature of some of the accreditation requirements and whether they ought be adjusted to provide further opportunities in rural and regional settings?
A. I think - I haven't done it but I think the conversations have been had with our executive director of medical services. A recent conversation around our emergency physicians and how many do they think we need and how many do we think they need and, you know, how is that going to work. We've had that conversation, and the college welcomed us inviting them to have that conversation.

Q. Of course, there is a significant number of colleges and they each have varying accreditation requirements, correct?
A. Yes, that's right.

Q. Do you think that conversations and discussions of that kind are better had at the ministry level rather than each individual LHD trying to drive those changes?
A. And I believe they have had been at the ministry level. I think they do have those conversations. Because often, you know, the concerns that are shared across the LHDs, they're the same concerns. So I'm - you know,

I think the people and culture, that workforce division, they have those discussions, and I think the ministers and secretaries have had those discussions.

Q. Just to be clear, you agree with the proposition, though, that those conversations are better driven by the ministry rather than the LHDs trying to effect that change individually?
A. I think so.

Q. When I was directing your attention to paragraph 79 in your statement, you told us that the requirement for additional funding for supervision that you were referring to there was primarily directed to the supervision requirements for IMGs, correct? And why is that? What about the supervision requirements of international medical graduates requires that additional funding?
A. It takes longer to bring them up to speed. They sometimes have language difficulties or people have difficulties with their, you know, language; it goes both ways. There's cultural differences. What we have been doing - we've introduced a - we're about to introduce a program where in the last six weeks of JMOs' terms, we've actually offered for IMGs to be paid by us to just shadow those JMOs so that they get a feel for what happens in a ward, what happens in an operating theatre, you know, and so that they know where to go and what to do and who to speak to and who to ask if you've got a problem, to give them sort of that six weeks of orientation when they are under no pressure to actually do anything, but they get to see what they have to do in practice. And so that's a new initiative that we're - if we haven't started - about to start, I think, in the new year that we think will help bring them up to speed a bit more quickly.

Q. So this is support to those doctors above and beyond their technical skills, as opposed to integrating them into the service and how it goes about --
A. Yes, and obviously that needs to be done by senior clinicians. So I guess we need to be able to give them the time and space to do that.

Q. In the last sentence of paragraph 79, you tell us that:

> *Streamlining requirements and boosting supports to ease these challenges ...*

What requirements could benefit from streamlining in your view?
A. The details I don't have, but I know that bringing people from overseas, there's lots of requirements that sometimes people are asked to sit for exams that we don't think that they probably need to. There is only very few countries that we can just get someone over from overseas and they can just fit into the system. I think it's the UK, US and Canada, I think. So there are some very highly qualified people who, when we try to attract them and bring them over, then they have to do a whole lot of - meet a whole lot of requirements that they probably could meet, but it slows down the whole process.

Q. Are these AMC requirements, college requirements? What do you have in mind?
A. College requirements, mainly.

Q. And boosting support? In addition to the additional funding that you have identified at the start of paragraph 79, what other supports could we do?
A. Boosting supports is probably about helping them settle in. I know a lot of the IMGs tell me, when I go down there and I say, "What is your biggest challenge?", "finding somewhere to live", before they get paid, "How do I rent a place? How do I sign up? Who do I talk to?" you know, those sort of things. And we are - we now have appointors and concierge-type people to help them through that process.

Q. In paragraph 80 and following, you address locum usage, and I appreciate you have only been in your current role for a little over 12 or 18 months, but has there been an increased trend, as far as you are aware, in terms of locum usage within the district?
A. An increased, sorry?

Q. An increased trend of locum usage within the district over time?
A. The locum costs have gone up year-on-year, so we are obviously using more. Vacancies are harder to fill. So, yes, it is an increasing trend.

Q. And you tell us in the third sentence:

Facilities often find themselves bidding

against each other ...

Do you see that?
A. Yes.

Q. Are they facilities within the district that end up bidding against each other?
A. Yes, sometimes. Well, yes. And often locums can play a game that they sort of say to one hospital, "I'll go there," and then somebody else says - and they may not say which hospital. So they may not know they are bidding against each other. I don't think they mean to cannibalise each other, and they will say, "I have got an offer from somewhere else that they've said 'We'll offer you this'." Sometimes that happens and at the last minute they will leave that hospital in the lurch and go take another option. You know, it doesn't - we're trying to be much more transparent about it so that we don't do that to each other, but it's happened.

Q. When you say we are trying to be much more transparent so we don't do that --
A. Coordinate it centrally.

Q. Hang on, hang on. Let me ask the question
A. Sorry.

Q. What steps are being taken to try and address that issue?
A. So from our medical recruitment, we are trying to centrally coordinate that better so that we have got line of sight. Who needs a locum, who have we offered, and what's, you know, what is the offering.

Q. Has that approach returned dividends?
A. Yes. It's solved the problem of sort of people outbidding one another, but it's also streamlined things a bit and given us better line of sight o where locums are going.

Q. In paragraph 80(c), you tell us about the phenomenon of:

... permanent staff leaving... roles or taking leave without pay, to become locums ...

Do you see that?
A. Mmm-hmm.

Q. And then you give an example of junior staff at John Hunter Hospital. In the last sentence, you tell us:

> *This practice has now ceased to extent that leave without pay is not endorsed for JMOs ...*

But the practice that you are referring to there is the JMOs leaving after their PG1 to become locums; is that right? And by stopping leave without pay in that scenario, has that fully addressed that particular phenomenon at John Hunter?
A. I don't know if it has fully addressed it, but it has certainly slowed it down significantly. Perhaps people could tell you other reasons why they want leave without pay when we ask them why, but the thing is if they want a locum role in our local health district, we'll know.

Q. Can I take you ahead, please, to paragraph 83. This is in the context of the nursing workforce. You tell us that the district uses some of the attraction and retention incentives, including the Rural Health Workforce Incentive Scheme, but some of the incentive packages are limited by the modified Monash model classification; do you see that?
A. Mmm-hmm.

Q. The broader effects of the modified Monash model classification - I'll withdraw that and start again. Tamworth is classified as MM3?
A. Yes.

Q. And that has the effect that reduced incentives are available?
A. Yes.

Q. What is the nature of the incentives that is being - not available to Tamworth but might be available if the modified Monash model classification were different?
A. So at the moment, midwives/nurses can get $10,000 at Tamworth. What they would like is $20,000, but they don't qualify for the $20,000 incentive because the modified Monash model says that they're not in that much need. They're not that rural or regional or remote or whatever.

Q. And you would disagree in terms of need?
A. Well, in terms of need, the fact that we're talking about Tamworth hasn't changed the fact that we have still got big vacancies, and so more incentives obviously are needed.

Q. Yes, so tying those incentives to modified Monash model classifications doesn't always provide the levers that you might need to attract workforce where it is required?
A. Correct.

Q. Has that issue been raised with ministry, for example?
A. Yes, they're well aware and I think they're currently considering particularly the issue around midwives.

Q. When you say they're considering the issue about midwives, are you aware of what work is being done in that space?
A. They're aware that we - we and probably other rural areas, I'm not sure about others, but they are aware that we've got a critical shortage in Tamworth. The midwives in Tamworth have asked if they could offer a $20,000 incentive, and I believe they are now considering that.

Q. In paragraphs 87 and following, you tell us about the rural nurse practitioner workforce model. Do you see that?
A. Yes.

Q. That's a model that the district has had some success with?
A. Yes.

Q. In paragraph 91, you tell us:

From a clinical perspective there have been no significant challenges experienced by our [nurse practitioners] ...

What were you meaning to convey by that sentence?
A. When the concept of nurse practitioners were introduced - was introduced, there was - and this was before my time, but there was certain concerns from medical staff that either we were asking nurses to do something that was beyond what, perhaps, we should be asking them or they were encroaching into space that should be

predominantly for medical staff or perhaps, at worst, we think we can train up a nurse so that we can replace a doctor, and so they did suggest that, you know, we could be putting - well, I wasn't there at the time, but I know there were suggestions that we would be putting patients at risk if we do this, but, I mean, the evidence shows that it is a very successful model and what we're saying here is that we haven't had any incidents that would suggest that people, when they're trained sufficiently and appropriately, that they can't handle the scope that we say a nurse practitioner can have.

Q. The concerns that were raised when this model was first being implemented haven't come to fruition?
A. That's right.

Q. And do we understand from what is in paragraph 91 that you see opportunities to further expand this particular initiative?
A. Yes.

Q. In what way?
A. Well, when nurse practitioners are working alone, as long as they're connected with someone, you know, some supervision and there's probably other things that they could provide, and this gives an example that there are certain things like certifying Centrelink, IPTAAS, certificates of documents of death, things that they could do but the rules say they can't. So we're sort of challenging whether the rules could change, because we believe they are competent.

Q. And whether described to working to their full scope or expansion of scope, do we take it that you see that as an important step in addressing some of the workforce challenges you face?
A. Addressing some of the workforce challenges and also providing that satisfaction for the nurse practitioners who are taking on that extra responsibility and study.

Q. And the ability to provide services?
A. Yes.

Q. Key services where they're needed?
A. Yes.

Q. If we can go ahead, please, to paragraph 97.

A. Yes.

Q. You tell us there are shortfalls in services funded by the Commonwealth, including primary healthcare, aged care and NDIS services; do you see that?
A. Yes.

Q. Can you just give us a sense of what the shortfall is across the district, firstly in primary care?
A. In primary care there aren't enough GPs in the system. So in metro areas, that means that many people can't get an appointment with a GP or they have to wait for an appointment for a GP, or the GP - very few GPs bulk bill these days. So there are - we believe there are a lot more people presenting at our emergency departments because they really do need to see a GP but they can't access a GP, so they present at our emergency department.

Q. Has there been any analysis done across the district about the extent of that issue?
A. There has been. I wouldn't be able to tell you the figures, but I think it's a pretty well-known concept that people are presenting at our EDs because they can't get a GP.

Q. Aged care, we touched on. There is a shortfall between the number of aged care places available compared to community need; is that right?
A. Yes, depending on where you are. You know, we're a big local health district so there are a lot of aged care beds. However, it's not just the number of beds, it's the type of residence that they're prepared to accept. So we do have people that are in our hospitals, in our acute services, that have outstayed what would be necessary for them to stay in hospital, but we can't find an aged care facility that will accept them. And it might be because they have difficult behaviours, advanced dementia, things that mean that the nursing homes have to have more staff or more senior staff or more skilled staff to look after those people. And so it often takes us a lot longer than it should, we think it should, to place people out of acute services into nursing homes.

Q. And NDIS, what is the shortfall in NDIS services that you are drawing to our attention?
A. It's a bit the same. NDIS offer accommodation and support for people with disabilities or for people who are

eligible for NDIS for whatever reason. Those people come into the hospital. Sometimes they come because their NDIS provider and carer has relinquished them, because they can no longer care for them or don't want to. So we become the provider of last resort and they come into the hospital, they're admitted to the hospital, and it is very difficult then to get them out of the hospital into appropriate accommodation. There is a lot of paperwork to do. There's a lot of - it is a complex process to get people appropriately placed, and that burden is then on us to do that if we want to free up an acute bed for the patients that they're probably there for.

Q. In the last sentence of paragraph 97, you tell us that as a result of those shortfalls, the district is subsidising those services. Just so we're clear, what do you mean when you say the district is subsidising those services?
A. Most of the time the people from aged care facilities and NDIS eligible patients are admitted for appropriate reasons, but then there is a time where they don't need to be in the acute service anymore, but we can't discharge them. So that's when, I guess, they're taking up a bed that we really need for state-funded people that come through the ED or, you know, admitted for surgery. So whilever those people are in that bed, we either have to open additional beds to meet our surgery targets or admit people from the emergency department. So we're paying a premium for not having that bed available.

Q. You tell us about some of those effects in paragraph 99 of your statement.
A. Yes.

Q. There, you tell us that on 29 August there were 44 NDIS and 83 aged care patients who have exceeded their date of discharge. These are patients if there was an appropriate space for them, they could be discharged immediately, correct?
A. That's correct.

Q. And then you tell us it has had a major impact on the operations of the hospital and causes bed block in the ED and impacts KPI performance?
A. Yes.

Q. Towards the end of that paragraph, you say:

If there was a mechanism to charge back to the Commonwealth for these services being provided in an acute facility, this would free up more budget ...

Do you see that?
A. Yes.

Q. What do you have in mind by way of chargeback?
A. I'm not sure exactly how it would work, but I guess what I'm saying is that while those people - it's not appropriate or they're able to be discharged. Whilever those people are taking up one of our beds, where's the incentive, I guess, for the Commonwealth to do anything about that, because they've got a bed and they're safe? So I guess if we could get their attention by charging them for every day that they're sort of in one of our beds outside the scope of when they should be in our beds, then perhaps we would either get their attention, or they would think that they could use the money that they have to pay us better to, I don't know, fix the problem.

Q. Taking an aged care patient, for example, is the point that you're driving at that once that patient is beyond their appropriate discharge date, the hospital is, in effect, providing a form of aged care --
A. That's right.

Q. -- in the acute setting?
A. That's right.

Q. And is it the case that the district doesn't receive Commonwealth funding for the provision of that notional aged care in the acute setting; is that right?
A. That's right.

Q. And what you are drawing to the Commissioner's attention is that, really, in your view, the district should be funded from the appropriate source which, in that case, to your mind, is the Commonwealth?
A. That's right. I think there's another complication, though --

Q. Yes?
A. -- which is that they're not getting the best and most appropriate care while they are in an acute hospital when

they should be in an aged care place or a place that's suitable and appropriate for someone with a disability.

Q. That's right, and as a general proposition, it's not good for anyone to be in hospital for one day longer than they ought to be; is that right?
A. That is exactly right.

Q. In that paragraph, you raise it has an impact on KPI performance. There are a number features of that issue which might affect your KPI performance about which the district might have little control; is that right?
A. We do as much as we can to get those patients discharged, is that what you mean?

Q. Yes.
A. But we - no. I mean, we can't throw them on the street, which we would never do, so we have to look after them until we can help find the appropriate accommodation, which sort of comes back on us then to make it happen.

Q. Other KPI metrics about which the district has little control might be the amount of activity coming through the facilities in the district, correct?
A. Yes.

Q. And the number of ED presentations?
A. The facility - emergency department, yes.

Q. And all of these things combine to have an overall effect on the district's performance as against those KPIs, right?
A. Correct.

Q. Can we come to paragraph 101, please. And here you tell us about the Tomaree Medical Centre.
A. Yes.

Q. You tell us it is the hospital campus and is operated by the LHD and provides, amongst other things, GP services?
A. Yes.

Q. Is that GP service one that is funded by the district?
A. Yes.

Q. Is it an employed model?
A. I'm not - it came before that particular employer

model, but we used to have a contract - we have a contract with a GP provider that gives - supplies us with the GPs to work in that service.

Q. Sorry, I might have missed something, but does the LHD operate that GP service or does it contract someone to come in and operate it?
A. We contract - this is my understanding of it, so I might be wrong, but I'm pretty sure we just - we contract GPs to come in to fill the rosters to run the service. So we pay for it and we have - we used to - I'm just trying - I know we had an arrangement with Ochre where they used to provide the GPs for us to come into that service.

Q. Does the district receive any Commonwealth contributions --
A. No.

Q. -- towards the operation of that service?
A. No.

Q. Well, who receives the MBS payments?
A. I think they can be MBS - so yes, you are probably right. They probably do the MBS.

THE COMMISSIONER: Q. You might need to take some notice about and come back to us about the Tomaree Medical Centre about exactly what the details are of who is funding it and how it operates in terms of finance.
A. Yes, it would be MBS funded.

MR GLOVER: I was going to ask you some similar questions about the clinic in Inverell, but if you need to take on notice the precise nature of the funding --
A. Yeah, that - I think that one does say it is MBS funded.

THE COMMISSIONER: The way that we might approach this is after we are finished, you might do a list of questions that you want answered and we'll send it.

MR GLOVER: Thank you, Commissioner.

Q. Can we turn now to the issue of funding generally, and to introduce the topic I might have the service agreement brought up on the screen. It is [SCI.0011.0421.0001]. This is the most recent service agreement entered into in

about July, correct?
A. Correct.

Q. If we go ahead to doc ID page 14, please. There you will see the budget schedule.
A. Yes.

Q. Can you just describe to us the process that was engaged in to arrive at the budget that's reflected in this schedule, from your perspective, please?
A. This comes from the ministry. There's conversations while we're preparing this between most often our director of finance and the finance department at the ministry. But I guess it's often based on history. You know, we've had a budget last year, what's the changes between last year and this year. We usually agree - when I say "agree", we accept what's proposed for us. If there are some concerns about what's proposed, usually they come up with a proposal and we say, you know, "That looks okay, yep, we're prepared to accept that." Often it has an increase in activity that we've got to just make sure that we feel like we can achieve, but it's pretty well formed by the time we get it from the ministry.

Q. So if something is presented --
A. Yes.

Q. -- from the ministry, is that the first step of the process?
A. Yes, the first step.

Q. And then you say there are conversations --
A. Yes.

Q. -- when it is being prepared? What are the topics that are raised in those conversations?
A. Well, they're not extensive conversations. They're more about, you know, "We're proposing that you achieve this much activity. We'd like to put that much activity in your budget for next year." That would mean that many NWAUs times efficient price or - and converts into dollars, and - but, you know, it is what it is. They've got a pool of funding and it's allocated across local health districts, and that's our budget.

Q. So from that, do we understand that there is really limited opportunity for the district to influence what the

budget will be?
A. Yes. For example, we're opening a new residential eating disorder service. We have estimated what that costs. We have given that to the ministry. They've given us $6.6 million in this new budget to provide that service. So that's the conversation we had. We wanted to make sure we had enough funding to do that. But they're very specific sort of one-off. It is sort of a bit of a rolling budget and then there are just specific things that we would talk to them about.

Q. In that example, the $6.6 million that was allocated in the budget, does that reflect the district's estimation of the cost to open and operate that service?
A. Yeah, we were happy with that figure.

Q. At the beginning of your evidence, we discussed the need to plan services by reference to an assessment of the health needs of community.
A. Yes.

Q. In arriving at the budget that we see on the page in front of us, to your understanding does that process take into account any of the results of an assessment of the health needs of the district's community?
A. We do have autonomy as to how we allocate the budget once it's received. So a lot of those issues are managed in-house, internally. It would only be if we want to do - there was a need, we felt there was a need for some of the really expensive things like ICU beds. But often that, again, is included in the planning that we do with the ministry. For example, we'll be opening additional ICU beds in the new stage 1 of the John Hunter refurbishment. We will have that conversation, we will know those beds are coming so we can plan for that in the future. So there is rarely any surprises in this.

Q. Can I just go back to the start of that answer. You said, "We have autonomy as to how we allocate the budget once it is received"?
A. Internally. So we could move it to - we could move something from one hospital to another hospital if we decided that's what we needed to do.

THE COMMISSIONER: I understood your question to be, "Does the ministry take"? Is that what you were --

MR GLOVER: That is what I was driving at.

THE WITNESS: Sorry, maybe ask it again.

THE COMMISSIONER: Ask it again. It is at 5433, line 32.

MR GLOVER: Q. At the beginning of your evidence, we discussed the need to plan services and service delivery by reference to what the community needs.
A. Yes.

Q. And really what I was raising with you was the extent to which those health needs assessments form part of the budget-setting process?

THE COMMISSIONER: As an example, is there a discussion with the ministry about, "These are" - I mean, the activity is largely based on the prior year's activity, I think, but in terms of non-acute care, as an example, is there a discussion about, "Well, we're going to need an investment in," you know - it might be that primary care is thin in a particular place or that there might be thought to be a need for a program of community health in a particular place to improve population health of a particular - is there those sorts of discussions?
A. Not really. Not really.

Q. Okay.
A. No.

MR GLOVER: Q. When earlier you said that the district has autonomy, beyond moving services and activity that is required to be delivered from one facility to another, what autonomy does the district have?
A. Well, as long as we're - you know, this is - as long as we meet our KPIs, and in an effort to meet our KPIs, we can move budget. For example, we're trying to get better - more surgery done. So we're actually moving some surgery to Belmont from John Hunter so that we can allow for more planned surgery in Belmont to allow for more unplanned surgery that comes through John Hunter, because it's such a busy ED, so we can change those sort of things internally.

Q. But one of the KPIs is the need to meet activity targets within --
A. Yes.

Q. -- a relatively narrow tolerance above and below, correct?
A. Yes.

Q. And if your health needs assessment in the district suggested that perhaps we'll need to direct some services to preventative measures in the community rather than acute admitted care, the district wouldn't necessarily have the autonomy to do that, would it, in the context of your KPIs?
A. If we thought that a move like that would move budget, would make a difference to help us achieve the KPIs, we could.

Q. What I am raising with you is the KPIs in that context would weigh against you doing that, wouldn't it, because you are still required to meet your activity target?
A. Well, yes. Yes, so that would have to come into account if we decided that that was the thing to do, but - so I think what you're saying is: do we have the luxury of investing in things that we think might help down the track when we have immediate things that we need to respond to, and that is the case. So often we don't get to do everything we would like to do because we have to concentrate on activity targets.

Q. Can I take you to paragraph 48 of your statement, please and in paragraph 48, and again in paragraph 50, you refer to the ABF model in a couple of places. Just so we are clear, when you are referring to the ABF model, what, in particular, are you focusing attention on?
A. So the ABF model is where there is a targeted number of NWAUs, which are activity, that we're set, multiplied by a price, which is the state efficient price that produces a number that says you should be able to do this much activity for this much budget.

Q. So when you're referring to, for example, the downside of the ABF model in the context of paragraph 48, you're drawing attention to the use of that model in the allocation of the LHD's budget, correct?
A. Yes, but it is very complex and it is hard to unpack because our budget is not just ABF, it's small hospitals as well.

Q. At the moment I'm just --

THE COMMISSIONER: Q. Concentrate on the ABF for the

time being.
A. Okay. Yes.

MR GLOVER: Q. Just drawing attention to your use of your use of the phrase "ABF model".
A. Yes.

Q. And when you describe the downsides of the ABF model in paragraphs 48 to paragraph 50, you are drawing attention, are you, to the use of that model in the allocation of the district's budget?
A. Yes, because as you are probably aware, the ABF model is based on a lot of average costs and average prices. So, for example, my interest, I guess, and where I focus with the ABF model, is to compare what Hunter New England's average cost is compared to what the state efficient price is.

THE COMMISSIONER: Q. Your cost is greater than that?
A. Well, our average cost is $15, is only $15 higher than the state efficient price. So ours is 5690 and the state efficient price is 5675.

Q. Yes.
A. However, if you then look at - so that doesn't seem too bad. But then if you look at our hospitals that are ABF funded and you just divided them between Hunter, which is more metro, and New England, the Hunter hospitals, their average cost is $216 less than the state efficient price, but in New England, the rural hospitals, they're $490 more than the state efficient price. Okay? So there's a lot of cross-subsidisation around all of that, and it does - yeah. So I guess that's what I use the ABF model to see. How do we compare with the state efficient price, and then what's the difference? And it sort of leads to me saying that if the New England more rural ones are $490 more than our average cost is more than the state efficient price, that would suggest that it costs more to provide those services in the rural areas, and we know where that cost is, it is in locums and patient transport and, you know, those things.

Q. What you have just described to me, is that how you are basing the comment about the national weighted activity unit not accurately accounting for your higher costs in rural regions, because the NWAU is a unit of activity on which there's based first the national efficient price,

which is, someone told me before, 6,000-and-something, but the state efficient price is as you have described it?
A. Yes.

Q. But the costs to you in the centres are higher.
A. That's right.

Q. Meaning that if you're as efficient as you can be, for you to be funded for your actual costs as distinct from under the state efficient price, as an example, there would have to be additional funding for you to come out even?
A. Correct.

MR GLOVER: Q. So is it the case that in this passage where you draw to the Commissioner's attention what you describe as the "downside of the ABF model", it is really, in particular, the effect of the state efficient price and the fact that it doesn't reflect the cost of doing business outside of those more metropolitan sites?
A. Yes, that's part of it. As I said, it's very complex, but, yes, that's --

Q. What are the other parts of it?
A. Oh, well, I guess there - there is only a finite budget that's passed to treasury to the ministry, and the ministry then have to dole that out to each of us. So there's got to be a formula, and, you know, on top of that, we often have an efficiency target that we've got to beat. And over the last four years our efficiency targets have sort of added up to about $40 million. So there's lots of aspects of it, you know? So it's not all explained in the ABF, I guess, is what I'm suggesting, that the ABF, I guess, is - there's a view that it is flawed because it doesn't account for the, I don't know, the additional costs that are incurred in rural and remote areas.

Q. Yes, but I just want to focus your attention on this, that the reason why you're suggesting it's flawed is because the state efficient price doesn't accurately reflect the cost of delivering care outside of metropolitan regions?
A. That's right.

Q. Have I understood you?
A. Yes, yes.

Q. Are there any other aspects to the activity-based

funding approach that you see as contributing to the downsides that you describe in paragraphs 48 to 50?
A. No, that's it.

Q. In paragraph 50, you tell us that the ABF model does not prioritise moving to newer models of care. Do you see that?
A. Yes.

Q. Why do you say that?
A. Because often with newer models of care, you are trying to take - you are trying to reduce activity or, you know, it's a bit, perhaps, more like your example before about, you know, prevention. There's other things that we would like to do, but because we have to focus on reaching/meeting the activity targets, it does make it harder to be innovative, I guess.

Q. Again, though, that's a function of the --
A. Of the ABF model.

Q. -- of the limitation as used by the State --
A. Yes.

Q. -- to deliver the budget to the district, correct?
A. Yes. I think there's also a timing difference with the ABF model, that you do things this year, it's probably not going to impact funding for a couple of years, the way it goes. So that's part of the other issue, I guess.

Q. What is your understanding of the timing difference?
A. The ABF, the state efficient price, there's a calculation based on the DNRs, so the returns of our costs, and then it's two years ago and then it sort of escalated twice to bring it to today's, but what happens in two years, I guess --

Q. Is the point that even if the escalation rate is applied, it still doesn't necessarily reflect the actual cost as of - that they are currently?
A. Yes, I and I'm not sure what the escalations are, but I know if I look at how the locum costs have grown over the last two years, an escalation back from two years ago was probably not going to cover it.

Q. In paragraphs 51 to 53, you tell us a little bit about the funding challenges in particular at the John Hunter

Children's Hospital; do you see that?

THE COMMISSIONER: Q. Do you have any - what's your understanding as to why the national efficient price for an NWAU unit is more than the state efficient price?
A. Well, I guess the ministry will be taking a part of that to fund particular directions it might want to take. You know, we often - recently, we've been asked to - they're going to help us fund a roster improvement process, which is one of the efficiency performance strategies we have. So they have given us some money to help us do that. There's --

Q. What, out of a pool of the money, the difference between the 45 per cent that they get --
A. Well, I don't know exactly if that's it. So they do --

Q. -- it's at a higher price than what's passed on to --
A. So as I said --

Q. -- the (indistinct), to you?
A. So I think - yes, so I guess they're taking some of that to hold centrally to try and get initiatives to help us do things better.

MR GLOVER: Okay.

THE COMMISSIONER: Yeah.

THE WITNESS: I don't know for sure, but I'm assuming that they've got to get the money from somewhere.

MR GLOVER: Q. If we go ahead to paragraph 51, and there at paragraphs 51 to 53 you tell us a little about some of the challenges associated with funding the John Hunter Children's Hospital. Do you see that?
A. Yes.

Q. In paragraph 52, you draw the distinction between the John Hunter Children's Hospital and the approach taken to funding the Sydney Children's Hospital Network. Do you see that?
A. Yes.

Q. In what way does the funding of the John Hunter Children's Hospital forming part of the overall Hunter

New England LHD budget affect the operation of that facility?
A. So Sydney Children's Hospital Network is to children's hospitals, and the funding is entirely focused on providing those tertiary and quaternary services that they provide. With the John Hunter Children's Hospital, while there is particular specific funding that happens for paediatric ICU beds and a few other things, they are then - the rest of what they do is subject to ABF funding, just like everything else, and I guess we're saying a different - the sort of focus and the funding formulas that are used for funding the Sydney Children's Hospital, I guess the question is are they the same as funding the John Hunter Children's Hospital, because we feel like it's not. You know, we feel we could be potentially disadvantaged by having different funding.

Q. In paragraph 52, you tell us that John Hunter Children's Hospital being funded as part of the LHD's overall budget limits the children's hospital's ability to enhance its service and infrastructure.
A. Yes.

Q. Do you have any practical examples?
A. Well, I guess it's as much about the fact that we receive activity and admissions from right up to the Queensland border, so Mid North Coast and Northern New South Wales, and it might change with the Tweed Valley Hospital, I'm not sure. So there is quite a demand on our services without the full recognition that, you know, we're treating people outside of our services. Where the Sydney Children's Hospital is there to treat the people from all over the state, you know. But there is a referral pathway to John Hunter Children's Hospital that puts pressure on John Hunter Children's.

Q. But in what way does the inclusion of John Hunter Children's Hospital, as part of the district's overall budget, limit the John Hunter Children's Hospital's ability to enhance its services?
A. Well, to enhance John Hunter Children's Hospital, we will need to take it off someone else to do that, because there's no additional funding for us to do that. So if they're saying, "Demand's increased and we really need to put on extra paediatricians," or something, well, where are we going to find that funding from?

THE COMMISSIONER: Q. Unless you are given additional funding without having to taken from somewhere else?
A. Unless we get additional funding, yes.

MR GLOVER: In addition to perhaps additional funding, is there a different approach that could be taken to allocating resources to the John Hunter's Children Hospital that would overcome the difficulties that you have brought to our attention?
A. Well, I guess we're suggesting that perhaps if it was treated - there's a view, and I don't know how correct it is, but there is a view that John - that Sydney Children's Hospital is funded a different way to John Hunter Children's Hospital, because John Hunter Children's Hospital is part of - even though we try to separate it, it's still part of John Hunter Hospital.

Q. When you say "funded in a different way", what do you understand that perception to be?
A. I think --

THE COMMISSIONER: To be based on?

MR GLOVER: Q. Yes.
A. Yeah, to be based on. The level of service that, I think, Sydney Children's Hospital Network funded of is assumed to be higher than the service that we provide, even though I think we're probably offering a service that is at a high level that's not recognised in the funding model.

Q. Is what you are saying that in setting the overall activity targets for the district --
A. Yes.

Q. -- that doesn't accurately reflect the demand for services that sit within the John Hunter Children's Hospital?
A. That's right.

Q. Have I understood you?
A. Yes, that's right.

Q. And are you suggesting then that a way to overcome that would be for there to be a separate stand-alone funding stream for the John Hunter Children's Hospital?
A. Yes.

Q. Has that prospect been raised with ministry?
A. Yes, it has.

Q. And was there a response given to it?
A. Well, at this stage that's not on the table, but it's part of an ongoing conversation.

THE COMMISSIONER: As stand-alone or part of the network?

MR GLOVER: Q. No, I don't - sorry, I will be clearer. I don't intend to suggest that John Hunter Children's Hospital become part of the Sydney Children's Hospital Network?
A. No, and we don't want that either.

Q. I think you understood me.
A. Yes.

Q. But do we understand you to be saying that it would be preferable if John Hunter Children's Hospital received, from the ministry, a quarantined pipeline of funding for the services that it needs to deliver?
A. Yes.

Q. Whilst maintaining part of the district?
A. Yes.

Q. And that what has been raised with ministry?
A. Yes.

Q. And there's been a response that that's not on the table at the moment?
A. Well, yes, basically, because it hasn't happened. But --

Q. You have been told why?
A. I think those things need - there's processes that need to be, I guess, discussed further. I don't think there has been a long enough discussion, perhaps.

Q. Well, you have been told at least why it wasn't something to be taken up in the current budget?
A. Not so much, no, but just it's been "no" for now.

Q. I take it you see that change as being pretty important for the sustainability of services at the John Hunter Children's Hospital?

A. Yes, we do.

Q. In paragraph 54 and following, you identify some of the challenges of the district to meet its financial KPIs. Do you see that?
A. Yes.

Q. And you tell us that in 23/24 there was a budget shortfall?
A. Yes.

Q. How much was that budget shortfall?
A. Net cost of services, 73 million. So 74 million unfavourable in expenses and 1 million favourable in revenue.

Q. And you tell us that was driven by increasing demand and length of stay, premium labour as well as the substantial costs of transporting patients between facilities. Do you see that?
A. Yes.

Q. And they're the main contributors to the budget shortfall, as you understand it?
A. Yes.

Q. Are they matters about which the LHD has a high degree of control?
A. Well, no. No, we've got to provide the services; therefore, we need to provide the labour, and at this point in time there's a lot of it in premium labour. There's a lot of --

THE COMMISSIONER: Maybe break it up.

MR GLOVER: Yes, I will.

THE COMMISSIONER: I mean, demand I wouldn't have thought --

MR GLOVER: We will take it in stages.

THE COMMISSIONER: It depends how much money you are spending in prevention might drive demand, but at least for today you couldn't control demand.

MR GLOVER: Q. Length of stay?

A. So length of stay we can control to a point. We can improve, and we're trying to improve that, and that's getting our processes better, making sure we discharge as efficiently and as effectively as possible, but the bit sort of out of our control is the NDIS and aged care patients that are still in our hospital that we find very difficult to move.

THE COMMISSIONER: Q. If there's just not a bed available?
A. That's right.

MR GLOVER: Q. Premium labour, there is little that the district can do in that space; you would agree?
A. Yes. We might be able to manage it or roster it better. We might be able to say, "Do we really put that locum on today or can we do without that locum?" So there are some conversations that we could have of the strategies we could put in place to maybe improve it, but at the end of the day to deliver the service we need the clinicians and we have to pay a premium.

Q. And that is in the context where the district is making every effort it can to recruit to permanent positions where they are needed, right?
A. That's right.

Q. And the use of premium labour is only resorted to when that can't happen,
A. That's right.

Q. Save for backfilling leave and things like that?
A. That's right.

Q. The substantial cost associated with transporting patients between facilities, that's just a feature of this district, is it not?
A. Yes. Yes, and often to try and move people, say, out of Maitland Hospital, we need to put them in Kurri or Cessnock or something just so we can sort of free up beds in our busy acute hospitals. So the need for transport has increased, but also the cost of - since COVID, like everything, the cost of transport has increased.

Q. In paragraph 56, you tell us that:

[The district] has had several efficiency

improvement plans in place to actively monitor progress towards financial recovery targets.

A. Yes.

Q. What do those plans involve?
A. So some of it - we get an escalation for CPI, which is around 3.5 per cent. A lot of our goods and services have gone up more than that, so we're engaging with the ministry and sort of whole-of-government procurement initiatives to try and bring the cost down. So there's lots of things like having - restricting the catalogue of things that people can order so that people don't go off and buy the most expensive things, that we've got the things that we've got, perhaps health contracts in that have the best price possible. So trying to make sure we purchase the right things that aren't as expensive.

I think reducing length of stay is still something that we're trying to focus on, because if we could reduce length of stay, we could potentially - at the moment, we have got a lot of surge beds open because we're trying to replace the beds we're missing that are taken by NDIS and aged care patients. But also if we don't quite get our discharging right. So if we can improve our length of stay, I think we can reduce some of our costs for additional beds that we've opened.

I mentioned that there is a roster. There's a - what's the word I'm looking for? An optimum way to roster. And I don't know, with the turnover of the people who roster nurses on shifts, I think we don't have everyone as educated as they could be on the premium way to roster, and sometimes that's what hours people work, the seniority of the nurse or we've got ENs or, you know, there is a way that you can roster that is optimal for care but also optimal for cost, so we're trying to educate our rostering people so that we get optimal rosters and I think that will bring some reduction in costs.

And we also have seen a creep in FTEs. I think after COVID there seemed to be a need - once activity came back, there seemed to be a need for some places more staff to do potentially what we used to do before with less staff. So there has sort of been a productivity change, so we're looking at that. And we've made recruiting to

non-frontline services that - we've got a process there just to make sure that we don't put on non-frontline services that would be nice to have, but at this point in time can't afford.

Q. Just in that last example, you said, "after COVID there seemed to be a need - once activity came back, there seemed to be a need for some places more staff to do potentially what we used to do before with less staff."
A. Yeah.

Q. Is that a feature of more part-time working?
A. Yes, yes.

Q. Anything else contributing to that feature?
A. It's mainly people want more flexible arrangements. We did have a lot of people that worked full-time and probably worked above and beyond that have now left or decided they don't want to work above and beyond, which is actually probably the right thing to do. So - but it just feels like we've got to employ more people to get the same job done, and it's creating some inefficiencies.

Q. In the second sentence of paragraph 56, you tell us that achieving the savings through these efficiency improvement plans without having a further impact on performance KPIs is a fine balance.
A. Yes.

Q. What's the tension that you are referring to there?
A. So some of the KPIs feel like they're working against each other. Obviously, if we didn't worry about budget we probably could meet all our KPIs if we could get the staff. So transfer of care is - we need to get the staff there so, again, if we need to get the staff to make sure that we have enough workforce in our emergency departments, we often have to get them at premium labour: budget goes up. So they're the sorts of things that we're constantly juggling. You know, do we need that staff to meet this KPI, or --

Q. Does having KPIs that --

THE COMMISSIONER: Q. Do you have in mind any particular KPIs that you think work against each other, off the top of your head?
A. So the - I think average length of stay is key to a

few things. I think when people stay longer in hospital than they should, we're at risk of increasing health-acquired conditions. People, you know, as you said, it's best that people don't stay in hospital longer than they need to. So that's potentially an issue.

Q. Sorry, did I misunderstand the part of your answer that I was thinking of, Mr Glover asked you:

> *In the second sentence of 56 you tell us achieving the savings through these efficiency improvement plans without having a further impact on KPIs is a fine balance.*

And then he asked you what is the tension that you are referring to? And you said:

> *Some of the KPIs feel like they're working against each other.*

I've taken that to mean that perhaps some of the KPIs are inconsistent with each other. Is that misunderstanding?
A. No.

Q. What do you want to convey by that?
A. I - probably what meant to say is that if you are going to reduce budgets, the easiest way to reduce budget is to reduce FTE, and reducing FTE is going to potentially impact.

Q. I see, not impact you achieving --
A. That's right.

Q. Right, got you.
A. Sorry, I didn't express that very well.

THE COMMISSIONER: That's all right.

MR GLOVER: Q. And as we discussed earlier, some of the KPIs involve performance metrics that the district has only a limited, if any, ability to actually control?
A. Yes.

Q. Finally, can I take you ahead in your statement, please, to paragraph 124. The paragraph commencing:

> *However, to continue meeting ...*

THE COMMISSIONER: It is the very last paragraph?

MR GLOVER: If it is the same in yours, that's the one I'm going to.

THE COMMISSIONER: That is exactly the same but it is 129, but that doesn't matter.

MR GLOVER: Q. In the first sentence of that paragraph, you tell us that:

> *... to continue meeting the unique healthcare requirements of our regional, rural and remote communities we need a funding model that's both responsive and adaptable and holds all contributors to the provision of health care accountable.*

What does that funding model look like to your mind?
A. There is a different - there is a Commonwealth and State responsibility in provision of healthcare. I've already mentioned the fact that I think that when we are accommodating in our acute services aged care/NDIS people, then that has an impact on us, and, you know, I suggested that perhaps we could charge them for that so that, you know, it's not our funding that's used for those beds.

THE COMMISSIONER: Q. "Charge them" means to charge who?
A. Charge the Commonwealth.

Q. Charge the Commonwealth?
A. Yes. When I've said - you know, that's a very crude way of how it would work, I'm sure, but, you know, for every day that someone who should be placed by, and funded - providing care that's funded by the Commonwealth, could we charge them for that because they shouldn't be in our care, or at least them acknowledging that, yes, they should be in our care. And I guess it's the same from the primary healthcare where, you know, the lack of GPs means that the workload is going up in our emergency departments.

And also, I think, lack of GPs, and I think it was said the other day in one of the round tables, that people are presenting more acutely ill once they do present because they haven't been to a GP prior to - you know, they've been holding off, holding off, of waiting for

appointments or whatever, but when they do present, they are sometimes sicker than they might be if they --

Q. One single model for this might be a challenge to --
A. Oh, I agree totally.

Q. But you're really - tell me if I'm wrong - the impression I'm getting from you, because you have raised aged care and primary care, and where perhaps thin markets, where that care isn't readily available, your concern, I'll put it that way, is that there needs to be at least a recognition and perhaps some additional funding heading from Canberra towards the State to acknowledge where NSW Health is having to provide primary care services, or has a cost to it from aged care that is coming out of its budget or your budget?
A. Yes.

Q. Yeah?
A. Yes.

MR GLOVER: Q. And avoid using "funding model" because it might be a range of different measures, but what way might approaches to funding be responsive in the sense that you raised in paragraph 124?
A. So if it's possible - and I'm not - and it's very difficult or it probably would have been done by now, but I guess understanding the impacts of some of the unique situations that either rural and regional have, and I know there are unique situations that tertiary services. So I guess having a little bit more delineation between what services we're funding and where and what that - the value - you know, the price or the cost of that funding is, and that sort of being taken into account. So, you know, rurality, Aboriginal communities, the percentage of Aboriginal people in your population, those sort of things.

Q. You're referring to approaches to funding that accurately reflect the cost of delivering services where they're needed, correct?
A. Yes.

Q. And the variations of that cost, depending on the community to whom those services are being delivered and their location?
A. Yes.

THE COMMISSIONER: Q. For example, in relation to acute care, the Commonwealth is providing the State with 45 per cent funding for 45 per cent of the activity in New South Wales public hospitals?
A. Yes.

Q. At the national efficient price?
A. Yes.

Q. Leaving aside any further grants by the Commonwealth to New South Wales, whether it is under the grant scheme or something else, the decision-making beyond then rolls from New South Wales Treasury to the ministry, to you?
A. That's right.

Q. And then with your autonomy, correct?
A. That's right.

Q. But with the state efficient price, at least in relation to activity in relation to the hospitals?
A. That's right.

MR GLOVER: Q. In what way might approaches to funding be more adaptable in your view?
A. Well, I guess that's, you know, creating the ability to try new things without potentially - and, you know, I think the ministry does help us with this. They do often provide you additional funding to trial something or pilot something to see if that's going to make a difference and is that something that we can roll out. So it's just being able, but if you think of something yourself, you either get it funded or you have to find some funding yourself to try it, to see if it's going to work. So I guess it's - and that takes some time, and it takes, like, "How are we going to take that off that?" So just maybe a little bit more ability to try new things.

MR GLOVER: I have no further questions for this witness.

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

MR CHENEY: Not so much another question, Commissioner, but may I request this. In Mr Glover's list of questions that you floated earlier --

THE COMMISSIONER: Yes.

MR CHENEY: -- might there be added or included a question along the lines of that which you put to the witness, which was what is your understanding as to why the national efficient price for an NWAU unit is more than the state efficient price?

THE COMMISSIONER: Maybe that should just be a question direct. I don't know that it needs to be part of the questions for the witness. It might be better just to - this is all going to be part of the funding hearings.

MR CHENEY: Yes. I just wanted it on the agenda.

THE COMMISSIONER: It is undoubtedly on the agenda, but I don't think it needs to be on that agenda because - and this isn't a criticism of the witness, but this witness shouldn't take full responsibility for answering that question.

MR CHENEY: What I was trying to convey is, Commissioner, I think there is an answer, and we could --

THE COMMISSIONER: Of course. Of course. But - yes, through another process but definitely on the agenda. Thanks for raising it. I think no-one has any further questions for you, so thank you very much for your time. We are very grateful, and you are excused.

THE WITNESS: Thank you

<THE WITNESS WAS RELEASED

MR GLOVER: The next witnesses are at 2 o'clock.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock. Thanks.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Thanks. Yes, Mr Fuller.

MR FULLER: Thank you, Commissioner. The next witnesses are Richard Nankervis and Alison Koschel.

THE COMMISSIONER: Dr Nankervis, can you hear me?

MR NANKERVIS: Yes, thank you. I can. Can you hear me?

THE COMMISSIONER: I can, thank you. Good afternoon. Would you prefer to give your evidence by way of oath or affirmation?

MR NANKERVIS: Affirmation, thank you.

<RICHARD NANKERVIS, AFFIRMED VIA VIDEO-CONFERENCE [2.05 pm]

THE COMMISSIONER: And Dr Koschel, what about you?

DR KOSCHEL: Oath, thank you.

<ALISON KOSCHEL, SWORN

<EXAMINATION BY MR FULLER

THE COMMISSIONER: Yes, thank you.

MR FULLER: Thank you, Commissioner. Mr Nankervis, starting with you, my name is Dan Fuller. I am one of the counsel assisting the inquiry. Can you hear me okay?

MR NANKERVIS: Yes, I can thanks.

MR FULLER: I think you can now --

THE COMMISSIONER: I called Mr Nankervis "Dr Nankervis". Is it - what am I - what's right?

MR NANKERVIS: "Mister" would be better. Thank you.

THE COMMISSIONER: No worries. Thanks.

MR FULLER: Mr Nankervis, can you state your full name, please?

MR NANKERVIS: Sure, Richard Nankervis.

MR FULLER: And you are the chief executive officer of HNECC Limited, which is the operator of the Hunter New England Central Coast Primary Health Network; is that right?

MR NANKERVIS: Correct, Dan, yes.

MR FULLER: Sorry, I just missed that?

MR NANKERVIS: Correct, Dan, yes.

MR FULLER: Thank you. What is your business address? Where are you located?

MR NANKERVIS: I'd have to look it up. I'm in Broadmeadow in Newcastle right now.

MR FULLER: Which city are you based in?

THE COMMISSIONER: Broadmeadow.

MR FULLER: Broadmeadow.

THE COMMISSIONER: Newcastle, yep.

MR FULLER: Thank you. Dr Koschel, can you state your full name, please.

DR KOSCHEL: Yeah, Alison Joy Koschel.

MR FULLER: And you are the executive manager populations access and performance for the Hunter New England Central Coast Primary Health Network?

DR KOSCHEL: I am.

MR FULLER: Are you able to tell me your business address where you are usually located?

DR KOSCHEL: Yes, it is 155 Marius St, Tamworth.

MR FULLER: Thank you. Mr Nankervis, just starting with you, can you just describe your role as chief executive officer of the primary health network? What does that involve?

MR NANKERVIS: Sure. So I have responsibility for the operational performance and delivery of the primary health network functions across the region which covers Central Coasts from the Hawkesbury River in the south and through the Hunter Valley and New England in the northwest up to the Queensland border, and incorporating Tenterfield to the northeast and Moree-Mungindi to the northwest.

MR FULLER: Mr Nankervis, you've signed a statement

recently to assist the inquiry; is that right?

MR NANKERVIS: Yes, I have.

MR FULLER: Do you have a copy of it with you?

MR NANKERVIS: Yes, I do.

MR FULLER: It is dated 16 September 2024. It is tab K-105 of the proposed tender bundle. The number is [SCI.0011.0433.0001]. Mr Nankervis, have you had the opportunity to look at your statement recently?

MR NANKERVIS: Yes, I have.

MR FULLER: Is everything in it true and correct to the best of your knowledge and belief?

MR NANKERVIS: Yes, it is.

MR FULLER: Dr Koschel, you have also signed the statement. Is everything in it true and correct to the best of your knowledge and belief?

DR KOSCHEL: Yes, it is.

MR FULLER: Dr Koschel, can you tell us about your role as executive manager populations, access and performance, please?

DR KOSCHEL: Yeah, sure. So I have several teams within my portfolio. So I look after First Nations health, rural health. I look after planning and strategic initiatives and data as well.

MR FULLER: Mr Nankervis, it's right to say that your primary health network effectively covers the local government areas in the Hunter New England Local Health District and the Central Coast Local Health District, is that right?

MR NANKERVIS: Yes, that's right. Our boundaries line-up with those.

MR FULLER: That is quite a large physical area, would you agree?

MR NANKERVIS: Yes, it is. We equate the land area to the size of England. It is very similar, with a population of around 1.225 million people, largely condensed around Newcastle and the Central Coast but then very dispersed and diverse up through the region.

MR FULLER: Do you think that the size and diversity, as you have said, of the population in your PHN can make it difficult for you to be responsive to local issues?

MR NANKERVIS: In some respects yes, in that there are significant challenges across the region and each town has its own characteristics and key stakeholders. There are some similarity initiatives, but there are also many differences across different towns or locations. And so, we have to really look at the needs of different rural towns differently, and they're not all the same. And we find when we look at primary care services and provision, that there are unique arrangements in terms of primary care provision and needs across various towns.

At the same time, we do find that having urban, regional and rural footprints means that we can test different approaches across urban, regional and rural locations and we can use the scale of our size to further assist some rural towns and locations more so than we may be able to do otherwise. So I think there are certainly advantages and disadvantages.

MR FULLER: What does your PHN do to try to make sure you address the diverse needs of the stakeholders within your primary health network?

MR NANKERVIS: So there are probably a few different ways that we do that. One is that we undertake a comprehensive needs assessment, and within the needs assessment, we have a framework that outlines the local identification of needs and the local consultation and engagement that occurs to support that. Also because we work with --

MR FULLER: Just pausing on that one, the comprehensive needs assessment, is that documented? Is it published somewhere?

MR NANKERVIS: Yes. If it's okay, I might hand over to Alison to provide a more detailed response on that.

MR FULLER: Thank you. Dr Koschel?

DR KOSCHEL: Yes, thank you. So that sits firmly in my portfolio within the planning portfolio. So we do undertake that comprehensive needs assessment, and the process is documented, as are all the results of the comprehensive needs assessment. We do a full assessment every three years, and we do interim assessments in those in-between years.

MR FULLER: When you say "we do it", is that at the primary health network level?

DR KOSCHEL: It is. We do consult and work with our local health districts as well while we're doing those needs assessments so we can get their viewpoint, and we do that across all of the 23 different LGAs that we actually service in the region.

MR FULLER: What's the - can you just briefly, at a high level, describe the process that you go through to prepare the needs assessment?

DR KOSCHEL: Sure. Yeah, so the first step in the process is to understand the data that we see and then that starts a conversation. We then do webinars and consult with communities, particularly in that first year when we do a needs assessment, to just confirm that what we're seeing as issues in their town are real issues and to hear from a qualitative perspective what they think the main issues are in their towns.

In the in-between years, so years two and three of the needs assessment process, we do a more in-depth place-based. So we will go to a particular town and we will - more than just webinars, we will talk with people from youth profits, from CWA, from Men's Sheds, from all sorts of walks of community, to find out what the issues are in that particular town.

MR FULLER: You do this on a town-by-town basis; is that right?

DR KOSCHEL: Yes, yeah. And the data helps drive where we prioritise that. So we look to where the biggest needs are and we work with those places first.

MR FULLER: Can you just elaborate on that in practice. So once you have done the needs assessment, what does the PHN do with it?

DR KOSCHEL: Yeah. So we identify both the health needs and the service needs, and then we triangulate that data together to get a really good picture of what's available to a particular town and where the particular issues are. From that, we can map it against the services that we are commissioned to provide and we can map it against the services that we know are provided in that town, and that helps us identify the gaps. So when future funding becomes available or opportunities arise to be able to fill those gaps and meet those needs, we're able to plug those services into it fairly quickly.

MR FULLER: Are you able to give an example of a gap that's been identified and something that the PHN has done in practice to plug the gap?

DR KOSCHEL: There would probably be many different examples we could use, but, for example, in towns where we see perhaps higher rates of psychological distress in - particularly when you have a town that undergoes, you know, closure of an industry or, you know, has that particular issue - we've been able to identify that there's need for mental health services, and then through the mental health funding schedule we get, we can actually prioritise putting those services in those places.

MR FULLER: Are you able to give an example of a particular - sorry, Commissioner?

THE COMMISSIONER: That might be an example of something that is a response to an event. You mentioned something, a business or whatever closing down, and another event might be some climate event like a flood or a fire?

DR KOSCHEL: Absolutely, yes.

THE COMMISSIONER: But what about something that's more chronic, as an example?

DR KOSCHEL: I guess mental health is a fairly common thing.

THE COMMISSIONER: Yeah, yeah.

DR KOSCHEL: It's fairly high on the list of chronic diseases. For example --

THE COMMISSIONER: So that exists independent - as a large problem, independent of any particular event?

DR KOSCHEL: Yes, it can. Absolutely. It doesn't necessitate an event to actually have a significant cohort of people within a town that actually have those conditions and require treatment for them.

THE COMMISSIONER: Are there examples of - I mean, this is a big region. Are there examples of towns where you've seen, for example, much higher rates of particular chronic disease where a gap needs to be filled?

DR KOSCHEL: Yes. Respiratory diseases can rank fairly highly, and often in rural areas that's due to cropping and farming and asbestos in the land. So you can actually get a cluster of people that have respiratory disease.

THE COMMISSIONER: And mining?

DR KOSCHEL: Yes, mining can certainly lead to those disorders as well. By and large, when we then look at the services that are available for those, they're probably okay, so we don't necessarily have to do anything. But as I said, the data starts a conversation, and so you can go to the community and say, "Okay. Well, you do have high rates of respiratory disease here, and how is that being managed? Are you able to get to a GP, a pharmacist, do you get the medications you need? You know, do the LHD have respiratory clinics that you can attend?" So by and large there are not a lot of gaps in that, but that then allows to say, "Okay, well, where are the gaps and what should we be providing?"

MR NANKERVIS: If I may, Commissioner?

THE COMMISSIONER: Yes, please feel free to - both of you should feel free to either defer to the other witness or to add.

MR NANKERVIS: Thank you.

THE COMMISSIONER: So please go ahead.

MR NANKERVIS: We have also started commissioning some multidisciplinary teams where there are some of those chronic disease issues. So, for example, in Muswellbrook in the Hunter Valley a respiratory focus, and in Moree for a chronic disease focus. And --

THE COMMISSIONER: The Hunter, that would be associated with particles in the air, I take it?

MR NANKERVIS: Correct. Yes, that's right.

THE COMMISSIONER: Sorry, I interrupted you. Go ahead.

MR NANKERVIS: And where we've seen some particular priority population issues - for example, the Ezidi refugee community in Armidale - we have stepped in and commissioned care navigation and additional services to support GPs.

THE COMMISSIONER: Just explain "care navigation"; what does that mean precisely?

MR NANKERVIS: Sure. So it can sometimes vary a little bit between care navigation models, for example in Armidale with the Ezidi refugee population, we commissioned a social worker as the care navigator working with general practices. And so for general practices and GPs, they know that if they have one of the Ezidi population seeing them to help that community member to navigate through health and social services, they can link them with a care navigator.

And sometimes it is a matter of simply understanding the Medicare system, knowing how pharmacies work and how the prescribing process works, and sometimes it's accessing other trauma-informed services like our Mental Health Commission services in Armidale because the refugee population has a range of, probably, trauma backgrounds but also other disease backgrounds and profiles as well.

THE COMMISSIONER: Right. Thank you.

DR KOSCHEL: May I add to that?

THE COMMISSIONER: Of course you can, yes.

DR KOSCHEL: The other thing that the care navigator is

able to do is link those patients with some of the LHD outpatient services and specialists as well. And another example of a priority population where we have a very similar care navigation approach is the veterans cohort on the Central Coast and in Newcastle now. Veterans who leave the safety of the Defence Force and a very prescribed way of accessing services come out into the community, and accessing services is a minefield for them. So again we have care navigators that are actually able to help the veteran and their families access primarily mental health services. They largely access those services as well, but they do also have a range of physical disabilities sometimes and need to use those services.

THE COMMISSIONER: Sure. Thank you.

MR FULLER: Dr Koschel, just coming back to the needs assessment for a moment, does that result in any documented plan?

DR KOSCHEL: Yes. We have an obligation - all PHNs have an obligation to complete a template or a needs assessment report and publish that on their website, and that helps inform other people, not only ourselves, in how we can deliver services. So they are always readily available, but - but from that needs assessment as well, when our activities are - when our schedules come through to us, we complete activity work plans and we link those activity work plans to the needs we see, so that we know we are always addressing a gap that we've found. And then we look at those unmet needs and seek to find some funding to be able to address them as they arise.

MR FULLER: Mr Nankervis, I think I interrupted you when you were living me a list of initiatives that the PHN engages in to try to make sure you are meeting the needs of the diverse population. Did you have anything - any other initiatives that you wanted to draw to the inquiry's attention?

MR NANKERVIS: Yes, I'm happy to. Thank you. I suppose we have the set commission programs that are funded via the Commonwealth through PHNs and a range of those, but we do have the ability to also more flexibly meet some needs in local communities and areas. So we have funded some transitional care programs, for example, in mental health for those people who are being discharged from our local

health districts into the community to better support them to find the right services for them in the community, and then, in particular locations we've been able to fund and support primary care provision, particularly rurally.

So through the work that Alison has been leading, for example in Glen Innes we are establishing a multidisciplinary health hub. In a rural town like Spring Ridge we have been collocate primary care services in a small town that has not had a GP for around 30 years to re-establish GP services. And there are different approaches that we can take at a local level.

We also have been able to assist some general practices at risk of closure to keep the doors open.

MR FULLER: I'll come back to some of those initiatives shortly. Just on the mental health transitional program that you mentioned, can you just tell us a bit more about that program?

MR NANKERVIS: Yeah. So that program initially focused on children in the Central Coast and Newcastle regions on discharge from mental health units to assist them and their families to find the right services in the community that will continue to support them. As we have learned more from our needs assessments for the region, we have then increasingly needed in the past few years to commission mental health services for children aged zero to 12.

In saying that, the predominant age group is 8 to 12 that are utilising those services, as you would imagine. So it is assisting in what can be quite a complex system outside of hospital to find the services that meet those needs and attempt to reduce re-admission.

MR FULLER: Dr Koschel, was there anything you wanted to add on the question of how the PHN tries to address the particular needs of its diverse population, given its size and diversity?

DR KOSCHEL: Look, I think another example would be, in a priority population, is domestic, sexual and family violence, where we have been doing some leading work. And an example of that is women who go into refuge and take children into refuge, it became very clear to us that the children in refuge were really struggling and had some

language difficulties due to the trauma that they see. So they often shutdown and they can't speak, they're starting school and they're not able to speak.

And it is a prime example of where we work with the local health district. We were able to access and co-fund the speech therapist of the local health district with a general practitioner to go into refuge and be able to provide services to those women and children. Because traditionally, they look at all of the social needs that happen and they address those social needs, but they weren't addressing the health needs and particularly of the children.

MR FULLER: How did that interface with the local health district work in practice? In other words, what led you to the point of co-funding that particular work with the local health district?

DR KOSCHEL: Largely it's driven by a lack of ability to get speech therapists. They're very short on the ground, and where they are generally located is within a local health district service. So being able just to get a dedicated speech therapist for this particular program wasn't going to likely have a good yield. So, working with the health district to say, "Well, can we co-fund this position and they do their work in the local health district but they come out and do this work in refuges?", you know, seemed a pretty perfect solution.

MR FULLER: Is this a situation where the PHN identified a gap through a needs assessment and then approached the local health district --

DR KOSCHEL: Yep.

MR FULLER: -- to try to work together to fill that gap?

DR KOSCHEL: Absolutely it is. And that's been recognised now and more significant funding has actually come across not only to our PHN but to go throughout the State to actually increase those services into different refuges as well.

MR FULLER: Where has that funding come from?

DR KOSCHEL: Commonwealth funding.

MR FULLER: And is that the PHN approaching the Commonwealth to seek more funding for this?

DR KOSCHEL: Absolutely. Richard has had multiple trips to Canberra with our specialist manager lead, who is very passionate about this area and is very engaging. And they've done multiple trips to Canberra and we have put multiple submissions to Canberra, and that has resulted in that funding now, in the last budget round, coming out and being able to go to other PHNs as well.

MR NANKERVIS: Sorry, I think my camera just turned off automatically, so I apologise for that.

MR FULLER: Were you able to hear Dr Koschel's answer, Mr Nankervis?

MR NANKERVIS: Yes. That's right. And that's right. It is an example of a need that was identified and that we worked very hard to address. We were unable to secure, initially, ongoing funding to support that primary care outreach team into refuges and shelters. However, the Commonwealth has, through the May budget, been able to provide some funds not only to extend the existing service, but to expand it for us. So we're really pleased about that.

MR FULLER: Would you describe it as being on the scale of easy to challenging to get funding for that program from the Commonwealth? How would you describe it?

MR NANKERVIS: Very challenging, because it's outside of the usual government decision process and the existing programs that were funded by the Commonwealth. However, we were able to put a compelling case for the increasing need based on what we've been able to identify through the data that Alison's team has been able to pull together and the qualitative needs of women and children in refuges and shelters, and identify clearly not only the issues, but the potential benefits for the approach.

THE COMMISSIONER: I imagine the thing that the Commonwealth required convincing of is, (a), there is a real need for this service; (b), no-one is currently providing the service, so you're not competing; and, (c), it's anticipated there'll be these positive outcomes that

will benefit the community generally, as well as the people that are getting the service?

MR NANKERVIS: That's been exactly the case that we put forward, Commissioner. I think that that is very accurate. The other factor that is important when we look at this from a primary care perspective is that it does interface back with the women and children's regular GP where it's most appropriate to do so, so that we're not setting up something that's increased the fragmentation from a system perspective, but does link back in where it's safe and appropriate to do so. So that's probably just the other factor for us.

MR FULLER: You mentioned data that Dr Koschel's team was able to pull together. Dr Koschel, do you mind telling us what sort of data you were looking at and then presenting to the Commonwealth to support your case for additional funding?

DR KOSCHEL: Yeah. Look, there's sometimes a plethora a data and there's sometimes a dearth of data, and it is really hard getting that right. This was just based on local data from the local refuges. So we went to the refuges themselves and talked - you know, asked how many children they had there and how many issues they were seeing. So that was how we were able to identify.

It was part of a broader piece of work as well that the PHN were funded to do, and that was around working with general practitioners to identify and respond. So we were also working with general practitioners and saying to the practices, okay, "Well, what are you seeing in terms of people coming in and presenting?" So some of the data also came to us through the local health district, with presentations through them.

MR FULLER: How would you, Dr Koschel, describe the strength of the PHN's relationship with the two local health districts in its area?

DR KOSCHEL: Yeah, I would suggest in this area we have a very strong relationship. It is a very formalised relationship with both LHDs. So we have integrated partnership meetings with each of the LHDs, and it has a terms of reference. Both the CEOs take alternate turns in chairing those meetings. We have common goal projects in

each of those LHDs that we work towards. So one notably for Hunter New England is the Diabetes Alliance Plus program; that came out of the integration partnership. But we similarly have - based on a joint need, we determine what project would work best for each of the different LHDs. And it is a very formalised approach, but we have links, very direct links, from our team through to their team and in both of those LHDs.

MR FULLER: In terms of it being a formalised relationship and approach, is there any kind of memorandum of understanding or similar agreement between the PHN and the districts?

DR KOSCHEL: Yes, absolutely. So we do have those memorandums of understanding and it is also notable that both of the CEs of both local health districts sit on the PHN board.

MR FULLER: How often --

THE COMMISSIONER: What do you see as the benefits of that?

DR KOSCHEL: Having them at the table?

THE COMMISSIONER: Yes.

DR KOSCHEL: Yeah, so they actually get to hear what the issues are for primary care. And it really enhances their ability to look for those opportunities where we actually can work together and make sure that we're not duplicating services, but we're complementing each other.

THE COMMISSIONER: Yes, and I suppose gives them the benefit of hearing from you, as you say, about issues relating to primary care, because it's that care that's going to have an impact in relation to the people that are walking through their emergency department doors?

DR KOSCHEL: Absolutely.

THE COMMISSIONER: And also being acutely unwell, I suppose, as well, in the long term?

DR KOSCHEL: Absolutely. It's - whilst there is a way that you would respond in the acute sector and there is a

way you would respond in the primary care sector, they are intertwined.

THE COMMISSIONER: Yes.

DR KOSCHEL: Yes.

THE COMMISSIONER: If the first one falls over, then the acute system gets overburdened.

DR KOSCHEL: Absolutely. And likewise if the acute system don't know what is happening in primary care and they're not working with primary care then people who are transitioned back into primary care fall and fail and end up back in the acute system.

THE COMMISSIONER: Perhaps a better expression than "overburdened" by me is that if there is good or readily available primary care, then the extent of avoidable acute illnesses and avoidable hospital admissions drops?

DR KOSCHEL: It should.

THE COMMISSIONER: It should. In theory.

DR KOSCHEL: In theory, it should.

THE COMMISSIONER: It probably does. Is it more than in theory? There's evidence about it, isn't there?

MR NANKERVIS: I think it is more than in theory. It definitely helps to plateau the increase, you'd say.

MR FULLER: Mr Nankervis, is there anything you wanted to add on the strength of the relationship and the features of the relationship between the PHN and LHDs?

MR NANKERVIS: I think that Alison has described it very well. The board relationship with having the two chief executives has definitely showed the benefits outweigh the risks. I think of that, in that we have been able to identify more needs and solutions together.

Recent examples are in aged care, where you will probably hear from the district how many older people that they have in beds, and we've been looking at ways that we can address that jointly. So, for example, jointly funding

nurse practitioners to support multiple aged care facilities, to potentially address that. And that's come out of the strength of the relationship.

Also in addition to the formalised memorandum of understanding, we have service agreements between us which outline key services that we're co-funding or working on together, and we see, for example, that for HealthPathways, which is a key resource for primary care in our region, we have one of the highest utilisations in the country of that service.

THE COMMISSIONER: Can I just ask you a question, Mr Nankervis. It is almost out of curiosity, but I see in paragraph 6 of the statement that in the last sentence, you say you were previously the CEO of the Central Coast Medicare Local. Am I right that the Medicare locals were, for want of a better expression, the precursor to the PHNs?

MR NANKERVIS: Yes, that's right.

THE COMMISSIONER: Can I ask you, how does your role as CEO of HNECC or the HNECCPHN, how does that differ to your role when you were CEO of Central Coast Medicare Local?

MR NANKERVIS: In a few key ways. One is that the region is significantly different.

THE COMMISSIONER: Yeah, I noticed. Leaving aside the geography.

MR NANKERVIS: Yes, I spend a lot of time on the road. But also Medicare locals were significantly smaller and had a smaller remit of primary care services under its responsibility. And they were primarily supporting general practice and allied health practices, but also commissioning some First Nations and mental health services, or in some cases providing those services. But PHNs have been established as commissioners, so they're not providers of the services.

And the remit of PHNs or primary health networks is significantly larger and broader in that we have a much wider range of mental health services that we're responsible for commissioning, so: youth, children, a range of different adult services as well, some Indigenous mental health services and psychosocial supports that align

with those mental health services. And also areas like alcohol and other drug services in the community, rural allied health and nursing services, some rural multidisciplinary team services.

And then for us, the last sort of two or three years, the largest areas of growth have been in urgent care services and for us in domestic, family and sexual violence services. So it's that change from being a service provider to a commissioner of services and then the much larger breadth of services.

THE COMMISSIONER: And was that shift from service to being a commissioning body, albeit in a far broader way, partly driven by a concern that the service might be - when Medicare Local was providing a service, might be competing with a service that is already there in a community, is that --

MR NANKERVIS: I think that's completely accurate to say. That was some of the feedback that the Commonwealth was receiving. It was not only a perception of that competition, but actual competition between the Medicare Local and other community-based services that, I think, were in play.

THE COMMISSIONER: Understood. Thank you.

MR FULLER: Can I come to the workforce challenges that you have addressed in your statements from paragraph 12. Dr Koschel, is this within your remit?

DR KOSCHEL: We have a primary care workforce and development team within the PHN and that's managed by a different executive, but there is a lot of crossover through to the rural space as well, because a lot of those workforce challenges sit within the rural space more so than some of those urbanised areas.

MR FULLER: I will start by asking you these questions and, Mr Nankervis, please feel free to jump in as well and, Dr Koschel, tell me if you can't answer a question.

DR KOSCHEL: Sure.

MR FULLER: In paragraph 12 of your statement, you say in the second sentence:

One in four general practices have a staff turnover of more than 20 per cent each year.

Do you know what the source of that data is?

DR KOSCHEL: Yes, absolutely. So it's the 215 general practices that actually enrolled in the SAVI study which is run by primary care workforce and development team. We have always supported the GP workforce and - and the allied health workforce as well through continued professional development and through having officers that go out and work in practices. But we - very smartly John Bailey, our executive, realised that what was really important for practices was working out about the sustainability and viability. So we've often been concerned about, you know, the ageing GP and the practices closing which led us to think about sustainability.

THE COMMISSIONER: Just pausing there.

DR KOSCHEL: Yeah.

THE COMMISSIONER: You used a phrase that I think was SAVI.

DR KOSCHEL: Yes.

THE COMMISSIONER: What does that stand for?

DR KOSCHEL: The Sustainability and Viability Initiative.

THE COMMISSIONER: Okay. Does that study cover more than staff turnover?

DR KOSCHEL: Yes.

THE COMMISSIONER: I imagine it does. What is the full gamut of what it covers?

DR KOSCHEL: So practices have opened up to our SAVI team and provided information - because they are all private practice so there is no obligation for them to share, but they have opened up to our team and completed a survey that has provided all of their financial information and so that's how we found that some of these practices, on a quarterly basis, are not able to pay all of their bills.

THE COMMISSIONER: Right.

DR KOSCHEL: So, you know, their viability is really in question. That's where we found out about the turnover of their staff.

THE COMMISSIONER: The practices you're talking about, were they bulk-billing practices or a mix of bulk-billing with a gap payment or --

DR KOSCHEL: Look, there will be a mix of practices. There are few bulk-billing practices in the Hunter region at the moment.

THE COMMISSIONER: It's just not economically viable.

DR KOSCHEL: It is not economically viable at all which leads to, you know, about a quarter of them, on a quarterly basis, not being able to meet all their bills. So what some of those principles --

THE COMMISSIONER: You are telling me, is this based on a recent survey?

DR KOSCHEL: Yes, it is. We started this last year - correct me if I'm wrong, Richard, or was it earlier this year?

MR NANKERVIS: It was right at the end of last year. Yes, as Alison said, yes, it's been around 215 practices and they had provided --

THE COMMISSIONER: Across the breadth of the PHN?

MR NANKERVIS: Across the breadth of the PHN so from our more urban parts of the region to regional and rural, and it's been a really rich mix of financial workforce and other operational information that they have provided to us in order to not only highlight their issues but enable us to provide them with tailored support, which is more proactive support than we have been able to provide before.

THE COMMISSIONER: Would a rule of thumb be that greater rurality - and I am not going to say that again - is where there is thinner markets for GPs, or is that too broad a brush?

MR NANKERVIS: I think that's a general rule of thumb that you can apply. The other element in terms of this Sustainability and Viability Initiative work is that we have found that there is a correlation of practice viability with practice size. So, in general, the moderate size and larger sized general practices have stronger viability and the smaller practices, so this is your practices, generally from a one to five full-time equivalent GPs, have higher risk in terms of their viability, and then in a range of rural --

THE COMMISSIONER: But is it too simplistic to say this is economies of scale or is it more than that?

MR NANKERVIS: That's certainly the case in some - for some practices that there is an economy of scale there and you see that in some of the corporate practices, for example, that the economy of scale does help, but there is also correlation with the digital health and digital technology take-up of practices as well, and, in some cases, the culture and workforce turnover within practices which can vary as well.

The other thing to say is that in some of our rural towns, in general, some of the size of the general practices is smaller, just because of, you know, the population size and the number of GPs that would be needed to support that. That then automatically means that for some rural towns, the viability of practices is less, I suppose.

THE COMMISSIONER: Yes. It would be a mistake, though, wouldn't it - and tell me if I'm wrong - to assume that even in some of the larger towns or regional centres, let's use Tamworth, where there is a high population, obviously, but there are viable GP practices, that does not mean everyone has got ready access to a GP in the sense that there are both significant waiting times for, I guess, in particular, non-urgent general practice medicine, but also books being closed?

MR NANKERVIS: That's right. That's absolutely correct. And we see that to different extents in different towns and locations as well. Tamworth is a very good example where it's very difficult to obtain a timely appointment to a GP.

THE COMMISSIONER: We have had some evidence about that this morning.

MR NANKERVIS: Yes.

THE COMMISSIONER: But it's consistent with evidence from, well, every regional LHD we have been to.

MR NANKERVIS: Yes. Yes, that's right.

MR FULLER: Dr Koschel, you agree with all of that?

DR KOSCHEL: Absolutely, yes.

MR FULLER: Is there anything you want to add on that issue?

DR KOSCHEL: No. I guess that we have also seen a downturn in GP registrars coming out to the regional centres as well, like, a significant downturn.

While there are some particular issues with having your GP registrar, as in a GP then has to supervise, so that also impinges on the practice because they can't just deliver general practice and supervise so it impinges on their financial viability, but that lack of registrars means that there's not a ready workforce waiting to come through.

MR FULLER: Do you have a sense from your position as a PHN as to why fewer GP registrars are coming out to rural and regional areas?

DR KOSCHEL: Oh, look, it's extremely complex. It's not just one thing. It's the medical training system and how people come through. They go into the acute system and it's very hard to get them back out into general practice. It's probably a perception that general practice isn't, you know, one of those sexy specialities and that, you know, general practitioners are providing grunt work, which is not the case, it is an absolute specialty, and you really have to have significant knowledge to be a general practitioner. So it's probably right back to the people that are choosing medicine in the first instance, and then those that are moving through; to also living in small rural towns.

The issue when you lose a practice, which is one of the issues in Glen Innes, you lose a practice and then the services around it start to dwindle as well because people have to find practices elsewhere, so they drive up the road to Armidale. And when they do that, they go to the optometrist in Armidale and they do their shopping in Armidale, so the town leaks money and the town shrinks. So, general practitioners don't want to come out into these very small towns. They may have families that, you know, they want access to the best of high schools and to the best of services and if they don't feel they can get them in rural and regional areas, they don't choose them because they can work in urban areas.

MR FULLER: You tell us a bit later in your statement about a couple of initiatives that the PHN has in place to, I think, try to address some of these issues, including with registrars coming to rural and regional areas. One, in paragraph 24, is the single employer model.

DR KOSCHEL: Yes.

MR FULLER: Is that something that helps to address the registrar issue or not?

DR KOSCHEL: Look, it certainly could and it was initiated in the Murrumbidgee region which I was at previous to coming here. One of the issues for GP registrars is that when they come out, they go to a practice, they're employed by the practice; they move to the next practice, they lose all of their entitlements. They don't - you know, if they're women, they don't, you know, maintain their entitlements to be able to get maternity leave, if they want to have that, so it's actually unattractive to GPs to move around.

The single employer model has them employed by the local health district because, as part of their registrar training, they have to do anaesthetics and emergency medicine, and a few other specialties, anyway, so the single employer model just has them employed by them and able to portably move around those general practices, so they keep their entitlements. That's certainly - it is relatively early days in terms of long-term keeping them, we haven't got the evidence on that yet, but the early signs are that the people that have a really good experience, and don't lose their entitlements in the single

employer model, are far more likely to stay in a regional area.

MR FULLER: In paragraph 24, you tell us that the Hunter New England Local Health District and the PHN jointly recommended to the ministry that the model be adopted in this region, and I take it from what you have gone on to say, that the ministry agreed with that; the ministry has provided funding for four to five registrar positions --

DR KOSCHEL: Yes.

MR FULLER: -- that you go on to describe; is that right?

DR KOSCHEL: That's correct.

MR FULLER: And how is the --

THE COMMISSIONER: Was that the recommendation for a certain number of registrar positions or --

DR KOSCHEL: Actually, it was more than we wanted to start piloting. We'd actually decided on two or three just as a pilot to get things started, because they are intensive, you have to support GP registrars, so we had suggested two or three and the funding came through, I think, for the four to five registrars in the region.

MR FULLER: Has there been a challenge in terms of making sure that those registrars have supervision in the community?

DR KOSCHEL: It's absolutely a challenge. Our role in that is to work with those practices to make it as simple as possible and easy as possible for them to take on registrars. For example, one is in Inverell but it is in a practice that has got multiple doctors with it. That makes it easier to take a GP registrar because you've got, you know, multiple people that work in a practice. It is actually hard to do that when you're a solo practice or you've just one or two GPs; you know, doing that supervision of registrars is more difficult. So being able to get a practice to sign up because, you know, they're hosting those GP registrars in their practice and it comes at a cost. So there has to be some compensation to them because the billings that they can make while they're there go back into the ministry to help support the single

employer model. So, the practice has to be able to get some funding out of that for it to be viable for them to take on a GP registrar, and that's a challenge.

MR FULLER: You mention later in paragraph 24 that the PHN has been exploring opportunities in relation to allied health and nursing and implementing some kind of single employer model in those fields. What is the PHN doing in relation to nursing and allied health?

DR KOSCHEL: So the nurse practitioner model is a perfect one that Richard mentioned earlier. At any given time in the Tamworth region, there's around about 40 people in Tamworth Base Hospital that can't be moved into aged care. There are beds available for them but they can't move there because they don't have a general practitioner, and the Commonwealth law is, or rule is, that if you are moving into aged care, you must have a general practitioner. So we have explored the nurse practitioner model because employing a nurse practitioner in general practice is difficult because they need - they need other nurse practitioners to form co-ops to give them support. So doing it with the local health district and co-sharing those positions means that you can sign off on supervision of them because the LHD have to provide that anyway, and they have those communities of practice so they can actually support each other. So the single employer model again there works well when you've got someone that's partially employed by the local health district and partially employed through either aged care facilities or through general practice, you know, putting money towards it and, initially, in this stage, the PHN putting money towards it, you get that nurse practitioner that, again, has that surety of service and, you know, access to long service and maternity leave, et cetera. So it is another example of a model based on the GP model, but using nurse practitioners instead.

MR NANKERVIS: I might add to that that as a result of that, we're finding that either the GPs are able to cover more of the aged care facility beds, or the GPs - some of the GPs that were looking at scaling back their coverage of aged care facilities have agreed to maintain coverage of aged care facility beds with support of the nurse practitioner so that's, I suppose, an impact we are seeing for the GPs.

MR FULLER: In relation to the nurse practitioner, who is employing the nurse practitioner in that model?

MR NANKERVIS: It depends on the local construct. So, for example, where we have been piloting it in Newcastle, we've commissioned a non-government non-profit organisation to employ the nurse practitioner, and the nurse practitioner then covers multiple aged care facilities. There is a relationship that the nurse practitioner has with a number of aged care facilities and the GPs that are providing coverage to those facilities.

For Tamworth, the intent is, I think, for a non-government non-profit service provider in the community to employ the nurse practitioner, but under an agreement with the PHN and the local health district.

THE COMMISSIONER: Just so we tick the boxes from the high level of what is in paragraph 24, when we're talking about the single employer model, in that paragraph the Ministry of Health, we're talking about NSW Health; we're not talking about the Commonwealth department?

DR KOSCHEL: Yes, that's correct.

MR NANKERVIS: That's right.

THE COMMISSIONER: And they are the employer, but the exemption that is provided enables those employed under the single employer model, those clinicians, to access the MBS.

DR KOSCHEL: The 19(2) exemption is absolutely how they access the MBS.

MR FULLER: We heard some evidence this morning from Dr Grotowski that the primary health network had been approached with a proposal to effectively engage a mental health nurse through a single employer kind of model. Are either of you aware of that approach, or something like it, that I might not have described precisely?

MR NANKERVIS: I can't remember receiving such a proposal. However, it's certainly one that we're interested in and we'd be interested in exploring.

MR FULLER: Okay. One of the other things that you mention in your statement about trying to address GP

workforce issues, in particular, is in paragraph 27, providing grants to assist clinicians to relocate. Dr Koschel, can you just tell us a bit about that initiative?

DR KOSCHEL: Sure. So we have had, and we still do have, GP bush grants, so there are two components to that. One component is a small amount of money that goes to the practice to help with recruitment and advertising for a position. So, to get the grant, they have to have, you know, a vacancy and then a viable person that they think they're targeting, and if that additional small amount of money helps them to bring them on board, well, then, we pay in instalments on that.

There is another component attached to that which is called the Welcome Ambassador package which they also get, and that has a local person here who works with the practitioner once they arrive, and the practitioner's family, to introduce them to the things that, you know, they're interested in and the people that, you know, they're interested in and touches base with them regularly to make sure that they're settling in and they meet needs.

One example was a doctor that moved to Moree and she was a champion at ping pong table tennis and she wanted to be able to practice. So in that Welcome Ambassador grant, we were able to link her up with someone she could practice with regularly, so she kept up to speed, and to help support her to get a robotic opponent so that she could practice as well, and that Welcome Ambassador pack makes a real difference to a GP that is coming to a new town.

MR FULLER: That is something that is funded by the Commonwealth through the PHN, is that right?

DR KOSCHEL: Well, yes, it is. It comes through the PHN funding and we fund it through the Commonwealth, so it's funding we set aside for those grants.

MR FULLER: Has there been any research done, or do you have any evidence, as to whether that initiative has had a positive effect on attracting GPs to more rural and regional areas?

DR KOSCHEL: Yeah, absolutely. So I think - was it 13 or 15, Richard? I'm never sure about, I can never remember

and I should remember because it was certainly through the rural health team. We've had 13 to 15 of those grants that were successful in the past and we've got eight that we're currently running through the workforce team. And the evaluation of that program that we've had is that those GPs have stayed and are very happy and have settled well into their new environments.

MR FULLER: Mr Nankervis, is there anything you want to add in relation to those grants?

MR NANKERVIS: I don't think so. I think Alison has described that very well. We tried to analyse the benefit from an MBS billing and access perspective for local patients and that seems to also, I suppose, backup the benefit of the grants and seems to indicate the value for them. We were providing a GP registrar relocation set of grants as well. However, that's been taken on by the RACGP now, so we're focusing on the ongoing general practitioners, I should say.

MR FULLER: Just in relation to those GP registrar relocation grants, that's something that's now been funded through the college, is that right?

DR KOSCHEL: Yes, that's correct.

MR FULLER: Okay. Dr Koschel, I think Mr Nankervis mentioned this earlier, the Glen Innes Health Hub. Can you tell us a bit about that, please?

DR KOSCHEL: Absolutely. So approximately two years ago, a couple of general practitioners, a married couple retired, and that displaced 600 people in Glen Innes and we had been doing a rural communities project, looking at Glen Innes, Inverell and Tenterfield to work out which of those areas we would trial a new health hub.

The health hub is based on a multidisciplinary team as opposed to just a general practitioner. It's not easy to get a general practitioner there but the STEM model that we have employed in Spring Ridge demonstrates that you can bring in a GP that does some face-to-face services and supplements that with telehealth. So we thought if we could bring in a multidisciplinary team, use people to the top of their skills - nurse practitioners might be able to provide some limited clinics. There is capacity for wound

clinics, there's capacity for more allied health as in physiotherapy and other services, and so we wanted to not be in competition with the two existing general practices there but to supplement and make life easier for them by providing, you know, additional access to general practitioners and the multidisciplinary team.

THE COMMISSIONER: I take it by that is they just didn't have the capacity to absorb 600 extra patients?

DR KOSCHEL: They did not. So what we hear from the community is some of them are travelling to general practitioners in Sydney, which they see once a year, and then have telehealth.

THE COMMISSIONER: Glen Innes is up north, isn't it?

DR KOSCHEL: Absolutely it is. Some move across to Brisbane and receive the service there.

THE COMMISSIONER: I was going to say Brisbane is closer than Sydney.

DR KOSCHEL: It absolutely is. It is. And it's where your family is, so, you know, if your daughter is in Sydney, you go to Sydney, you link into your GP and you get your telehealth services.

There were some people travelling up the road to Armidale.

THE COMMISSIONER: What's "up the road" mean?

DR KOSCHEL: It is an hour.

THE COMMISSIONER: In the country.

DR KOSCHEL: You get in the car, you drive.

THE COMMISSIONER: It's a fair way?

DR KOSCHEL: Well, yeah, you would consider it a fair way. But I guess, you know --

THE COMMISSIONER: I would.

DR KOSCHEL: An hour to us is just up the road.

THE COMMISSIONER: Listen, I think the CBD in Sydney to Paddington is a fair way so my standards are wrong.

DR KOSCHEL: As Richard said, we spend a lot of time in the cars travelling.

THE COMMISSIONER: Yes.

DR KOSCHEL: So they go up the road to Armidale and they get a GP there. Now, the issue with that becomes as they age and then they might go into an aged care facility in Glen Innes, they may have a GP in Armidale but that Armidale GP is not going to come and see them in their residential aged care facility. So, you know, it is really tricky and there are a lot of people we know that just are not accessing services. It's not a town - it is an ageing population, it's probably low on the socioeconomic scale, so it's not a town where they can afford to go online and pay, you know, significant amounts of money for healthcare.

The difference, and why we receive some innovative model of care funding for that, is not only were we looking at a multidisciplinary model, we were looking at service navigation. So that's slightly different to care navigation. That's thinking more broadly around, you know, all of the services that help with health, so housing and justice, and as well as helping them in terms of care navigation to access a telehealth service on site if they don't have access to internet. And the other thing about that model was we wanted it owned by the community, so we have been working with the business cooperatives and Mutual, and they have been helping advise us so that what we can do is set this health hub up to be governed and run, once this funding ceases, by the community. So we're in the process of bringing that to fruition.

THE COMMISSIONER: What is the funding to establish this health hub?

DR KOSCHEL: So it is innovative models of care, so it comes through the Rural Health Commissioner's office. So it is around five of her grants, or the past commissioner's grants.

THE COMMISSIONER: That's a Commonwealth office?

DR KOSCHEL: It is a Commonwealth office, yes, so it is Commonwealth funding.

THE COMMISSIONER: Is that now Professor --

DR KOSCHEL: Jenny May?

THE COMMISSIONER: -- May, yes.

DR KOSCHEL: Yes, who you have had the pleasure of meeting --

THE COMMISSIONER: Yes, we have.

DR KOSCHEL: -- at these hearings from Tamworth. Yes. Sorry, Richard?

MR NANKERVIS: And we have provided some PHN funding towards establishing the health hub as well, and --

THE COMMISSIONER: So is it entirely Commonwealth money at the moment?

MR NANKERVIS: Yes, it is. In saying that, the local council has offered local facilities to accommodate.

THE COMMISSIONER: They're going to provide a building, are they?

DR KOSCHEL: They have offered to provide a building.

THE COMMISSIONER: Right. Which they would lease? Or --

DR KOSCHEL: Yes, and as we all know setting up anything new is when it's most --

THE COMMISSIONER: There is a fit-out, yeah?

DR KOSCHEL: There is fit-out, but it is when it is most critical in the first couple of years, so it may result - when it is a sustainable and viable business, it may result in having to have some rent, but initially they have offered a rent-free --

THE COMMISSIONER: They are just providing the building?

DR KOSCHEL: -- building. Mmm-hmm.

MR FULLER: And - sorry?

MR NANKERVIS: Just the other element of the service is that the University of New England and the partnership there whereby it won't be when the service first starts, but I think after the first 12 to 24 months, Alison, we're looking at having a student-based element to the clinic and ensuring that there are students going through.

DR KOSCHEL: Yes.

THE COMMISSIONER: And what should I understand by "primary care healthcare services"? It's GPs, plus?

DR KOSCHEL: GPs and allied health, so physiotherapy, speech therapy, occupational --

THE COMMISSIONER: So will it be two GPs? Or is that not clear yet?

DR KOSCHEL: We'd be grateful for one GP to start with.

THE COMMISSIONER: Right. You have got to find someone.

DR KOSCHEL: We've got to find somebody.

THE COMMISSIONER: Yeah.

DR KOSCHEL: It may be a model where it doesn't necessarily have to be a GP. It might be a model where - there are a few models now that we know of, and STEM is one of those, where a GP in Newcastle actually comes out every six weeks, provides a service and goes back and provides us telehealth.

So what the - and it will be a commissioned service operator that will run the multidisciplinary clinic for us, but the PHN will keep the general practice and the service navigation roles because we're piloting those. And so the general practitioner, they will house them in that service and work with them and integrate the care. So initially, you know, it might be one particular service. There may be another one that says they will come up in a different month and provide a service, and we would gratefully accept that as well.

MR FULLER: Do you have a timeframe for when the health hub will start?

DR KOSCHEL: We do. It's been a two-year process, and we have pivoted often because you go to take some steps and to do some things and then you have to change. We are hoping, and we are very close now - we have the service operator - very close to being able to sign a contract probably in October. So we're hoping to have doors opened towards the end of this year or very early next year.

MR FULLER: When you say "service operator", what do you mean by that?

DR KOSCHEL: So one of our local service operators, so it is a for profit business that actually works within the health arena and has other contracts with us. So this particular provider at the moment has a Parkinson's nurse that we have commissioned them to deliver that service, but they are expanding their services and have a suite of different practitioners they are able to work with now, so they will be the operator of the health hub.

THE COMMISSIONER: When did the husband and wife GPs, when did they retire?

DR KOSCHEL: It was approximately two years ago. And that town also has two other practices. Both those practices have ageing GPs that really should be retiring. One in particular, his wife retired. He has stayed on, but he really wants to retire and should be able to.

THE COMMISSIONER: Yes, but that would just add to the crisis.

DR KOSCHEL: It will add to the crisis, yes.

MR FULLER: Do you envisage a similar multidisciplinary kind of model being rolled out elsewhere in the PHN?

DR KOSCHEL: I surely do, and we have KPIs for that to happen. I guess this is a prototype, it's a pilot, it is at a pilot funding, it's over three years. But if we can prove that it is successful - and it may not be that funding comes to the PHN; it might come to the community to be able to set up these health hubs, but we will have a prototype of how you can do this and we will work with

these communities. And, as Richard said before, some of those communities will embrace that and want to do that, some communities won't. It won't work everywhere. But we will have a pilot and we do envisage we'll be able to roll this out in other key markets across the region.

MR FULLER: Dr Koschel, in paragraph 28, you tell us about some initiatives --

THE COMMISSIONER: Sorry, just before you get to that, can I just ask something about 25?

MR FULLER: Yes.

THE COMMISSIONER: In the paragraph where you have got:

> *It may also be beneficial ...*

Should I take from that that what follows is a potential idea that hasn't been trialled or funded, or is this something that's actually happening?

DR KOSCHEL: Look, it - sorry, if I can just read for just a moment.

THE COMMISSIONER: Yes, take your time.

DR KOSCHEL: Yeah. So the nurse position could certainly be that nurse practitioner position where I think in --

THE COMMISSIONER: See, the first bit talks about, "It may beneficial to establish jointly funded positions", et cetera.

DR KOSCHEL: Yes.

THE COMMISSIONER: And then - but then halfway through the paragraph it changes to:

> *We are currently trialling this model with nurse practitioners ...*

DR KOSCHEL: That's the aged care nurse practitioners.

THE COMMISSIONER: Yeah.

MR NANKERVIS: I think our experience as well is that in

some towns for an allied health provider such as a physiotherapist or dietician or speech pathologist there might be enough work for a part-time job in a practice and part-time in the local hospital. The ability for us to try to put those together to make an attractive proposition, you know, to recruit one of those physios or speechies or dieticians, would be beneficial in some rural regions.

DR KOSCHEL: Yes.

THE COMMISSIONER: Yes. Okay. Thank you. Sorry.

MR FULLER: Paragraph 28, session planning. Dr Koschel, can you just describe for us briefly what the PHN's initiatives are in relation to GP succession planning?

DR KOSCHEL: So we worked with both the local health district and the Rural Doctors Network, and we have been doing that for a significant time and it is a very formalised partnership as well. And I think I said to you before sometimes there is a plethora of information and sometimes there a dearth of information. We know an awful lot of general practices and general practitioners, but we don't necessarily know their ages, which Rural Doctors Network, because they have access to that information, have. So it actually, when we combined to get --

THE COMMISSIONER: This is all part of the SAVI thing that you --

DR KOSCHEL: No, this is separate.

THE COMMISSIONER: This is separate?

DR KOSCHEL: Separate to SAVI, and we have been doing this for a significant period of time. And I do know Rural Doctors Network do this with other PHNs and LHDs as well. But we are very - I think we are quite advanced in this region in terms of we work together, we share that information, they sit down and they pinpoint where those practices are really at risk, and we're able to provide that information to the Commonwealth so that they're prepared when there is a risk. And, for example, the Glen Innes practice that closed would have been identified in their success planning meeting.

THE COMMISSIONER: Is this government structure or

whatever we wish to call it where you, the LHD and the Rural Doctors Network are getting together in relation to this LHD to discuss imminent practice closures, as an example, do you know if other regional LHDs have similar - they do?

DR KOSCHEL: Yes, they do. As I say, this one is quite advanced in how it identifies those practices, and then our practice support teams go in and assist those practices and those communities. And so an example of that would have been the Uralla practice, which we knew was closing. And when we know that's happening, we can work with the Armidale practices because they're going to suddenly get an influx of people in there that are going to go there.

So I know of other - particularly in the Murrumbidgee, I know that they do a very similar thing, but they're not quite as advanced in terms of what they then mobilise to be able to support that succession work.

MR FULLER: What is it that the PHN actually does practically to support, for example, the Armidale practices in this scenario?

DR KOSCHEL: So we have - we have a practice support team that do development and previously did liaison roles. So those practitioners have a group of practices that they support regularly. So they go out and meet with the general practitioners and with the practice managers. They can assist them to identify some practice incentive support programs that they can work with which can help to supplement their income. They can actually link up with other practices for support. For general practitioners, they often do dinners where they bring people together so that they can meet each other and provide support to one another.

We have a continuous professional development team that also work with all of those practices to bring them, you know, the most up-to-date information that they need and to provide whatever those supports are to keep them viable and on point.

MR FULLER: Mr Nankervis?

MR NANKERVIS: A couple of other examples are where our team has sat down with the principal GPs or practice

managers and looked through their MBS billing and their clinic operations and provided detailed advice on how they can improve their MBS billing and their business performance to enable them to stay viable for a longer period, particularly as an interim sometimes while we assist with recruitment.

MR FULLER: Just jumping back for a moment in your statement to paragraph 17, in that paragraph you talk about international medical graduates and say they're heavily relied on to provide primary healthcare services as a result of workforce challenges in the Hunter New England Local Health District. Mr Nankervis, do you have a view as to whether it is desirable for international medical graduates to play such a significant role or otherwise, or it's just a practical reality?

MR NANKERVIS: I would say at the moment it is a practical reality, and it's an extremely valuable workforce for us because we have not had the local pipeline of GPs coming to our region to be able to sustain access for a range of regional and rural locations.

THE COMMISSIONER: Can I just ask you, that band of 60 to 80 per cent is quite a wide band.

MR NANKERVIS: It is.

THE COMMISSIONER: Should I raid that as 80 per cent in certain parts in the LHD and 60 in others?

MR NANKERVIS: Yes, that's right, Commissioner. So it is not universal, and it's not a clear pattern either. So, for example, in Cessnock in the lower Hunter Valley, I think we have over 75 per cent of local GPs are international medical graduates. So it doesn't follow a clear pattern or trajectory.

DR KOSCHEL: And that would be the case in Narrabri as well, Richard, where we have a board member currently who is a GP and we have a high proportion of international medical graduates there because he goes back to his own country and recruits people to come across and work. And again, you know, they come to those places because somebody is there, because they get support networks by doing that.

THE COMMISSIONER: Does the 60 to 80 per cent band means

it's no longer than 60 per cent anywhere and up to 80 per cent in some spots?

MR NANKERVIS: I think for regional and rural towns that would be reasonably accurate to say. Obviously, it will be different in our urban and outer areas.

THE COMMISSIONER: Yes.

MR NANKERVIS: And I think if we look internationally, it's far from ideal that we're drawing GPs from other countries where they have workforce issues themselves. I think that would be the other, probably, ethical component for us.

THE COMMISSIONER: I take it by that you mean that where we're recruiting international medical graduates from countries that at least there is an argument that they can't afford to lose them?

MR NANKERVIS: Countries in the Middle East, southeast Asia, even South Africa, New Zealand and I think if you looked a little over a decade ago, our international medical graduate would have had a predominance of GPs from the UK and South Africa, but it has significantly broadened over that time.

MR FULLER: In the last sentence of paragraph 17, you've told us about some of the work that the PHN does to try to support international medical graduates and, Mr Nankervis, you refer to information being provided through the HealthPathways system and partnered electronic referral initiatives. Can you just explain those to us, please?

MR NANKERVIS: Yes, I can, and Alison can also provide some detailed information around HealthPathways. However, HealthPathways provides the local assessment, I suppose, criteria and local services and referral criteria for different services. So, for example, in the case of a GP at Narrabri, they can have at their fingertips while they're seeing a patient information about a particular condition that they have diagnosed, where they can refer different levels of diagnosis to the local services, the other broader Hunter New England Local Health District services, and then we have that across the region so that for an international medical graduate who is not necessarily as familiar with our health system and local

services, they're able to access, in a few clicks on their computer while they are seeing a patient, information about where to best refer patients with particular diagnoses - actually, many, many different diagnoses - the contact information for services, how to refer, and included in that for a range of them are the electronic referral processes. And they're locally designed and developed, some of those key pathways.

MR FULLER: Dr Koschel, did you want to add anything to that?

DR KOSCHEL: Yeah. So what it significantly does, it ameliorates the GPs' bombardment of 200-plus different emails per day with different new updated guidelines and, you know, different products that are on the market. So we don't promote products through it, but certainly when those guidelines are updated and you want best practice care, the Pathways program is able to have that best practice care. And as Richard said, all PHNs have Pathways, and so you can get that localised information. So if you don't know where you are going to refer someone to, you can. And with one click to an outpatient service at the local health district, you can make a secure electronic referral. And that's a great benefit to a GP, and it is certainly a great benefit to privacy where you don't have a multitude of faxes going to the wrong fax number.

MR FULLER: Coming now to what you tell us about funding issues in your statement, in paragraph 18 of the statement, you talk about some integrated healthcare initiatives. I just wanted to ask about near the end of the paragraph you mention reduced LHD funding having an impact on the delivery of those services. Can you just elaborate on what that impact has been in practice, please?

DR KOSCHEL: Yes. I guess when the ministry give the LHDs funding, it's very prescribed. And so, there's not a lot of ability to react to whatever the integrated activity is that you want to do. Sometimes there's funding for it, but often there's not. And that impact comes back on the PHN, because you want to do some partnered work together, and we can find some funding because we have a little bit more flexibility to be able to do that, but it's not always the case for the LHDs. So it's not so much that their funding has been reduced to do that; it's just that it is not really available in the first place because it is

activity-based funding that they get and it's very prescribed for what they do. So what it means is where we can localise, they can't.

THE COMMISSIONER: It's (indistinct) services.

DR KOSCHEL: Yes. Yeah. So it just makes it more difficult to do those localised initiatives.

MR FULLER: When you say it's very prescribed, is it that your perception is that there is an overwhelming incentive to spend the money that they get from the ministry on the delivery of acute services rather than, for example, on integrated care? Is that the perception from your end of --

DR KOSCHEL: Absolutely. The acute system can suck up money like you would not believe.

THE COMMISSIONER: It might be the reality rather than the perception.

DR KOSCHEL: Yes.

THE COMMISSIONER: I'm not making --

MR NANKERVIS: I think it is partly the result of the episodic-based activity-based funding mechanism.

DR KOSCHEL: Yes.

MR FULLER: And you go on to tell us about your views on activity-based funding in paragraph 19. Mr Nankervis, can you - you tell us ABF does not effectively align with integrated care models and investment in primary care. Can you elaborate on your views on that, please?

MR NANKERVIS: Yes, I can. So there are some initiatives that we co-fund between the PHN and local health district. Some of us are integrated care enablers such as HealthPathways and electronic referrals where you can't count individual patient treatment episodes for that because it is a systemic mechanism to improve pathways of care between the acute and primary care sectors.

There are other examples of services where you might want to bring specialists and GPs together to provide joint

case conferencing or telehealth-enabled appointments for key local needs. So examples of that example are ear, nose and throat services in rural areas where we have a significant deficit of specialty services, we have children waiting significant periods of time, and if there is funding available, then we can potentially commence telehealth-enabled joint appointments between local GPs in a rural town and an ENT specialist at John Hunter Hospital.

And you can potentially do that with other key areas of specialist need. We have significant need in our region for diabetes and other chronic diseases. We have access challenges for other specialist services as well, where potentially there could be the ability to join up specialist and local GP services to provide access to specialised care in rural locations.

THE COMMISSIONER: Should I take - those first two sentences of paragraph 19, should I take them to be expressions of your opinion, but more in the nature of observation rather than criticism in the sense that I don't think ABF was designed to do these things in any event?

MR NANKERVIS: No, that's absolutely right, Commissioner. I think there with these things there are intended consequences and unintended consequences of funding formulas, and I just think it is an unintended consequence. And certainly not wanting to be critical of the local health district either, because I think there is a very strong and positive intent around this work.

THE COMMISSIONER: You mean in the sense that they're given the budgets they are given and they have to work with them?

MR NANKERVIS: Yes.

THE COMMISSIONER: Is that the short point?

MR NANKERVIS: That's an excellent summary.

THE COMMISSIONER: Yes.

DR KOSCHEL: And they have similar frustrations.

THE COMMISSIONER: I'm sure.

MR FULLER: Dr Koschel, did you want to add anything else on this topic of ABF funding?

DR KOSCHEL: No, I think Richard has covered it very well.

THE COMMISSIONER: Can you explain just the sentence, one or both of you:

It also acts as a disincentive.

What precisely do you mean with that in relation to primary care service options?

MR NANKERVIS: Sure. So I suppose when you have a funding mechanism that is based on a diagnosis and an episode cost for treatment, episodic treatment of that diagnosis, but you're trying to design a service that connects local GP and specialist services, sometimes those multi-disciplinary or case conference or telehealth-enabled services, they're either longer appointments or that they have multiple practitioners in there, so the costs of actually doing them are higher than the episodic funding provided through the ABF formula.

MR FULLER: Finally, in paragraph 20, you both express the belief that effective service and workforce planning would be based on a needs assessment of a community so that the allocation of resources reflects this need. Firstly, when you say, "effective service and workforce planning would be based", is it - your perception is that at the moment it is not fundamentally based on those principles; is that fair?

MR NANKERVIS: I'm not sure that's a completely accurate summary of what we're trying to put across, because --

MR FULLER: Please tell me --

THE COMMISSIONER: Is it that the acute needs - we've lost them. Can you still lost me hear me, Mr Nankervis?

MR NANKERVIS: Sorry, I can, but - sorry, that was not me turning the video off.

THE COMMISSIONER: Would it be fair, and tell me if this is either wrong or needs further elaboration, that the acute needs, health needs, of populations within LHDs are generally funded by the LHDs in the sense of the acute

services offered in the hospitals, but it's the primary services, the preventative services, the early intervention services and related services where there are gaps in what's provided and what resources are provided?

MR NANKERVIS: I think that is an accurate --

THE COMMISSIONER: Dr Koschel is nodding her head in general agreement, but please feel free to say something as well as nodding your head. So both of you, you can respond to that in any way you want.

MR NANKERVIS: Just to start with, I think that that's a reasonably accurate summary. The other element for us, I suppose, is that some of the local primary care workforce also provides a service in the local hospital, in the local large aged care facilities. So, you know, you have local GPs with VMO rights in the hospital and coverage in the aged care facility, and so sometimes, you know --

THE COMMISSIONER: What I said was said at the highest level possible.

MR NANKERVIS: Yeah.

THE COMMISSIONER: You're free to embrace that but then provide the nuance.

MR NANKERVIS: Yes. Thank you. So I am embracing it. But yes, there is that interface between the two, and obviously, as you've identified earlier in the discussion, the local deficits in general practice and in practice-based allied health workforce do impact the provision of care in the local health districts, either through additional demand of more people accessing services in the local hospitals, or where there are joint - there is coverage across in some way of the same GPs or allied health providers, either in the ABF facilities or in the local health district facility, or both. And so there is this real interplay of the workforce issues that we see across different parts of the sector at a local level.

THE COMMISSIONER: Do you want to --

DR KOSCHEL: Yeah, and I guess what I would add to that is when we do a needs assessment, there obviously are different needs, and one of the most perfect examples of

that I can give you is, you know, we see rates of cardiovascular disease and hospitalisations due to cardiovascular disease. If you are having a heart attack, you should go to a hospital. We don't want you to wait in primary care. But where the deficit often is, is in the early intervention because, you know, were we able to manage, you know, excess weight and exercise and diet and reduce all of the risk factors, which is that prevention work and that early intervention prevention work, we might avoid some of those hospitalisations. So I guess, you know, when we do the needs, if people are having a heart attack, we absolutely want them to be able to go and access an acute service. But, you know, that always --

THE COMMISSIONER: Or delay that as long as possible or avoid it altogether, or the person dies of something else?

DR KOSCHEL: Absolutely. So I guess, you know, the funding though naturally gets taken to the acute things that you have to do first, and so that leaves very little left over for early intervention, let alone any true prevention.

MR FULLER: They are my questions for these witnesses. Thank you very much.

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

MR CHENEY: Just quickly, Commissioner. I am conscious of the 3.45 deadline.

THE COMMISSIONER: I forgot all about that, but it would be rare for you to take more than eight minutes, Mr Cheney, so we're probably safe.

MR CHENEY: I'll pump my brakes, keep my head down.

<EXAMINATION BY MR CHENEY

MR CHENEY: Perhaps I should direct this to both witnesses. You have spoken today about the very strong relationship that the network has with the two LHDs, Central Coast and Hunter New England, and in paragraph 18 of the joint statement that you were asked about just now, Mr Fuller referred to the financial constraints that can serve to limit the amount of funding that the two LHDs can provide to the PHN for integrated care.

One of the responses, I suggest, to the acknowledged funding constraints and one of the practical ways that this strong relationship manifests itself is in the provision by the LHDs of in-kind support to the network; would that be fair?

DR KOSCHEL: Yes. There is in-kind support from both sides, often. But, yes, there is the capacity for LHDs to provide in-kind support. And an example of that is that supervision of nurse practitioners. If they have a supervision system where they're employing a co-funded person, if they provided that in-kind, that is a benefit.

THE COMMISSIONER: What should I understand exactly by in-kind support?

DR KOSCHEL: It means that they may have supervisor of a nurse practitioner. We wouldn't necessarily have one of those in primary care, and it's required, you know, to be able to work. So if they say, "Well, your nurse practitioner that isn't fully funded by us could access that service," then that's in-kind support.

MR NANKERVIS: I think there are other examples as well. So, for example, in developing HealthPathways, specialists working in the local health district will contribute to the local HealthPathways without us providing additional funding. So they're employed specialists by the local health districts providing their time, I suppose, to support the development of HealthPathways, and similarly for us with some of our staff and other joint projects.

MR CHENEY: And another example, I suggest, of - a practical example, is in the Hunter New England area, the provision of dedicated clinical spaces adjacent to the emergency departments at various of the hospitals to facility after hours GP and care?

MR NANKERVIS: That's right. We have been able to set up after hours GP clinics in a number of locations in and around Newcastle, but also in two locations on the Central Coast as well. So they are provided out of the local health district facilities at minimal rent. So you would absolutely call that a very valuable in-kind contribution.

MR CHENEY: And I assume that shares a - or it at least

serves as a dual purpose of taking a load off the EDs in those hospital settings?

MR NANKERVIS: Very much so. That's the intent of them, and it does seem to support that to a certain extent.

MR CHENEY: In that example, do patients present initially to the ED and then get referred to the network's private clinical spaces in the hospital?

MR NANKERVIS: In some cases, yes. There is a combination. So, for example, in the Newcastle-based after hours GP clinics, there are certain appointments that are kept available for referrals from the emergency department into those after hours GP services. The majority of those appointments are for the community, but there are some that are kept for those emergency department transfers.

THE COMMISSIONER: Should I understand this as if it's like, I think, when we were at Batemans Bay, is this the local health district making available rooms for a GP practice in the public hospital site?

MR NANKERVIS: Yes, that's right, Commissioner. That's very accurate to say.

THE COMMISSIONER: To run their private GP practice?

MR NANKERVIS: I suppose it is private. However, the after hours GP clinics for us are operated by a non-profit - what you would call a deputised service.

THE COMMISSIONER: That you are provided some funding for?

MR NANKERVIS: Yes.

THE COMMISSIONER: Or funding entirely?

MR NANKERVIS: We're not it funding entirely, no, because --

THE COMMISSIONER: Right, providing some for?

MR NANKERVIS: We are providing some funding. There is a significant obvious MBS revenue component for these services.

THE COMMISSIONER: Of course, yes.

MR CHENEY: And similarly, Hunter New England supplies some sterilising and imaging services, made available to the GPs?

MR NANKERVIS: They do make those available for those after hours GP services, yes.

MR CHENEY: And some pharmacy and clinic consumables?

MR NANKERVIS: Consumables, yes. Pharmacy, no.

MR CHENEY: And we've spoken of the Hunter New England in-kind provision. Similarly, the Central Coast provides some in-kind support through its women, children and families unit? Do I understand that?

MR NANKERVIS: There are actually a couple of really strong examples of that. So we do commission headspace youth mental health services through Central Coast Local Health District's, so we do provide funding. However, the local health district operates the service out of - and in - I suppose in liaison with their children and young people mental health service. So there are, I think, economies of scale, being able to align those services. And also after hours GP clinics on the Central Coast out of Central Coast Local Health District facilities.

MR CHENEY: I think Mr Nankervis, you co-chair a steering committee of an alliance between the LHD and the network? Is that right?

MR NANKERVIS: Yes, that's right. So it is a very similar formalised partnership between the primary health network and the local health district on the Central Coast.

MR CHENEY: And the purpose or the role of that alliance is to work on shared priorities?

MR NANKERVIS: That's right. It is to identify work on those shared priorities. And that's included on the Central Coast HealthPathways. We've been trialling some joint work to try to address chronic pain. We look at opportunities and needs when working on particularly older people's needs and locally developed integrated and partner

solutions for older people.

MR CHENEY: And the other co-chair of that committee is the chief executive of the Central Coast LHD?

MR NANKERVIS: That's right. It is co-chaired between us, and then we have our executives from each piece of the organisations sitting on that, and it is underpinned by a set of work streams where we have key staff from each organisation working on projects and solutions on those work streams. So it is a very deep relationship and partnership that we have.

THE COMMISSIONER: You have also told us about the diabetes alliance in paragraph 23, where you talk about these governance structures. So that's another example, correct?

MR NANKERVIS: Correct.

DR KOSCHEL: Yes.

MR NANKERVIS: And that's been, I suppose, a part of the partnership with the local health district, particularly effective in attracting additional funding as well in Hunter New England. We haven't been able to do that at the Central Coast, but it is a terrific example of a really strong partner there.

MR CHENEY: And just finally, you have established within the Central Coast a GP collaboration panel; is that right?

MR NANKERVIS: Yes, that's right. It is really interesting because it focuses on the local health district services and transition of services between the acute and primary care sector, and so that panel of GPs has a range of local health district service managers and service designers that come and discuss different pieces of work to really ensure that the services that are being provided and developed by the local health district do have an effective interface with primary care and are designed in that way to integrate as well as possible.

MR CHENEY: And the advantage of the panel is it gives the LHD access to, I think, no fewer than seven local GPs to consult with when developing new models of care?

MR NANKERVIS: That's right. Some years ago, we just had one GP, but we have seen there is a great advantage to have a panel of GPs. And that's right, having seven there provides different GP perspectives.

MR CHENEY: Thank you, Commissioner.

THE COMMISSIONER: I take it those GPs are from different towns? They're not all from - they're spread around?

MR NANKERVIS: That's right, in a whole range of different types of practices on the Central Coast as well, with different relationships. You get that mix of views. I think we often find that GPs have some diversity of views, but you get those around the table or just having a strong discussion with the local health district, it really adds benefit to what service outcomes we've got.

THE COMMISSIONER: Sure.

MR CHENEY: Thank you, Commissioner.

THE COMMISSIONER: Nothing came out of that?

MR FULLER: No, thank you.

THE COMMISSIONER: To both of you, thank you very much for your time, we are very grateful, and you are excused. Thank you.

<WITNESSES EXCUSED

THE COMMISSIONER: What time do we adjourn to tomorrow?

MR FULLER: 9.30.

THE COMMISSIONER: Thank you, we are adjourned to 9.30.

AT 3.51 PM THE HEARING WAS ADJOURNED TO 9.30 AM ON FRIDAY, 20 SEPTEMBER 2024

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