REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON REMOTE, RURAL AND REGIONAL HEALTH

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

At Macquarie Room, Parliament House, Sydney on Monday 27 November 2023

The Committee met at 9:05.

PRESENT

Dr Joe McGirr (Chair)

Mr Clayton Barr
Ms Liza Butler
Ms Trish Doyle
Ms Janelle Saffin (Deputy Chair)
Mrs Tanya Thompson
Mrs Leslie Williams

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Good morning, everyone, and welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health. Today's hearing is part of our inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health. We will be hearing evidence from a range of witnesses from across the healthcare sector. I am Dr Joe McGirr, member for Wagga Wagga and Chair of the Committee. The hearing is being broadcast to the public via the Parliament's website and we have a combination of witnesses appearing in person and via videoconference.

Before we commence, I acknowledge the Gadigal people who are the traditional custodians of the land we meet on here at New South Wales Parliament. I also pay my respects to Elders past and present of the Eora nation and extend that respect to other Aboriginal and Torres Strait Islander people who are present today or watching proceedings on the New South Wales Parliament's website. I thank everyone who is appearing before the Committee today. I declare the hearing open.

Mr SCOTT BEATON, Vice President, Australian Paramedics Association (NSW), before the Committee via videoconference, affirmed and examined

Mr GARY WILSON, Delegate and former Secretary, Australian Paramedics Association (NSW), before the Committee via videoconference, sworn and examined

Mr MICHAEL WHAITES, Assistant General Secretary, New South Wales Nurses and Midwives' Association, affirmed and examined

Mr PAUL HAINES, Clinical Nurse Specialist, New South Wales Nurses and Midwives' Association, before the Committee via videoconference, affirmed and examined

Dr ANTONY SARA, President, Australian Salaried Medical Officers' Federation NSW, sworn and examined

Dr CHOONG-SIEW YONG, Vice President, Australian Salaried Medical Officers' Federation NSW, sworn and examined

Dr GABRIEL LAU, State Councillor, Australian Salaried Medical Officers' Federation NSW, affirmed and examined

The CHAIR: I welcome representatives from the Australian Paramedics Association (NSW), the New South Wales Nurses and Midwives' Association and the Australian Salaried Medical Officers' Federation NSW appearing in the room and online. Can each witness confirm you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

SCOTT BEATON: Yes.

MICHAEL WHAITES: Yes.

ANTONY SARA: Yes.

CHOONG-SIEW YONG: Yes.

GABRIEL LAU: Yes.

GARY WILSON: Yes.

PAUL HAINES: Yes.

The CHAIR: There is now an opportunity for each organisation to make a brief opening statement. We request that the statement be restricted to two minutes and in fact we will have a timer on that. We ask that, where possible, it does not repeat the information already provided in the presentations. We might start with the Australian Paramedics Association.

SCOTT BEATON: My colleague and I have over 35 years combined regional and rural paramedic experience. This is my third appearance before committees, in regards to the rural health and ramping inquiries. Unfortunately, we've seen very little improvement in regards to any of the findings that have come out of the previous two inquiries. We have had regional intensive care paramedics rolled out. We're 18 months into that program of a four-year plan, but this is only in major centres and the small rural communities are missing out. We have had the announcement of 500 regional and rural paramedics, but these have still not been recruited and the

beginning of that is the next financial year. We have seen incentives increased for paramedics to move to rural locations. However, these positions are very limited to station officers only.

There was the announcement of 1,800 paramedics, but none of these have gone to regional or rural New South Wales, except for some small locations with new stations on the North Coast, in the main. We've seen no increase in non-emergency patient transport. This results in paramedics having to do non-emergency work, and in small communities this takes the emergency ambulance out of small communities for two to three hours to take someone from a nursing home to go and get a CT or an X-ray. There is no housing for our paramedics in some of the rural communities and this causes a great issue when we're trying to staff these small regional and rural towns. Paramedics are leaving for interstate. They're coming into New South Wales to be trained and they leave to go interstate because they are getting better conditions, better pay and $20,000 incentives to move interstate. We don't like to focus on the negatives, but there have been very few positives over the last two inquiries.

MICHAEL WHAITES: Thank you for our opportunity to appear today. You have our submission and we have handed up a subsequent letter to the panel today. We contest that the workplace culture and workloads will remain unresolved until ratios are implemented in every ward and unit across the State. We also draw the Chair's attention to our submission to the current birth trauma inquiry, as it contains information of interest to this inquiry pertaining to the workforce around midwifery. The challenges linked to workplace culture throughout the public health system are compounded by several factors, most notably are ongoing reports of violence and aggression towards nurses and midwives or, sadly, the growing incidences of bullying and harassment our members are experiencing. Aboriginal and Torres Strait Islander members advise us that they have a significant concern around the lack of cultural safety awareness between staff and highlight the need for policy and training to address this.

Avenues for staff to escalate workplace concerns are inconsistent or, at worse, non-existent, resulting in increased workplace health and safety complaints and increased psychological injuries. Tragically, we are aware of an increase in the number of deaths by suicide amongst our members. As recently as last week our association's committee of delegates unanimously passed a motion calling for the establishment for a commission to thoroughly investigate the workplace culture within NSW Health and to assess the existing challenges, identify areas for improvement and recommend necessary reforms to protect the wellbeing of healthcare professionals and patients.

With regard to funding, we refer the Committee to our submission to the Special Committee of Inquiry into Healthcare Funding. Whilst we acknowledge the Local Health Districts (LHD) within regional, rural and remote facilities are trying to improve the recruitment and retention of nursing and midwifery staff, a lack of appropriately resourced budgets means that this progress is limited or non-existent. We have heard suggestions that the health budget was overspent and that this money is to be recovered. If accurate, this would confirm operational budgets are largely insufficient to meet current needs, let alone to achieve the necessary workforce improvements. Unless we fund the staffing levels required for change, workplace culture would not significantly improve and will most likely continue to deteriorate.

ANTONY SARA: Thank you for the opportunity to present to this Committee. We have put in a written submission, which has been informed by our 1,250 members employed in rural and remote areas. Australian Salaried Medical Officers' Federation (ASMOF) is a state-registered union. We represent all salaried doctors in the New South Wales jurisdiction. We have written objectives of wishing to support our members and support high-quality health care. The first major point we would make is that we do support initiatives to increase rural, remote health care for the community, but we would make the strong point that the award is 12 years out of date and New South Wales is no longer the employer of choice in Australia. We are the worst paid doctors in the country. I would like to hand to my colleagues for some other mountain-top points.

CHOONG-SIEW YONG: Thank you. I just wanted to make the point that we certainly acknowledge the work done by various initiatives, such as the rural generalist Single Employer Model (SEM), but we also believe there needs to be a lot more work done towards the advancement of training pathways more comprehensively and to acknowledge the role of senior salaried medical staff in training and supervision of junior staff. The training of junior staff in rural centres is really essential to keeping those doctors in those regions. The other point we'd make is about workplace culture and complaints handling being really significant issues identified by our members, with misapplication of complaints processes, inadequate initial assessment and, sometimes, ongoing weaponisation against doctors who are seen as difficult or complainers within the system. I will pass on to Dr Lau.

GABRIEL LAU: I'm Gabriel Lau. I'm a specialist in rural New South Wales. I'd like to make two points. Virtual care is a useful face-to-face adjunct but it seems to be used as a panacea. We seem to be over-relying upon it. It's not going to be a substitute for all the problems we're having out here in rural New South Wales. Only 6 per cent of our members think there has been any improvement since the last inquiry, and a lot of it has to do

with salaries, inability to recruit—very similar to what the paramedics are saying—workload due to staff shortages and bed block because we have insufficient hospital beds.

The CHAIR: Thanks, Dr Lau. This is directed to each of the organisations. Thank you very much for your opening statements and your submissions. You've clearly highlighted that there are a number of challenges. We are actually interested in hearing where there has been some improvement or progress or activity—some reflection on that, just at the start. Perhaps I could start with the Australian Paramedics Association, then I'll ask the Nurses and Midwives' Association and then ASMOF before passing to my colleague Ms Saffin. Briefly, are there any areas where you would say there has been activity or improvement?

SCOTT BEATON: I would like to say that the improvement is the recognition that we need intensive care paramedics in regional New South Wales. That program is still in its infancy as it's a four-year plan to roll this out. That is one increase. However, there are also extended care paramedics, which would be very helpful. However, we've seen no movement with them. It would be handy to have those in our larger regional centres. The 500 regional and rural paramedics that have been recruited shortly will be an improvement to decrease fatigue, if we can, but that's the only two things that we can see that have been an actual improvement on the ground.

MICHAEL WHAITES: I think one of the improvements we have seen is a willingness to consult from the new government and their commitment to implement safe staffing levels—our ratios claim—across five key areas. Once implemented, that will provide significant improvements in regional, rural and remote New South Wales. We've seen the incentive scheme implemented but with very mixed results. I might see if my colleague Paul Haines wants to add any other improvements.

PAUL HAINES: Thank you, Michael. Thank you, Chair. I'm just hoping to give a bit of a reflection about the rural and remote incentive scheme to give you an idea of some of the failures of the scheme, unfortunately. My understanding is that the rural and remote incentive scheme was designed to incentivise people to work for New South Wales, as well as retaining members of staff that currently work within the health service. As a clinical nurse specialist, I'm part of the hospital's leadership team, which is responsible for the running of the hospital in which I work. Other members of the leadership team are the nurse managers and the clinical nurse educators. As the senior staff of the hospital, we've had to work incredibly hard over the last few years to keep the hospital running and the staff happy.

However, a few weeks ago the leadership team was advised that our position numbers were not eligible for the retention bonus because we didn't meet a metric as set out by the ministry of health as a criteria for being eligible for this bonus. This, of course, has made us feel very unvalued and unappreciated as a work group, as we put an awful lot of time and effort into the hospital. Also, those around us or working within our teams were eligible. In terms of us as a group, we've been the one group—the leadership team—that wasn't eligible, which makes us feel pretty devalued. In fact, contrary to what the retention bonus was designed for, this has made us feel like we'd rather leave the hospital in search of an employer that actually values us.

Prior to this, the implementation—for those lucky enough to qualify for the bonus—has been very inequitable. At the hospital where I work, you have nurses who do exactly the same job being paid half of the bonus of the nurses they're working with. That's purely due to the cost centre the salary is costed to. To be clear, you've got two nurses doing exactly the same job receiving different amounts of the bonus to the tune of $5,000. As well as this, we've got different grades of nurses being paid different amounts of incentive bonus. All this has done is cause animosity between staff and anger towards the employer, and increase the likelihood of staff leaving our hospital, which is contrary to what I believe the scheme was originally set up for. In my view, this scheme has actually failed to achieve its objectives.

ANTONY SARA: I'd like to support Michael Whaites' comment about the willingness of Minister Park to consult. It's been refreshing to have a Minister and his office actually say, "Tell me what's going on," and then attempt to do something about it. It's such a marked change to the last 12 years. I'd also like to comment that the incentive scheme is seen as a plus but, as my colleagues have already mentioned, it's with mixed views. Our 1,250 members report no discernible effect from the incentive scheme.

The CHAIR: Any other improvements?

MICHAEL WHAITES: I think we should recognise that there has been progress on improving cultural safety for patients within the workplace for Aboriginal and Torres Strait Islander patients. We also note that there is a move to implement Aboriginal health practitioners into the emergency departments from next year. We think that is a good step.

The CHAIR: Thank you.

Ms JANELLE SAFFIN: I've got a couple of questions for the paramedics to do with the relocation to regional and rural New South Wales and the challenges to it, with some particular focus on cross-border issues.

SCOTT BEATON: I'm not quite understanding about the cross-border issues in regards to the question, sorry.

Ms JANELLE SAFFIN: It was because I hear from the paramedics that that's a real issue in terms of retention but also getting people there. I live in border areas. There are a few of us here who do, so we deal with that issue as well. They come and then they go to Queensland.

GARY WILSON: Sorry, Scott. Perhaps I can help with this, living a bit closer to the border.

Ms JANELLE SAFFIN: Thanks, Gary.

GARY WILSON: My area borders the Victorian State service. We hear regularly and frequently that New South Wales paramedics are transferring down towards the border with a goal to moving into Victoria for simple reasons: wages, conditions and, in some instances, culture. What we're doing is leaking paramedics into the border communities and then they're transferring interstate. That provides a constant flowthrough of paramedics, a loss of experience and a loss of skills. We're decreasing the amount of experience that our paramedics have by training paramedics for other states.

Ms JANELLE SAFFIN: Thank you, Gary. My general question was about the main challenges recruiting to the regions, but that's also part of it because the recruitment speaks to the retention. That's why I asked in particular around the cross-border issue. Is there any other comment on that?

GARY WILSON: With respect to recruiting to the regions, again, housing is critical. We've had instances where paramedics have been sleeping in cars and tents because there has been no accommodation. Providing financial incentives is a positive step. Again, there are practical issues with the system, as has been highlighted by the other groups, but those incentives don't help if you don't have a roof over your head.

Ms JANELLE SAFFIN: We understand the challenge with housing. Further to that, is your organisation working with NSW Ambulance on looking at housing issues and housing options?

GARY WILSON: I'll hand over to Scott for that one.

SCOTT BEATON: We have had meetings in regard to infrastructure. Unfortunately, it seems that it falls back to NSW Health in regard to accommodation, not NSW Ambulance. NSW Ambulance is more concerned about the ambulance stations—and rightly so—and the equipment and the paramedics to be there. They then pass the buck back to NSW Health to provide accommodation, whether that's the department of public works or whoever looks after government housing. But we're falling down. There has been no increase. We have houses in some of our communities—I'll give Collarenebri as an example—where there is a four-bedroom house that is the old station officers' house, as they used to term them. There have been no works done on that house in the last 18 years, and that house has now fallen into ruin where it's uninhabitable by anyone to live there. It's unfortunate that we can't get these people. We have also worked with NSW Ambulance and talked over the past six years in regard to a targeted recruitment for regional and rural people so that they come back to work where they're recruited from. However, every time this appears to just get off the ground, the person in charge seems to leave the job and the program never gets off the ground.

Ms JANELLE SAFFIN: Can I turn to patient transport? Is there any progress in funding that you know of for patient transport? Equally, the transport patient schemes that you know of, are they accessible enough for patients? I know in your opening statement you talked about taking people from residential care for scans and things like that.

SCOTT BEATON: We're unsure of the funding issues in regard to that, but non-emergency patient transport is run by the local area health service in our area out here. We haven't seen any increase in the last couple of years of more patient transport vehicles, but there seems to be some sort of contractual issue around what those patient transport vehicles can actually transport. They can't pick up a patient from a nursing home and take them to the hospital for a routine CT scan or X-ray; that's left to NSW Ambulance to do. However, patient transport can take a patient from the hospital back to the nursing home. So there seems to be some confusion there around why this can happen, yet in metropolitan Sydney, there are multiple non-emergency patient transport vehicles not only run by NSW Health but also by private companies, which do the majority, if not all, of these non-emergency jobs. There is quite a disparity between regional and rural areas and what happens in metropolitan Sydney.

Ms JANELLE SAFFIN: Thank you for that information.

Mrs TANYA THOMPSON: My question is to the Nurses and Midwives' Association. I firstly wanted to thank you for your frank and transparent submission. It was quite brutal, but I thank you for that. It's important

that you are open and honest about what the system is actually like at the moment. I note that in your submission you make reference that you don't feel that the scheme has been rolled out very well. My question would be what other measures do you feel would encourage nurses and midwives to relocate to the regions and actually stay in the regions if this incentive scheme is not up to par?

MICHAEL WHAITES: Of course, we're going to say reasonable, safe workloads and pay that will attract and retain. We see nurses leaving border towns, as Ms Saffin was asking about just a moment ago. Tweed has terrible trouble hanging on to nurses and midwives. We need access to housing—we see priority given to locums or to agency nurses on contract, so permanent appointments struggle to find housing—and access to child care, given the demographics of our membership. We know that incentive programs can work. I was speaking to a third-year undergraduate nurse at an awards ceremony, living and working in Port Macquarie. They had come to New South Wales from another State to do the nursing course here, very excited to be working in regional emergency care.

When I said, "That's fantastic. Where are you going to work? We desperately need you," she said, "Queensland. The pay is better." Devastating. So we know that the incentives can work. It is the inequitable application and the way each LHD interprets how it's applied. As we say in our correspondence, some Certified Nurse Educators (CNEs) get it, as you heard from my colleague Paul just now; other CNEs do not. You have people working side by side, with some getting the incentives and some not, so they're resigning to go and get a job where they can get the incentives. It needs to be refined. We've been asking the ministry to refine the policy. We're still not seeing the shifts that we need.

Mrs TANYA THOMPSON: Do you think that NSW Health has provided greater care for staff to speak up? Do they feel safe now to speak up with their concerns around workplace culture?

MICHAEL WHAITES: It's very mixed. Both across LHDs and within LHDs, some staff are able to speak with their management, survive the experience and, indeed, see change; others, quite frankly, are not. They're bullied and they're harassed as a result of raising those concerns.

The CHAIR: In terms of incentives, one thing we've heard has been a desire to have clearer, better pathways for professional development. The comment was made on one of our visits that it would be better for the incentive payments to have been put into a more comprehensive program around that. Do you have any reflections on that view?

MICHAEL WHAITES: What we need to do is have, with respect, more time than is allowed today to canvass some of those things. We're very keen to be working with both government and NSW Health as to how to do those things. The opportunity to align those sorts of incentive programs with the expansion of nurse practitioner roles, midwifery-led models of care, endorsed midwives and attracting people to regional, rural and remote New South Wales because they will be able to fulfil their career expectations makes an awful lot of sense.

Ms TRISH DOYLE: Thank you to you all for appearing today and speaking truth to power. That's needed. I'm going to ask a quick question, an important one, to the Australian Paramedics Association (APA), linking a couple of questions here. In your view, the mental health supports by NSW Health and NSW Ambulance for our paramedic workforce, are they adequate? And linking that to one of your recommendations, which is about the equitable distribution of paramedics at all levels, so the Intensive Care Paramedics (ICP) and the Extended Care Paramedics (ECPs), across regional areas—I will put that question. Do you think they're adequate, given the demand and the lack of equitable distribution?

SCOTT BEATON: The equitable distribution, as I covered earlier—the regional ICP program is only limited to the larger metropolitan centres. First up, we have ICPs in what they class as category A stations. In our area, we've got Albury and Wagga. We move through the north, you have got Orange and Dubbo. You've got Tamworth and Armidale. In central New South Wales, they are the stations that are getting the Intensive Care Paramedics being sent to. That leaves a large portion of the State that doesn't have that distribution of intensive care paramedics. So not only does it provide better coverage for their advanced skills that an Intensive Care Paramedic has but it also has the ability to train the other staff up. So the professional development of the other junior staff that are being sent out here to regional New South Wales—they can learn from the Intensive Care Paramedics and get themselves up to a level where they can then maybe apply. In regards to that side, there is not an equitable distribution across the state of ICPs.

As far as the mental health coverage goes, we do have staff psychologists that work around the state. However, they're also based within the sector offices. They do try to get out and around to see the staff but really at the moment that's by phone. If you're in Bourke and the staff psychologist is in Dubbo, you're not really seeing the staff psychologist other than phone consultations, which is the same that we have for our patients in a lot of these places, that do a video consult with a psychologist or psychiatrist. Whether that's acceptable, I'm not

100 per cent sure but it's a system that seems to, at this point in time, be working. However our staff psychologists are actually flat out and whether we have enough of them is for NSW Health to decide.

Ms TRISH DOYLE: Just further to that, Scott and Gary, is it fair to say that some of the younger paramedics, and even some of the students who are sent on placements out to these areas that don't have that coverage, are actually undertaking the work of an ICP and ECP which contributes to the stress and fatigue and therefore impacts their mental health? Would you say that that is happening?

GARY WILSON: Perhaps I might take that. In my area, we don't have ICPs by and large. Specifically to that question, the ICP role is very specialised. It does include advanced skills. It isn't so much that the junior staff or even staff like myself are doing the ICP role. What we're finding is the mental stresses of not being able to provide those services to our patients. So we feel hamstrung. We feel as though we haven't been able to provide the service that our patients need and the protection to our community because we don't have access to those skill levels. There are many people out in the regional areas, such as myself, who have no clinical pathway to advancement because, even in their latest documents, NSW Ambulance seems to be committed to limiting ICPs and ECPs in regional areas despite the undertakings and the recommendations.

Ms TRISH DOYLE: And the need.

GARY WILSON: And so it does create a lot of stress for us because you're getting junior staff who are dealing with patients that in metropolitan or major centres would get an ICP.

Mrs LESLIE WILLIAMS: I have a question for ASMOF. I'll give everyone else a break for a minute. You did, as we heard before, talk favourably about the Single Employer Model, and we know where it has been rolled out. But what do you see are some of the barriers for it not to be continued to be rolled out across the state?

ANTONY SARA: If I may, Chair, through you. The primary blockage has been the Commonwealth department of health declining to give the exemption under section 19 (2)—something like that—so that someone can be an employee on the state payroll, either the LHD or whatever, and still able to bill Medicare. We understand that blockages have been undone in respect to the trials in South Australia, Queensland and Tasmania. That has been the primary blockage; that is less of a blockage now. The other issue of course is that it has been used for the rural generalist pathway, and we think that it probably should be used for general practice training in its own right. General practice now has 13 to 14 to 15 per cent of graduates opting to enter into it compared to the 50 per cent when I graduated, so general practice is on its last legs. If this is one of the measures that we can use as a community, as a profession, as a health system to encourage young doctors into general practice, then we should try it. So it needs to be rolled out more broadly.

The coverage is via the state award. Then there is a payroll system in the local district, there is union coverage, there is HR expertise to address one of the perceived blockages to people entering general practice. Is it going to be enough? Not by itself. As we've seen in the medical press over the last few months, bulk-billing rates are going down, large numbers of general practices are marginal and general practices are continuing to close. The freezing of the Medicare rebates by Minister Abbott all those years ago has come to the point where general practice is not viable in many places. It's a mechanism to assist.

Mrs LESLIE WILLIAMS: Just a supplementary on the same issue. My understanding is in Murrumbidgee it's being used. Is that right?

ANTONY SARA: Yes, correct.

Mrs LESLIE WILLIAMS: So how did they get over those challenges, for example, with the Commonwealth?

ANTONY SARA: The Commonwealth gave the exemption that's required to allow the employee of the New South Wales health system to sit in a general practice and do Medicare billing. So the Commonwealth gave that exception. It was some years ago under some pressure, and the Commonwealth has subsequently given the approval to give that exemption for the trials in Queensland, South Australia and Tasmania.

Mrs LESLIE WILLIAMS: But not for further expansion in New South Wales?

ANTONY SARA: I'm not an expert in the space but as I understand it the Commonwealth has endorsed those trials in Queensland, South Australia and Tassie.

Ms LIZA BUTLER: My questions are around the First Nations people not feeling culturally safe in the workplace. Is there training being undertaken for other staff, to upskill them? And then on top of that, are there any measures currently being undertaken to attract more First Nations people into the healthcare workforce? If staff feel uncomfortable, then the patients must definitely feel uncomfortable. Especially around midwives, are there any moves for birthing on country initiatives?

MICHAEL WHAITES: That's a lot.

Ms LIZA BUTLER: It is a lot.

MICHAEL WHAITES: Please remind me if I forget some places. We are seeing some improvements in targeted recruitment for Aboriginal healthcare workers. That includes within nursing and midwifery. Cultural safety for patients is perhaps ahead of the cultural safety for staff. It is a requirement of our registration to ensure that we are aware of cultural issues for the people we are providing care to. It doesn't seem to flow so well to colleagues. On a number of occasions I've tried to look for the policy on cultural safety awareness training for Aboriginal and Torres Strait Islander colleagues within NSW Health. I haven't come across an awful lot. During the referendum our members reported targeted, ignorant racism: allegations that colleagues were going to lose their properties, that they'd be able to go walkabout whenever they wanted—terrible things that you would have thought disappeared last century.

The CHAIR: Sorry, were they comments made by staff to staff?

MICHAEL WHAITES: Yes, to staff. Correct.

The CHAIR: Made by staff to—

MICHAEL WHAITES: To staff.

Ms LIZA BUTLER: Was anything done about that?

MICHAEL WHAITES: The difficulty in reporting up racism in the workplace when complaints are made, our members tell us that what they receive is "It wasn't intended; you should harden up" sort of responses. We have a very long way to go. On a more positive note, around birthing on land, there is a very good case study—Waminda down in the South Coast. It gets referenced an awful lot.

Ms LIZA BUTLER: I know that. I got heavily involved in that one.

MICHAEL WHAITES: Excellent. It gets lauded everywhere, and so it should. It's not only a good model of culturally appropriate practice but midwifery-led practice that's saving money and having better outcomes—a win-win.

Ms LIZA BUTLER: So you're just looking at that case study now? It's not being implemented anywhere?

MICHAEL WHAITES: It's implemented. It's running. There needs to be more of it.

Mr CLAYTON BARR: I have a question for all three of you as groups, and hopefully it's just a brief one. All of your submissions seem to say that if you're in regional, rural or remote New South Wales, advancing and upgrading your skills is a real problem. Is that fair for me to take away as a summary?

ANTONY SARA: The staff specialist award has got a generous allowance for trainee education study leave. Our members rurally report that it is difficult to get the leave because there's no-one to backfill them. There is generally pressure against full use of those entitlements by management, so it is therefore logical to say, yes, it is hard for members to keep up to date.

Mr CLAYTON BARR: Nurses?

MICHAEL WHAITES: I might ask Paul to give an example of that, if he would like.

PAUL HAINES: It definitely is very difficult for our staff members to access education. It's very multifaceted with regard to the reasons why. We often don't have the educational support system around us to provide that education in the first place. The other issues are, as educators—for example, I don't have the resources to do the education, or the time. Myself and the other nurse educator that works in the hospital, we spend most of our time plugging gaps. We're supposed to be spending our time working with the junior staff, educating and upskilling these members of staff. Unfortunately, because we're just filling in gaps all the time because of lack of staffing, the education really gets put on the backburner. As a result, a lot of the initiatives that are being passed down from the Ministry of Health or the peak governing bodies don't get implemented because we don't have the time to do it properly. If staff do want to take the time to increase their knowledge or education, they sometimes have to travel for hours and hours and hours to go to a site that has the ability to provide the education needed.

SCOTT BEATON: It is certainly an issue. To be able to get people to upskill from regional New South Wales, it takes a commitment for them pretty much to move to Sydney for a period of time of up to three to four months to upskill to ICP, which is a long time to stay away from your family to be able to upskill. Ambulance does have a process of maintaining skills. We have education centres spotted around the entire State, where paramedics attend for two days every six months to maintain their current skills. But there's no increase of skills training done in regional and rural New South Wales; it's done in Sydney at head office.

Mr CLAYTON BARR: I have a question for all three of you. Recommendation 40 talks about Local Health Districts commissioning an independent review of workplace culture, as well as commissioning the conduct of independent and confidential staff satisfaction surveys. Have any of the three of your organisations seen any evidence of that being implemented since this initial report came down from the upper House? We'll go in reverse order, if that's okay.

GARY WILSON: The simple answer is no. I'm not aware of any progress on recommendation 40. We'll leave it at that, in the interests of time.

Mr CLAYTON BARR: I have an add-on specifically for paramedics. You interact with hospitals, so which survey would you do?

GARY WILSON: In New South Wales, ambulance is effectively its own Local Health District (LHD). We just have a very large geographical area. We've been conducting anonymous independent surveys since our inception as a union. As far as I'm aware, NSW Ambulance hasn't done so, certainly since the inquiry. One of the issues that we have similar to the others is in terms of culture. One of the things that keeps coming back is when we do the surveys, there is very little expectation of action or any meaningful outcomes, so we struggle with participation rates. If you look at even the internal NSW Health surveys, the higher you go in the organisation, the higher the participation rate tends to be. That shows where our members are in terms of their faith in the system.

Mr CLAYTON BARR: So a slightly different metric. Nurses?

MICHAEL WHAITES: We're not aware of individual LHDs progressing this. We point to the annual People Matter survey that is carried out by NSW Health and all other agencies. That data provides LHD-by-LHD results. We also draw your attention to the very slow progress made around cultural improvement and the fact that it keeps flagging, that there are burnout issues and other matters. We saw one LHD try to put a positive spin on a 0.1 per cent increase in people's perception about their workplace from a very low base. What we know is that the people matter surveys come out, but if I was a person conducting a business or undertaking (PCBU). I'd be going, "There are work health and safety risks here," and wanting them to intervene pretty strongly. Year and year passes. We would welcome, as we said, our committee of delegates unanimously passing a resolution seeking an investigation into the culture of NSW Health workplaces. We welcome discussions on progressing that review in one form or another.

GABRIEL LAU: It probably happens on a very ad hoc basis, depending on which hospital district you're in. I know we've certainly seen them in our area. I think the issue is that they're not done on a regulation basis. The real question is that everybody is saying the same thing and it doesn't seem to be acted upon. The common themes we've had in our submission seem to go into our surveys and yet we see nothing down on a year-to-year basis. It doesn't make sense if you're going to ask the question and if you're not going to do anything about the answer.

The CHAIR: To ASMOF, one of the issues that comes up repeatedly has been the extensive use of locums. It applies to agency staff within nursing but particularly to specialist medical staff. It also seems to be the way many small hospitals are kept going. It's expensive and it seems to undermine the ability to attract resident staff. I'm interested in your views on that and how you might go about solving it.

ANTONY SARA: We're not opposing the use of locums to backfill specialists. That's a reasonable use of locums. However, the culture of medicine and hospitals has changed over the years. There's a greater interest in work-life balance by young doctors. Sixty per cent of young doctors will not get on the training scheme of their choice. Some people take time out from a training scheme to do locum work because it makes a lot of money. It's partly due to work-life balance changes in the community. It's partly due to the very poor award in New South Wales. You can make $100,000 more north or south of the border as a staff specialist. The problem of rural and regional Australia is that there are not enough resources and not enough interest. To go back to that question, locums make sense for specialists to have leave and to do training and to take their families on holiday. We are not in favour of locums, but if that's the only way you can staff a small rural or regional hospital, it's better to have a third or fourth or fifth year out young doctor than have no-one. As we've already made the point, telehealth works for part of the time. It does not fulfil the need for a doctor on the site most of the day.

Ms LIZA BUTLER: That's where paramedics step in.

The CHAIR: Dr Lau, do you want to make a comment?

GABRIEL LAU: I completely agree with what Dr Sara is saying. I don't think the locum problem is going to go away because there is always going to be a problem of not being able to recruit an adequate number of junior doctors or senior doctors. When we recruit them—which is unlikely to happen with the current award,

but if we did recruit them—you're always going to have staff going out on maternity leave or other sorts of leave and we are going to have the need for locums to step up to the plate and offer medical service.

One of the problems we have in the rural communities is that we generally are pretty well isolated, where we're not able to have people available to come in and work a shift at the drop of a hat—either you're working or you're not, either you're employed by us or you're not employed by us—unlike in the metro areas, where there may be people working fractionally, where you can pull them off the bench. So there will be a need for locums. I think the need for locums would be less if we could fill up our permanent staff a lot better with better conditions and better awards, but the locums thing is not going to go away.

The CHAIR: I think the point is that we all recognise the need for staff to have leave backfilled and services to be kept running. I guess the problem that we're looking at here is that once you introduce more and more locum staff, you basically undercut the award staff, the resident staff. You essentially replace a continuous social capital of health professionals in a community with a fly-in fly-out discontinuous service. As you pointed out, they're often not specially trained. They're often mid-career doctors without linkages to professional development. I think it represents a significant issue on a number of levels for New South Wales.

Ms TRISH DOYLE: My understanding is that often in some of these rural and remote areas, nurses in hospitals without a doctor are calling our paramedics in, so our doctors on wheels are actually filling that gap as well. Is that not the case, APA?

SCOTT BEATON: Yes, that is a regular occurrence. There is actually a process called a Clinical Emergency Response System (CERS) assist, which is a clinical emergency response to hospitals. In some of our smaller communities—Brewarrina, Collarenebri, for example, out in western NSW — that happens more than once a week where the paramedics are called in to assist the hospital with patients.

GARY WILSON: In my area, I'm very fortunate in my community. We're well serviced by our General Pracrtitioners (GPs), who are excellent. They're struggling with all of the things that ASMOF has brought up, but in communities larger than mine, in my area, they often don't have a doctor available [inaudible] are being called in. One of the problems with that is, because we don't have ICPs in regional areas, the paramedics that are being called in are often quite junior. So it certainly would be another benefit, until we can fix the doctor shortage problem—it would be better if we had more senior clinicians being able to provide those services in an emergency.

The CHAIR: It might be that we need to explore a range of workforce model solutions to that. I have another question for ASMOF. We've come across some instances where quite large rural and regional centres do not have specialist obstetric cover. Are you aware of that as an issue through your organisation?

ANTONY SARA: Partly, Chair, yes. But it's not something that we are broadly across. We have a number of staff specialists in rural and regional areas in obstetrics, but the primary model for obstetrics in New South Wales has tended to be VMOs.

The CHAIR: I have one specific question again of ASMOF in relation to a specific recommendation about junior medical officers in rural areas getting the same allowances of accommodation and travel as metropolitan. We received assurances that has implemented. As far as your members are concerned, has that been implemented?

ANTONY SARA: As far as it has in the sense that if you start as an intern in a rural centre, if you come to Sydney you get upped by one pay grade. We're not too certain as to how the relocation or the accommodation expenses have been managed. If you're a Sydney-based young doctor and you go to Newcastle, Wollongong, other places, there will be home units, there will be houses that are owned by the district and you get the subsidised accommodation in those places. We don't know whether the same facilities or same arrangements have occurred for people rurally who come to Sydney to do a rotation. My suspicion is that it is not the case.

The CHAIR: Can I ask you to provide more information on that?

ANTONY SARA: As a question on notice? We can certainly do that in the next days.

The CHAIR: I would appreciate that.

CHOONG-SIEW YONG: Chair, I can add a little bit. Certainly, in my specialty, when we have rural trainees come across to do an urban-metro term, there's no sort of accommodation supplied by the LHD. This appears to be an LHD issue where they're not willing to pay for it, whereas it's mandated at state level for other junior medical staff.

The CHAIR: It would be important to get some follow-up from you as a question on notice on that. Thank you. That's very helpful. Thank you, all of you, for appearing before the Committee today. Thank you sincerely for your work. We may also send you some further questions in writing. You will appreciate that the time was

very brief this morning and our hearings are trying to get across as much information as we can. We will perhaps send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

ANTONY SARA: Yes, Chair.

CHOONG-SIEW YONG: Yes, Chair.

(The witnesses withdrew.)

Mr RICHARD WESTON, CEO, Maari Ma Health Aboriginal Corporation, sworn and examined

Dr MARION TAIT, Bulgarr Ngaru Medical Aboriginal Corporation, before the Committee via videoconference, affirmed and examined

Dr STEVEN SKOV, Bulgarr Ngaru Medical Aboriginal Corporation, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses from Maari Ma Health Aboriginal Corporation and Bulgarr Ngaru Medical Aboriginal Corporation, who are appearing in the room and online. I wonder if you could each confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses. Can you confirm that?

RICHARD WESTON: Yes.

MARION TAIT: Yes.

STEVEN SKOV: Yes, I have.

The CHAIR: There's an opportunity at this stage for you to make a very brief opening statement. We're requesting that each organisation limit that to a couple of minutes. We've got a timer here, and I'll interrupt you when you get over the two-minute mark. Mr Weston, would you like to start?

RICHARD WESTON: I'd like to start by acknowledging the traditional owners of the country that we're on. I pay my respects to their ancestors past, present and emerging. I'd like to thank the Committee for the opportunity to speak today. I'll be talking about what I'll refer to as remote New South Wales, which is the north-west and Far West, also known as the Murdi Paaki region. My evidence refers to that part of New South Wales. I'm the CEO of Maari Ma Health. We are a regional Aboriginal health service, and I'm based in Broken Hill. There are four key points that I wanted to make today. There is a need for a remote health strategy, including on how well current Commonwealth and state boundaries have been proven to drive health improvement and sustainability of provider networks. We think the Murdi Paaki region needs its own specific strategy to ensure that the decline in services witnessed over the last two decades is reversed and that residents of this region, who are predominantly Aboriginal—outside of Broken Hill—have access to the sustainable primary healthcare services that will ensure their ongoing health.

Secondly, Aboriginal community controlled health organisations, or ACCHOs, need to have a greater opportunity to participate in the planning of services. Health services development in remote and regional New South Wales must include ACCHOs being a meaningful part of that planning process, including helping to design what the planning process is or looks like. Our third point is that there should be an unrelenting commitment to developing the Aboriginal health workforce, not just as an equity issue but as a critical element of good primary health care in Aboriginal communities. Aboriginal health practitioners improve access and help improve outcomes in their communities. Our final point is that there should be a clear and urgent commitment to the National Cultural Respect Framework, which has been endorsed by all states and territories.

STEVEN SKOV: I'd like to briefly acknowledge the traditional owners as well, and I'd like to also echo the comments of the gentleman from Maari Ma. We would certainly agree with all of those points that he has made. But the statement we'd like to make goes along these lines: much has been made of the need to prevent hospitalisation and attendance at emergency departments in the public hospital system and to address the potential crisis in rural health care. We believe this can only be done by strengthening the non-government primary healthcare sector. This is where the majority of health care is delivered, where enhancements to capacity are likely to have the greatest direct benefit and where the opportunities for preventative health care are greatest. Yet the very great majority of the $833 million earmarked for rural and regional health care is to go into the New South Wales health system. We believe far more investment is required in the primary healthcare sector both in material capacity but also in measures that relate to quality of care and accountability measures.

Secondly, there is much in health department plans and vision statements about community-centred and collaborative partnership approaches. In northern New South Wales there is a formal partnership arrangement between the three Aboriginal medical services (AMS) in that region, the primary health network and the Local Health District (LHD) but, in practice, our dealings with LHD management are a frequent source of disappointment and frustration. There seems a culture of arrogance, a lack of listening, a propensity to make unilateral decisions that have a significant impact on primary healthcare services and their clients, as well as a seeming failure to understand that people live in the community, not the hospital, and that the primary healthcare sector is where the great majority of health care actually occurs.

In our written statement, we have provided some detail on initiatives that the three northern New South Wales AMSs, working collaboratively, have undertaken in our region to enhance our clinical services, highlight important public health issues, work towards demonstrable improvements in clinical care that should improve overall care in the region and reduce demand on the New South Wales health services, and, by creating a more supportive environment, increase our ability to recruit and retain health and medical staff.

The CHAIR: We might move to questions now. I will commence the questioning. Mr Weston, you mentioned the decline in services in the past decades in your area, and we've heard frequently about the difficulties of recruiting health staff, particularly medical practitioners. What is the situation in the north-west of the Far West both for yourselves and, more generally, from your observations about the health workforce, in particular the general practice workforce? How easy or otherwise is it to recruit those, and what can be done about that? I'll also get some advice from Bulgarr Ngaru as well, but I'll start with you, Mr Weston.

RICHARD WESTON: I can speak with authority about Maari Ma Health. Our footprint covers the Central Darling shire, the unincorporated area, the Wentworth shire and the Balranald shire. That's our area of operation. We are a regional Aboriginal health service. We have a full complement of GPs at the moment. We've got a number of GPs that have been coming out to work with us for more than 10 years. We are doing quite well in that regard. But, having said that, it's not an easy process to recruit general practitioners and other clinicians. We work very hard at it. We have a workforce consultant based in Sydney that does a hell of a lot of intensive legwork with different agencies, locum services, educational colleges—a whole range of those stakeholders—to put forward the opportunities that we have to work within our region.

We provide GP services into Broken Hill five days a week, into Wilcannia five days a week and three days a month in Balranald. Balranald is a relatively new facility for us. We are intending that that will build up over time. The balance of other services for GPs primarily comes from the Royal Flying Doctor Service (RFDS). They fly in and out. They complement services in Wilcannia and they provide some services in Menindee. We also provide visiting services to Menindee two to three days a week. We have pretty good GP coverage, but it's not easy for us to recruit GPs. We've just only got back to what we would call our full cohort of general practitioners following the disruptions of COVID and also some internal changes within our organisation.

The CHAIR: Dr Skov or Dr Tait, would you like to comment on that question?

STEVEN SKOV: Yes. There are certainly issues in recruiting and retaining GPs for our part of the world as well, but one of the strategies that we've adopted in the last couple of years is to try to change the model that we are offering for GPs to work in. In many places it can be a bit of a drudge for a lot of GPs. They just see patient after patient, Medicare bill after Medicare bill. They don't get to do other stuff. They don't have much engagement with the health service policy or service delivery mechanisms. So what we've been working on is changing that by offering GPs opportunities to try to get more out of them but to give them different things to do in their work practice. Some examples might be that we have regular regional conferences at which we address health service issues with management present and work on them together to develop new programs or to change program delivery between the clinicians working together with health service management, and then we move forward together on that.

One of the other initiatives that has been important is looking at quality improvement. In the past, GPs have been expected to do their CPD and their quality improvement by themselves, on their own time, and the health service hasn't known anything about it and hasn't had any oversight or vision on what GPs are actually doing. So what we've done in our region is that we now have systems whereby GPs get paid work time, a couple of hours a month, to work on case note audits and quality improvement that they work on and decide what they need to do. They work on it together; they get paid time to do it. But the health service also sees what they are doing and can see that their quality is focused on clinical care improvement. So we've tried to change the experience for GPs.

Ms JANELLE SAFFIN: I've got a question for you, Mr Weston. It's about Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). Before I go to it, I just want to acknowledge in your opening statement how you talked about strategy for remote, which is your area. I want to acknowledge that because often we put rural, regional and remote—the three Rs—together and remote can be quite different.

RICHARD WESTON: It is quite different, yes.

Ms JANELLE SAFFIN: The fact that both of you have been able to retain GPs means you are obviously good employers. My question is around IPTAAS and how would you like that changed so that it could work better for the patients and better for you and your organisation. I know sometimes you're forking out.

RICHARD WESTON: For a long time we've always run at a deficit around that support we provide to our clients and our people to travel because most of ours flows from away. We can't get treatment in Broken Hill.

The Broken Hill hospital is into Adelaide. Families have to travel and often stay there more than one night and sometimes for prolonged periods, and a number of people end up down there for end-of-life situations. We cover those costs.

We have a policy and we have a process that supports people with payments and support to get accommodation, and a support mileage allowance if they're driving down. Predominantly they do drive down or they might use some bus transport. And then we recruit what we can from IPTAAS. We generally run at a deficit—probably $100,000 or $200,000 per annum. That idea of transport, again, is a critical part of delivering an Aboriginal health service and a primary health service, particularly in a remote and regional area. Transport is a critical part of helping our people access services.

Mrs TANYA THOMPSON: My question is around workplace culture for staff across the board. I want to ask if you have seen any progress in the reduction of bullying and harassment and support for complaints handling for Aboriginal health workers in the sector.

RICHARD WESTON: Are you asking me?

Mrs TANYA THOMPSON: Both.

The CHAIR: We'll start with you, Mr Weston.

RICHARD WESTON: I'm happy to let the other guys go first and mix it up a bit. But I'll answer first. It's not an area that I've paid a lot of attention to, to be honest, other than in our own organisation. We've just been undertaking a clinical governance review within our organisation. It only just started last week and will finish this week. There are a range of issues that get thrown up. Some of it has to do with cultural issues and cultural safety, which is something you're talking about. We're dealing with that within our organisation through better defining our governance frameworks and better defining that interface between where does cultural governance sit, where does operational governance sit and where does clinical governance sit. Sometimes there has been a blurring of lines for us.

We have around about 100 FTE employees, and two-thirds of those—60 per cent—are Aboriginal people. So we have a cultural service. Our connection to our communities is very strong and powerful. The community influences the way we govern and the way we shape our services, particularly things like having walk-in clinics and having teams that go out into the communities. Sometimes that has included general practitioners seeing people in the front yards of their houses and those kind of things.

In terms of mainstream services, I can't really comment other than to say that my experience working in government agencies—which is really not great. I've only really done two years in a government department over the last 20-odd years. But I think there is always a challenge for Aboriginal people working in mainstream environments. I think one of the best ways to address those sort of challenges—whether it's bullying, cultural insensitivity, racism, discrimination and those kind of things—is to address that document I referred to earlier, the *National Cultural Respect Framework*.

I think the other thing that influences mainstream is the sort of partnerships that it has with the ACCHOs. Just being in the room or being at the table influences the way mainstream can deliver services. We need strong Aboriginal leadership as part of those partnerships or collaborations, which we should be taking for granted now with the Closing the Gap agreement. That shouldn't be an issue to be argued. As the other witnesses said earlier, an example we've had where we just haven't been at the table is in adult dental services in our region. They've been non-existent for about 18 months to two years. It's very patchy, anyway, at best.

The LHD and the RFDS have gone away together, negotiated and come up with a model and then we've been offered an opportunity to either take up some of those offerings or not. But we weren't part of the process or the conversations although we had been, over the last 20 or 30 years, involved in services out there. Examples like that, I think, where we have major policy—Closing the Gap is a major national policy that's been signed up by Commonwealth, state and even local government with really powerful and useful principles of partnership within them, but they just aren't being actioned yet. It's taking a while for mainstream services to come to that.

The CHAIR: I'm keen to pick that question up with Dr Skov or Dr Tait. I note, Dr Skov, that you made some pretty strong comments about the relationship with LHD in regards to lack of listening and so on. Perhaps, Dr Tait, you might want to pick up on this issue first.

MARION TAIT: Sure. We have a lot of good examples of where, when we've been invited to sit at the table, we work very well together with the LHD. Rollout of COVID vaccinations across the region was a huge success for the LHD and for our service. We partnered really well and were able to do that, winning awards even for the way that it was delivered. Where it falls down is when, for instance, we have an opportunity to affect a major health service issue and have been invited into the health service, such as recently with our concerns about

increasing rates of rheumatic fever and rheumatic heart disease across the region. Whilst all the clinicians in the hospital are very welcoming and willing to work with us, at times management shuts that down and we're excluded then from progressing what could be an excellent partnership that leads to real outcomes for the community. I can speak further to that, if you wish.

There are other examples where, like Mr Weston said, when we work well together and we have a seat at the table, amazing things can happen. But when we're not listened to or excluded, it often is at the detriment for not only our health service but also the communities we look after. We often have to agitate quite strongly to get a seat at the table and to effect change, like we did with our antenatal service recently with needing more time by our Aboriginal maternal infant health service midwife with a surge in the number of babies to be delivered over the next six months. We were unable to get the LHD to agree that we needed increased midwife hours until we'd agitated sufficiently. We have just been successful in hearing that we do now have that. Another health service in our region, Aboriginal medical service, also lost their AMOS midwife when the original midwife was seconded to another job and there was no replacement. Again, there was no consultation or even knowledge that the AMS had lost their midwife for some period of time. So we speak quite strongly, the three AMSs, together when things aren't going to plan and we can see that we are losing service or we have lost the seat at the table.

The CHAIR: Can I just congratulate you on your leadership in regards to that rheumatic heart disease initiative. We heard about that on our visit, the extraordinary description of you as a general practitioner really leading the clinical response there, identifying that issue and then putting the work together with the specialists—as I understand it, only then to have that unfortunately stopped by the LHD.

MARION TAIT: Yes, that's right. We've managed to continue, though, to educate our clinical staff within the hospital by attending the ground rounds. So Steve, myself and Tara Douglas, a paediatrician involved in that working party, have presented at both Tweed and Lismore ground rounds and are about to present in Grafton. But we can't see that the LHD has extended any further education, as they had planned to do to any of their other staff.

Ms TRISH DOYLE: Thank you all for the work you do and for being brutally honest. That's what we need and for the communities that rely on you. It's a lot of stress there. I might just start following on from that point, Dr Tait. That sort of workload balance that you have there, where you divide your time between services you provide for Bulgarr Ngaru and work that you do for NSW Health—sometimes you sit at the table and oftentimes you don't. How is that workload sustainable? What else do you need? Here's your chance.

MARION TAIT: I think one of the most important things is having management of Bulgarr Ngaru onside. That has helped us effect a lot of change and the fact that our CEO has also taken a position on the board of the LHD. At many different levels we can have a seat at the table to make sure that we don't lose services, and, indeed, we can intend to build on the partnerships that we already have. Because I'm supported so well by Bulgarr Ngaru, as are all of our GPs, it helps us to retain and recruit staff. As Steve highlighted before, we have 10 GPs working here and across the region at the other AMSs we see an increase in the number of GPs wanting to come and work in the services.

A number of our GPs also work for the LHD. I've worked for the LHD for five years with their sexual assault service. I think the professional kind of relationships that we have with the doctors in the hospital helps us enormously. We just also need their management to see that those relationships are worth continuing and respecting and continuing to build, I think, to actually get us all on the same page. And we're very keen to remove work from the LHD. We know how much they're under pressure and under the pump. Actually being able to look after mental health patients or opioid replacement therapy patients or do a lot more of the shared care antenatal work actually relieves the burden of work that the LHD does and enables us to provide more comprehensive holistic care for our patients.

Ms TRISH DOYLE: Excellent. Mr Weston, your very diplomatic responses so far—

RICHARD WESTON: Are they? Well, I will try to be less diplomatic.

Ms TRISH DOYLE: Do you think there's enough work being done to address your very specific and unique workforce and funding considerations for remote regions? What else is needed?

RICHARD WESTON: I think you've heard it from the other service there earlier on. It was about a stronger investment in primary health care. That's our bread and butter. That's where we make a huge contribution to the system.

Ms TRISH DOYLE: It's good to hear that from you too.

RICHARD WESTON: It's not just because—it's driven by the needs of the Aboriginal community. The onset of chronic disease comes much earlier for Aboriginal people than it does for non-Indigenous people. We

have a chronic disease strategy that we've been running for a long time—for 20 years. We have what we call a Keeping Well program.

Ms TRISH DOYLE: So early intervention, more investment—

RICHARD WESTON: Prevention, early intervention and management of people who have a chronic condition—you know, with care plans. That's the part of our service: our Aboriginal health practitioners can go out into the community, follow people up, making sure they're sticking to their regimes, checking in on them.

Mrs LESLIE WILLIAMS: I'm going to go back to the issue of IPTAAS, which was raised by the Deputy Chair. Acknowledging that there has been an increase in the reimbursement, clearly it's still a significant cost to your service. I'm sure that's the same across the board. Do we need to see further increases in reimbursement, or is it about the eligibility criteria? I'm going to declare an interest, because I represent Lord Howe Island. The further you go out and the more remote you are, the more the eligibility becomes an issue. I am just interested to hear comments from both organisations in relation to IPTAAS, because it's something that is raised with me often, particularly from my Lord Howe Island constituents.

RICHARD WESTON: Yes, I can't speak for Lord Howe.

Mrs LESLIE WILLIAMS: No, but it's about the remoteness and eligibility.

RICHARD WESTON: Yes. I think we have similar issues. The further you are from services, the more it's going to cost. That's just a fact. We've been operating for nearly 30 years, our organisation, and IPTAAS has never been able to cover the full cost. It's just how it is. You could change eligibility criteria. Our obligation is to our community first. We wouldn't comply with eligibility criteria that prevented our people from getting the help that they need. We would somehow find a way, through whatever reserves we have or through our Medicare income and that sort of thing that helps subsidise what we get out of IPTAAS.

I can't speak categorically about this, but I suspect that there are people that we transport that don't get a refund, aren't eligible for IPTAAS. But we do it anyway as part of our service. Maybe IPTAAS needs to be funding into what an Aboriginal community-controlled model of care is that sees transport as a critical part of primary health care and access to services and care, that supports an unrelenting commitment to growing an Aboriginal workforce in areas where there are high Aboriginal populations. We care the most about our people and it makes sense to do it. Anything that improves access should be supported and understood, and that's where the investment should be.

The CHAIR: Thank you. Dr Tait or Dr Skov, do you want to make a comment on that?

MARION TAIT: We have found that we've needed IPTAAS to get patients to Brisbane for tertiary-level care that we're unable to access in Lismore. It's quite time-consuming and quite complicated. It's very difficult for patients to front up with the money and then to rely on a receipt process to get some of that funding back. So, yes, we often try to scrabble other funding together, if we can, to support our patients getting there. We generate enough Medicare to be able to employ transport drivers at Casino to actually assist our patients getting to all of their appointments, but we need IPTAAS to be easier to get our patients further afield to Brisbane and to the Gold Coast.

The CHAIR: Can I just flag with both of you that the Government did actually make significant changes to IPTAAS as a result of the recommendations of this report? In fact, there was almost a doubling of the rebates. So I'm just going to foreshadow a question perhaps that we would like you to give us any more information about whether you've noticed any changes, with those changes to IPTAAS, for your organisations. If not, then it would help us to know why that has been the case.

Mrs LESLIE WILLIAMS: Can I also add, Chair, it would be important to know what other changes could be made. Yes, the amount was doubled, but it seems to me from the comments we just heard, particularly from Dr Tait, there are still some issues around it in terms of you have to have up-front money, and it's time consuming.

The CHAIR: Absolutely.

Ms JANELLE SAFFIN: It's a reimbursement model.

The CHAIR: If you don't mind, we'll follow up with that.

Ms LIZA BUTLER: I'm really keen to know what improvements you would recommend to reduce the prevalence of treatable diseases in Aboriginal communities. If you had a wish list, how would you address it?

RICHARD WESTON: Well, that's what we do. That's our core business.

Ms LIZA BUTLER: Are there gaps there that we could fill?

RICHARD WESTON: I think one of the things we used to have in place that finished probably about 10 years ago—Maari Ma managed mainstream health services outside of Broken Hill. These were basically small hospital and community health centres. We were funded by what was then called the area health service, but is now called the LHD, to employ a general manager and an operations manager. We managed those and we really helped improve access. But they weren't really in-patient facilities. They were small hospitals offering emergency GP care through the RFDS and ourselves. But we were able to focus on primary health care, so the preventative approaches.

Again, I just say that an Aboriginal health workforce in our region is critical to getting better health outcomes. We have a service that has good GPs. We have good nurses; we have good clinicians. We have a few gaps in some of the allied health and other specialties, but we have a model where our non-Indigenous clinicians work really closely with Aboriginal health practitioners. The Aboriginal health practitioners help them get access to the people that GPs need to be seeing. I think it's a very powerful model. Just greater investment, and greater recognition that in a remote area, primary health care, preventative measures and early intervention, and strategies around early childhood health and early childhood education should be the priority for us. That is what we think.

We've also said in our submission that Broken Hill Base Hospital could be managed under a Sydney LHD. We've got this LHD that tries to operate the way the rest of the health system does, but it's dealing with a very small population and it's dealing with a population that is highly represented by Aboriginal people. Aboriginal health should be core business.

Ms LIZA BUTLER: Can I just ask a follow up question, if I may, around the early childhood health and education? We've heard from some other parts of New South Wales that children are presenting to kindergarten with health issues that have not been picked up. Are you finding that in your area as well?

RICHARD WESTON: We run services that try to address those issues. We do early childhood education work. This is prior to kindergarten. We have the Home Interaction Program for Parents and Youngsters (HIPPY) program, Aboriginal Families as Teachers and playgroups, and all of those are designed to address and pick up those developmental issues. We have a Healthy Start team which looks after the clinical side, maternal and infant health, immunisations and all those child development issues. But having said that, we still pick up issues around things like Fetal alcohol spectrum disorder (FASD). We struggle to get speech pathologists in our area, so that's an area that we're concerned about. I think we have a very good model and we've got an injection of Commonwealth funding through a program called Connected Beginnings, which will help us integrate the early education and Healthy Start work we do across our region. We still find issues.

Ms LIZA BUTLER: Dr Tait, you look like you had something to add on both of those.

MARION TAIT: I certainly agree with everything Mr Weston said. We also really struggle with those areas where the LHD has staff shortages. We haven't been able to access a speech pathologist now for quite some time in Casino. For all our patients that live not on the coast, which is the majority of them in the Richmond Valley, obviously, and also in Clarence Valley, it's very difficult to get access to paediatric health, to the point that we've had to employ our own. We now have a paediatric Occupational Therapist (OT) that comes to our service that we invoice separately, because we just can't get our kids seen otherwise. We're trying to recruit a speech pathologist so we're not dependent on the forever-changing staff shortages that happen with the LHD. I know they're having a lot of trouble recruiting to those positions in community health.

I think also around that, it would be great for the LHD to consider more resources into the public health sector, so more of that spoke and hub model which we've tried to implement really well at Bulgarr Ngaru, where we have visiting medical specialists from the LHD coming to do clinics in the AMS because our clients frequently don't feel comfortable attending, or are unable to travel, to the LHD. We actually have those clinicians coming into our trusted health service where our patients are very keen to come and engage. We often see we're the first people to lose services. If the LHD is a little bit short, all the spokes are pulled back into that hub model, and again our communities are left without access.

Mr CLAYTON BARR: I want to thank both groups for the contribution you have made to this inquiry process. It's something outside of the square of most of the submissions we get, so please stick with us. I want to very quickly ask a really simple question. Recommendation 34 is to formalise partnership with the ACCHOs. Is that happening or not happening since the inquiry?

RICHARD WESTON: No, not happening for us.

Mr CLAYTON BARR: Okay. Our job is to follow up on the recommendations of the Committee and to talk to NSW Health about what they are doing since the inquiry. If the answer to that is no, the answer is no, and we can ask that question.

RICHARD WESTON: Yes, that's right. There's a lot of good intent, but there's not much in actual—from our point of view anyway. The other fellas might have a different view.

The CHAIR: Dr Skov or Dr Tait, do you have a comment on that question?

STEVEN SKOV: Yes. I suppose it's a mixed answer to that question. Just recently there has been a formal partnership agreement signed between the three AMSs and the primary health network and the LHD, so that's been a welcome development. But in other areas, it's one thing to have a partnership at that sort of level; it's another thing to actually have things work on the ground once you get down into sort of middle management. We have developed an MOU between one part of the LHD to do with alcohol and other drugs around opiate replacement therapy that defines how it's all supposed to work.

That's going reasonably well. But in other areas, as Dr Tait pointed out, say, in relation to the midwifery service, it can be really difficult, and the partnership just doesn't work at all well a lot of the time, along the lines of the unilateral decision-making that's gone on in the past. So I guess it's a mixed answer. In some areas it can work, but in a lot of other areas there's really a need for a much better approach from the LHD.

The CHAIR: I think, Dr Tait, you might have made the comment earlier that your CEO is now on the board of the LHD. That also, I think, was a recommendation to the inquiry, that there be at least one representative Aboriginal community on the boards. I do want to note that, because I think, Dr Tait, you were suggesting that may lead to some better liaison and perhaps help address some of these issues about MOUs working better.

MARION TAIT: I'm hoping so, yes.

The CHAIR: Hoping so. Fair enough.

MARION TAIT: Scott's intention is very much that, across the region, Aboriginal people have access to better health care while he's sitting on that board, I'm sure. Not that I would speak for him absolutely, but yes.

Mr CLAYTON BARR: Mr Weston, has your LHD got Aboriginal representation?

RICHARD WESTON: They do. They have about three Aboriginal people on. We even had Dr Andrew Refshauge chairing the committee. He only retired this year. He's got a connection to the region. One of his tasks was to come out and fix the relationship between the LHD and Maari Ma but he didn't. We haven't seen much progress on that. I would just like to add that in spite of what I'm saying about formality of agreements, I don't believe that that's there but it doesn't mean that we're not working with the LHD, particularly our clinicians and health workers. We do lean on those services but some of the rhetoric, when they say they have a commitment to working with Aboriginal communities and Aboriginal organisations, the point's already been made that that intent or that rhetoric is there but in actual fact the formality isn't there. We have a pretty high standard for it because we were, at one point, managing a sector of outlying services. We know what that looks like.

The CHAIR: Thank you. I thank the witnesses for their time today. We may be sending you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

RICHARD WESTON: Yes, I am.

MARION TAIT: Of course.

STEVEN SKOV: Yes. Are we able to add any extra detail to some of the answers that we've already given to some of the questions today?

The CHAIR: Yes, by all means.

Mr CLAYTON BARR: Are you in a tent, Dr Skov?

STEVEN SKOV: No, I'm in a campervan.

MARION TAIT: In Tasmania.

Ms TRISH DOYLE: We thought so.

The CHAIR: Thank you, Dr Skov, for taking time to give evidence. The Committee will now take a short break. The hearing will recommence at 11.00 a.m.

(The witnesses withdrew.)

(Short adjournment)

Professor VICKI FLOOD, Director, University Centre for Rural Health, Northern Rivers, before the Committee via videoconference, affirmed and examined

Dr CHRISTINE AHERN, University Centre for Rural Health, Northern Rivers, affirmed and examined

Professor MEGAN SMITH, Executive Dean, Faculty of Science and Health, Charles Sturt University, before the Committee via videoconference, affirmed and examined

Professor JULIAN GRANT, Acting Head of School and Professor of Nursing, School of Nursing, Paramedicine and Healthcare Sciences, Charles Sturt University, before the Committee via videoconference, affirmed and examined

Associate Professor MICHAEL CURTIN, Head of School, School of Allied Health, Exercise and Sports Sciences, Charles Sturt University, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our witnesses from the University Centre for Rural Health, Northern Rivers (UCRH), and Charles Sturt University (CSU), appearing in the room and online. Can you each confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

VICKI FLOOD: Yes.

CHRISTINE AHERN: Yes.

MEGAN SMITH: Yes.

JULIAN GRANT: Yes.

MICHAEL CURTIN: Yes.

The CHAIR: Everyone has—excellent. There is an opportunity for each of your organisations to make a brief opening statement. We've requested that that be limited to two minutes.

VICKI FLOOD: I'm going to make that statement on behalf of University Centre for Rural Health, Norther Rivers, on behalf of my colleague Dr Christine Ahern and myself. We're here representing University Centre for Rural Health, Northern Rivers. It's based in Lismore and surrounds. We work closely with [audio malfunction] university partners, the Local Health District (LHD), the primary health and community partners to support education, research and workforce development. We train about 50 long-stay medical students and about 700 allied health and nursing students each year in clinical rural health placements in northern New South Wales.

Northern Rivers is an area that has gone through a lot in the last several years, as you would appreciate, and this is impacting on our health workforce. People are stretched. We are acutely aware of the challenges for our students and those who choose to stay and be part of that health workforce. In practical terms like accommodation, having services to support their families and, particularly, opportunities for career development, we know that people who are acknowledged, valued and see the opportunities, they can develop more and are more likely to stay in the area. They want to be able to contribute to the health of the populations they serve, along with meeting the practical needs for their families and for further training and development. If they don't feel these needs can be met in the regions, they are more likely to move on.

It is also of vital importance that we support a strong primary health presence for the community as this will ultimately relieve the pressure on our hospitals and support our health workforce more broadly. With the aging population—we have an older than usual population in Northern Rivers—resources that we put into prevention now will pay for themselves in the long term. Vulnerable population groups such as the Aboriginal and Torres Strait Islander people also need to continue to be supported and they need to be part of leading those solutions. We would like to encourage the Committee to consider the important role that university departments of rural health and rural clinical schools can play working alongside health and community partners to support the pathway for health careers, and in ongoing support for new graduates. This is important for all health professionals—not just medicine but also nursing and midwifery, and allied health.

MEGAN SMITH: Thank you for the opportunity to appear before the select Committee today. We are, on behalf of my colleagues, representing Charles Sturt University, a university with campuses located in regional New South Wales and with strong connections to our communities. We educate students across a profile of health professions meeting the needs of the regional health workforce in medicine, dentistry and oral health, nursing and midwifery, and allied health. Our graduates are contributing significantly to the rural health workforce with up to 75 per cent of our graduates each year choosing rural practice on completion of their studies.

At the end of 2025 we will graduate our first cohort of 37 rural doctors, who will have had 100 per cent of their training in a rural location. In addition to our rural cohort, each year we have a commencing cohort of over a thousand nursing students, over 200 paramedicine students and over 500 allied health students across a full range of the scope of allied health practice. We recognise there's a need to grow this workforce to meet current and future rural demands and to contribute to the ongoing training needs of rural health professionals, so we're very much looking forward to having a contribution to this conversation.

The CHAIR: Thank you very much to all the witnesses who have appeared. I'll commence the questioning. This is a general question to both organisations. This inquiry is looking at the implementation of the previous upper house inquiry recommendations. I'm interested to know if, from your perspective, you've seen improvements in the regional health system as a result of the recommendations from the previous rural health inquiry, in particular in regard to workforce and workplace culture and funding issues. Who would like to tackle that one first—any evidence of improvements?

CHRISTINE AHERN: I will just simply say that, as a primary care physician, we realise there's a crisis for GPs—which isn't particularly the focus of this inquiry—but we need to be able to send our patients, refer them to appropriate places and we're actually not seeing that. We're seeing diminishing referral pathways at the moment, despite, I think, everybody's best efforts. I believe that that was exacerbated in Lismore by the flooding and all of the social determinants of health inequity and the impact on the workforce. I would also just like to say that traditionally in the Lismore-Northern Rivers area we have relied on cross-border cooperation to refer our patients, and we saw in the recent pandemic that that's very fragile. I think there are genuine attempts, but all of the forces around are conspiring against us a little bit in the Northern Rivers.

The CHAIR: Could I just clarify, you mentioned—and we have heard of the crisis of GPs and can I assure you, that is an issue for this inquiry because it affects the staffing of regional and rural health facilities, so we are extremely concerned about that. But you link that to diminishing pathways for ongoing referral. Is that diminishing pathways of referral to general practice or by general practitioners into the health system more broadly?

CHRISTINE AHERN: I would say both, but from the GP perspective, to other agencies. And by that I don't just mean other specialties, I mean allied health. For instance, it's not helpful for me to pick up a global development delay in a young child if I don't have an occupational therapist (OT) or a speech pathologist to refer that person to. It's almost a disservice to find that out for the family and say, "Sorry, I can't do anything." It's referrals onwards and outwards from general practice, but with other specialties, we are lacking. For instance, we have one ear, nose and throat (ENT) surgeon in the Northern Rivers, so we rely on the cross-border referrals quite a bit. And, as I said, that's fragile at the best of times. The pandemic made it more so.

The CHAIR: Would anyone else like to make a comment about observed improvements since the inquiry?

MEGAN SMITH: I'm happy to make a comment on it. I would say overall—and I had the opportunity to speak to the original inquiry, so reflecting on the two years since then—I don't think I've seen a really substantial uptick. I think we've continued to have a commitment and a trajectory about trying to improve rural health. But in terms of specific direct changes as a result of the inquiry, I think we are yet to see those in any substantial way. I think there have certainly been initiatives, there is the *NSW Regional Health Strategic Plan 2022-2032* that's been developed and there are ongoing initiatives. But as a collective response to the original report, I would say that I haven't seen that particular change.

One of the things we brought to those recommendations was around the support for students to undertake their training placements in rural areas. And as yet, really, I think we're still very much seeing our Local Health Districts very committed to education and wanting to be involved and seeing the needs, but also being challenged. We also respect, coming off the back of the pandemic, how everybody's been challenged, and just delivering service has been the focus, but of course education for us is about thinking towards the future and I think we see that as still to come.

The CHAIR: Professor Flood, do you want to make a comment?

VICKI FLOOD: Yes. I will add to that. I think one of the things that we have seen improvements on is around connecting with community services, for our student placements, in some of those community service areas, as an opportunity that's just been—we've been working on it and we have been exploring in aged care, for example, and in schools. Community service-type placements have been a way that we've been able to support student placements and therefore their experience and potentially for their workforce development. But it will take some time for that to play out in terms of longer-term impact, and even evaluating that in a robust way. We really need some more time for some of those innovative approaches that we're taking.

The CHAIR: And, of course, those placements are not actually NSW Health.

VICKI FLOOD: No, they're not NSW Health.

The CHAIR: You referred to aged care.

VICKI FLOOD: That's exactly right. But if we can support the people living in those placements, it has a direct impact on the types of care and emergency presentations, for example, into the emergency department (ED) if those older people are being well resourced and supporting their mobility and function in their aged-care centre, so we do know that that helps.

Ms JANELLE SAFFIN: I have two questions and one's for both organisations. Post the 2022 upper house report that we're now examining the implementation of, were your organisations contacted as part of the development of the *NSW Regional Health Strategic Plan 2022-2032*? We're just curious to know if there was any sort of broad consultation.

VICKI FLOOD: We had an opportunity to have input to that plan. It was a brief, online opportunity. We could review the plan and provide any comments, which we did, and we circulated among our staff. That was the extent of the consultation.

Ms JANELLE SAFFIN: You could review the plan after it was done?

VICKI FLOOD: Well, it was in the process of its latter stages of its development that we had an opportunity to have input and to give an indication of what we saw as the priority areas. It wasn't finalised at the point when we had an opportunity to review it, but it was near completion.

Ms JANELLE SAFFIN: Thank you. And Charles Sturt University?

MEGAN SMITH: Our opportunity was really connected through a lot of our Local Health Districts, when there was local input. In terms of us having that sort of direct individual consultation, not as much. It was more a distributed opportunity to have input, and given the university has footprints in different Local Health Districts, that was predominantly the way it felt like we were connected into that. Michael or Julian may want to comment as well.

MICHAEL CURTIN: I would agree with what you said, Megan. Absolutely.

JULIAN GRANT: I certainly had no further consultation in any of the roles that I was in at that time.

Ms JANELLE SAFFIN: The second question is for the UCRH. Your submission highlights about health workers and adequate housing or even any housing. What, in your perspective, can be done to better support health workers in that area? I know that's a big question. Everyone has to grapple with it, but just any insight.

VICKI FLOOD: One of the things that we observe is that it's quite difficult for people when they're first coming, moving to an area, to get housing quickly. We had some student housing, for example, and we are always on the lookout for increasing the student housing. And that's helpful for those students, but it means that we put a limitation on how many students we can take in because of that housing. But we are also approached fairly regularly from the Local Health District to support new health workers who want to move into the area, who cannot find rental or housing in their first few weeks and months, and they need something to set up.

Occasionally we can help them but usually we can't, because of the pressures on our students' needs. We need some sort of short-term reasonable housing for new health workers moving into an area with their families and we just need to somehow make that available. As people spend more time in the community, they seem to be able to sort out their housing needs, but it's that start-up phase which is particularly problematic. And I would say there have been instances where people have turned down positions locally because they could not find any housing.

Mrs TANYA THOMPSON: My question is for Charles Sturt University and it has two parts. What are your primary concerns around regional training to meet health workforce needs? And then, are there any particular health professions that would require more assistance from government for students?

MEGAN SMITH: I'm happy to go forward. Our primary concern is overall the pathway. When we look at it and we see our students coming through at the moment—and I think about a student who's commencing their studies, say, as a nursing student—I think getting that student through their education at the moment and getting them into the workforce at the end of it is a challenge for us. And it's not so much the education of that student, it's the pieces along the way in that puzzle.

Of particular concern for us is the placement component for that. If I give you the example of a regionally based nursing student who wants to undertake a placement in their local area, that actually may be very difficult for them. They may need to relocate during that period of time. Financially, that comes at an impost for that student then having to find accommodation that they have to pay for, money for the travel and any lost income

that they may have had that they were receiving during that period of time. Sometimes those burdens become so much for some of our students that they choose to discontinue their studies or they prolong those studies. When we look at it and see the important role that we play in ensuring that of those 1,000 students who come into our programs 1,000 students exit in a timely manner into the workforce, there are a number of barriers along the way to being able to deliver that. That's probably my number one concern.

If I said I could change one thing for us to improve the supply of health workforces and us to be able to scale that in a rural location, it would be being able to focus particularly on being able to lift that capacity within our regional areas. I will say one thing about your second question, which is what are the disciplines that we're worried about, and then will hand to my colleagues to add their comments. The two for me are podiatry and radiation therapy. They're two professions that I'm particularly focused on. Podiatry because it is a small, essential profession for us, but the numbers of students in regional areas choosing to study podiatry are dropping right down and we are seeing really small numbers, such that we're worried about the volume of that profession upon graduation. I think that's not just our problem, but that is sector wide. So I think there are some very clear professions that we need to look at the total number of graduates we're going to have in a number of years and what that's going to mean for our health workforce.

The CHAIR: You mentioned podiatry there. Sorry, did you say radiation imaging or therapy?

MEGAN SMITH: Radiation therapy is our other one. It's a similar scenario. These are the small but significant professions where, in fact, from a university point of view, there are quite small numbers training but really big demands in terms of the amount of students. Some of these factors are the number of students who are interested in it, but I think that's the question around what government could do. And it's to look at what could incentivise some of these really small but significantly important professions in rural locations.

The CHAIR: Just to be clear for myself, the issue was that you need more placements in local health services—

Mrs TANYA THOMPSON: That they complete their placement.

MEGAN SMITH: There are two components to that. The first one is that a big, primary concern across the whole of our future health workforce is about the number of placements. Separating that out, though, to particularly focus on some disciplines that are particularly problematic, one of those is podiatry, and that's a broader conversation than just placements.

Ms TRISH DOYLE: Thank you, all, for appearing today, putting forward your ideas and backing that in with expertise. I'm going to turn to the UCRH for a moment and ask you about your submission, where you discuss the palliative care GP registrar program that was discontinued—or funding ended. How did that operate, including the monetary aspect? And why do you put this forward as a model that was successful?

CHRISTINE AHERN: I can probably speak to this. When I was the director of training for the GP training at the time in the region, two very keen registrars wanted to pursue their palliative care skills. We had a collaboration with the Local Health District and the palliative care physician there, who was the person offering the governance and overseeing it. We then came up with a model that worked Medicare-wise that would pay for the registrars to do this work. They were able to do home visits in a timely manner that prevented the crises that often take people in a palliative care situation back to hospital, which (a) is expensive and (b) is not what these people want. They actually prefer to be at home, and many of them express the desire to die at home.

In this pilot, what we did see was that more people against the controls who were under this program did manage to actually stay at home with less crisis admission to hospital and more dying at home. It was successful. I'm going to say two more things to that. One is that with voluntary assisted dying coming on board as of tomorrow, it's going to be essential to give people the palliative care option. For that, palliative care has to be working. We don't want people opting for Voluntary Assisted Dying (VAD) simply because that palliative care is not working for them. Obviously, they can opt for it if they want. So that would be important. I do believe our local training hub that we work with closely is looking to set up a training pathway in palliative care for the GP registrars in their hub. I hope that will be a different model that will help that training. But, of course, we do need enough GPs on the ground to enable some to be able to pursue that as their main interest.

Ms TRISH DOYLE: Thank you for that. CSU, you talk about the direct financial support for students that's required when they're undertaking compulsory clinical placements. I note that you indicate that there's a positive here because we've got State and Federal governments announcing plans to provide more support. What sort of feedback from students have you received and how dire was that feedback? I've heard some anecdotal stories of substandard accommodation in places, which makes that placement almost impossible to finish. Besides housing, which we've investigated, what are some other sorts of support, based on feedback? How can you, as the university, support those students? How have you been?

MEGAN SMITH: The accommodation is a really important one. If you've heard that message, it can be really dire. To some extent, people just don't go. It's a thing where you make a choice that if I don't have appropriate accommodation, I just don't take the placement up and I drop out. That's dire for the longer term. Living in cars, couch surfing and driving long distances backwards and forwards is probably the other component of it. I think the other one that's really raising its head for us is the cost of loss of employment for the period of time and the ability to maintain short-term employment while you're working. Where our students in the past may have been well supported and could afford to be a full-time student, we're seeing a much greater part-time student option. Students are tending to want to stay located in their home location and come to the university infrequently as they try to manage all of their life pieces.

I think it's the loss of income that is becoming increasingly more difficult around placement and the transience around that. Students will look to how can I juggle that and what's the timing of it. I did read the UCRH's piece around some of the medicine, and we're looking at those employment models where we can look at how do we actually support students with employment in the sector matching up against their education. There's some real opportunities for us to think about. We saw that in COVID with medicine. But a number of our health services are raising with us about the potential for allied health to have allied health assistant roles in between time to meet their workforce needs and our student needs. We've always had nursing students who've had various levels—particularly enrolled nursing and assistant nursing roles. Solving that issue for us is going to be a particular piece that would make a difference around students' ability to be financially viable.

The CHAIR: Professor Curtin, I think you raised your hand there? I noticed that Professor Flood has her hand raised. Maybe it was Professor Flood, sorry.

VICKI FLOOD: It was me. Just to add to what you've been saying from Charles Sturt University, we see similar. But also, we see a lot of students are not wanting to do rural placements because they do not have cars or they don't have transport that they can use. They have to be able to have cars. We have a small number of pool cars, but we don't have enough for all of our students, so that seems to frequently be a barrier as well. We do know longer placements mean that they're more likely to stay rurally too, so that's an aspect that we really like to support our students to do. That all ties into what the Charles Sturt University was just saying around being able to financially support them for a length of time and being away from their usual support services.

The CHAIR: Professor Curtin, now you have your hand up?

MICHAEL CURTIN: I do. It's on the same thing but I think that what we're seeing is a diversity of students as well—we've got a lot of mature students, a lot of students with children—so it actually makes it more complex these days with the expense of placements for people to go far from support services. They might have family in another town or whatever they can go to, but if they don't and having to be away from—it's getting to be really, really difficult. There has been a real change because of that. We want to encourage that diversity into our courses as well, so it's getting that balance.

Ms LIZA BUTLER: My question is to Charles Sturt University. You have 37 rural doctors about to graduate. If we think that 75 per cent stay rurally, that's about 28. Do you actually track where they're going and how long they stay in that and, if they leave, why they are leaving? That would help us address the issues.

MEGAN SMITH: With the 75 per cent, I'll say that that's on average across all of our disciplines. With those 37 medical students, they're in their third year and they will finish at the end of 2025. That is the first cohort. One hundred per cent of those have been rurally trained and all of their placements will be in GP practices in rural locations. Of that cohort, I think probably 100 per cent of them came from a rural background, so we selected into. So I would actually anticipate that we should see a much higher proportion of those students based on what we know. If you recruit from a rural area, you train in a rural area, the chances are these are going to be rural doctors and so everything would support that. But the broader number across our workforce is we probably see the lowest return to rural in our allied health, and the highest will be those doctors. Also, many of those nursing students are from local regions and intend to work locally.

Ms LIZA BUTLER: In your submission, there are currently 117 students across all disciplines enrolled and you've got the breakdown of male and female. Do you know what percentage are Indigenous?

MEGAN SMITH: Of our students? I will give that to Julian. I think the highest percentage of Indigenous students are actually in our nursing program. That would be our most common. Within our medical program, usually one to two each year were dedicated Aboriginal places within that. Julian, I don't know whether you want to comment on the nursing students.

JULIAN GRANT: I have the medical student numbers in front of me and we have eight identifying as Indigenous from the 117 students across the three cohorts. In the nursing, I'd have to just quickly look that up but I certainly can.

Ms LIZA BUTLER: While you're looking that up, how do you actually go out and recruit students from, especially, the more remote Indigenous areas that really need those services?

MEGAN SMITH: In our medical program we will specifically have an Indigenous pathway, so students in that pathway will apply specifically for that, and that involves an application process. They attend an interview. They're supported by a member of the community through that application process for medicine. For our students in our nursing cohort, they can apply through just a normal pathway, though we do have a special Indigenous pathway for students who haven't had a traditional education background. That provides them with an opportunity for access. We also have an opportunity during study for an identified First Nations cohort where students can come together and work within particular supports that we provide for our First Nations students in nursing. It just varies a little bit by the discipline, but in all cases there's an opportunity if students want to study with us to find a way into study.

Mr CLAYTON BARR: Obviously our role is to monitor the implementation of the recommendations and to check that that's on track and that some work is being done. Given the conversation we've had today and what's in the submissions around first of all the number of placements that are available at our universities, particularly Charles Sturt University, and secondly then around the placements when our students go out into the health workforce, whereabouts in the recommendations do you think there's the opportunity for the Government to tackle those big-picture issues?

MEGAN SMITH: My feeling on this one—and others may have this—is that when I look through the recommendations, I don't see a strong emphasis on the training pathway at the university and the education pathways through. There's a very strong emphasis on workforce, on graduation, on supporting the workforce but it's much less silent. Looking through, I think it was recommendation 14, there is a sense within there around education being important but it doesn't put a strong message about how we look at the end-to-end pathway that starts at the moment that a person decides to enter training into their profession, which I think from our point of view would be the time we should be looking at it.

If we're going to talk about recruitment and retention, I think there is an opportunity in those recommendations to extend that part and consider that someone has joined the workforce from the day they decide to sign onto an education program because they will inevitably start to identify as a health professional. They'll go to their placements when they're definitely involved in the health workforce and then it's a transition process into actual employment beyond there. To me that's probably the opportunity on what's otherwise more silent around education at the undergraduate entry to level practice. There are definitely, within there, recommendations around postgraduate training, and we provide some of that postgraduate training, particularly in rural and remote nursing. I'm talking about the undergraduate pathway component to it.

VICKI FLOOD: And in general, recommendation 11 talks about attracting and retaining healthcare workers, and we know that attracting and retaining is related to that experience in the education context right from the early stages. Circling back to the previous question around supporting Indigenous First Nations people to enrol in degree pathways and be well supported from an Aboriginal cultural safety perspective, we start doing that work with high school students and identify Aboriginal First Nations people who are interested in health as a career and we have conversations with them early on. That's led by our Aboriginal health team at UCRH. They do regular conversations every year of high school with them, several times a year, starting to get a vision that health could be a direction for themselves and then they are in turn supported similarly into the university sector or pathway. But that all is part of the pathway around attracting and retaining the healthcare workers, so it needs to be a continuum that works from the education perspective into the healthcare sector.

CHRISTINE AHERN: If I could just add to that, there is that pipeline. It starts at high school. We need to identify people and mentor them, attract them to rural areas. Charles Sturt has their full training. We have some long-stay students and we know both models work, but Charles Sturt may work better. We will see. Then we need to get them to stay in our area as junior doctors, and we were just going to mention the Assistant in Medicine (AIM) program somewhere that fell down in our area. We would like to see that as a program where people can have some experience as an assistant in medicine that encourages them to stay and then go on, and our regional training hub, so we all have to work together, then offers career pathways. General practice training is separate, but the regional training hub offers other specialties a way to train fully in our region, and I feel even if they don't stay with us, they will stay rurally, which we see as a win. And we were also going to mention that the regional training hub for the doctors is very successful and perhaps it's a model allied health could look at as well and that would be funded, hopefully, by NSW Health.

Mr CLAYTON BARR: Again, not to confuse this as an inquiry as opposed to following up on stuff, could you please help me to understand something here, and it's Charles Sturt University's submission. It states:

> … the University have mentioned Queensland's approach to the coordination of clinical placements as an example to follow. This level of coordination will require investment in building data banks that accurately may placement capacity. The tool generally used in NSW, Clin Connect …

Is this essentially a software tool that shows which universities are looking to send their students to which places across the State and that ours in New South Wales is a bit clunky and Queensland have got a good one?

MEGAN SMITH: I will let Michael answer that.

MICHAEL CURTIN: I don't want to insult New South Wales by saying it is clunky, but it is clunky. It's more than a software tool; it's a collaboration between the universities and Queensland Health that actually facilitates the allocation of students to Queensland Health placements. So there's not that competition for placements; it's a much more coordinated approach. Queensland Health employs people like OTs, physios and nurses who help run those programs and coordinate them with the universities. So there is software involved, but it's actually bigger than the software.

Mr CLAYTON BARR: So we don't employ people in NSW Health to do something similar?

MICHAEL CURTIN: No, not that I'm aware of.

Mr CLAYTON BARR: Sounds clunky.

MICHAEL CURTIN: I meet with NSW Health and their allied health, but you don't have somebody who is employed to facilitate placements and stuff like that.

Mr CLAYTON BARR: Thank you for helping me to understand that.

VICKI FLOOD: It's not done in that coordinated way.

MEGAN SMITH: Coordinated way.

The CHAIR: Professor Grant, you put your hand up.

JULIAN GRANT: I have two points speaking to additional information, specifically in relation to nursing and the placement challenge. It's the lack of coordination across public health services and the universities that makes it really difficult. The university has to go out to every individual health service and garner individual agreements with every single health service. Then that comes into our ClinConnect site, basically, which is really clunky. It also means we can't connect with any private health systems, because they're not part of that system. It also means we can't connect with private hospitals, individual practitioners, medical officers and private GP practices. That's the clunkiness of it, which also makes it time-intensive for the universities. It also means it's difficult for to us track student placements.

Also, with the changes with VicHealth and the ACT in relation to the extra contributions they're making, like free education for nursing and midwifery and allied health, and the ACT offering additional incentives for placement costs, that's making it even more difficult for us with the clinical placement piece. To come back to the First Nations question, I had a quick look and in our nursing cohort, at present we have around 5.8 per cent First Nations enrolments. The other thing to note is that we also run bachelor of health sciences, which is an identified program. It's called Bachelor of Health Sciences (Mental Health), identified for First Peoples only. All those students are placed within regions to work in Aboriginal medical services and also mainstream services.

Ms TRISH DOYLE: I wanted to follow on from my colleague Mr Barr in terms of this clunkiness and this lack of coordination.

Mr CLAYTON BARR: That's my word.

Ms TRISH DOYLE: We're adopting that new word, Committee—"clunkiness". There are challenges and opportunities for students, for communities. You mentioned, Dr Grant, about the privates not being part of this coordinated set-up. I will go back to the feedback from students, who may be part of a future workforce. What sort of stresses are you hearing as part of that feedback in relation to the private entities being part of a health response, where the students are participating in dealing with a need that exists where it's not coordinated?

JULIAN GRANT: I think the major challenge that students have is the communication piece. While they can communicate really clearly with the academics and their lecturers in the university, the communication then across to the clinical placement is mismatched quite often. It doesn't link through to a communication person in the health service that they can tap into. Depending on when their placement is, they may well be able to contact an academic or a workplace learning coordinator, but then the link back to the health service means they can't get information about when their placement is, or the timing for the placement might have been changed because of the health workforce needs, and then that whole communication piece gets missed. They are some of the biggest issues we have. Also, there is the notion of tracking student placements. Students certainly track their own

placements, but if they're sick or if there is an unexpected event in the health placement and they can't come to work, it makes it really difficult.

The CHAIR: We're very close to time. Professor Smith, you put your hand up. We have literally 30 seconds.

MEGAN SMITH: I was going to say that I think the lack of coordination gets really exacerbated in rural areas. It is a problem for us across the whole sector whenever we're using metropolitan placements. But if we have students who have, say, a potential opportunity part-time in the public service within a regional area and we want to put it together with a private opportunity, that is really clunky and difficult for us to manage. Across the board whole, because we are dealing with smaller numbers, distributed students, we see everything on a much more complex level and students end up often not knowing where they're going until the last minute because of the degree of coordination and supports required. In the implications for students, the later it is they find out what's happening, the more burden it is upon them and the harder it all is to bring it together. If it was smoother for everyone, it would be better for everyone.

The CHAIR: Importantly, to summarise that last set of questioning, traditionally the universities and the health system have been quite separate. NSW Health just takes people who graduate from the universities. What we've described here is the need in rural and remote regional areas to have a model in which Health is much more engaged right from school, all the way through. That would then create loyalty in the workforce, make the placement process a lot easier and hopefully lead to long-term recruitment. I have a question on notice for Charles Sturt University. Your submission notes that the NSW Health Workforce Plan 2022-2032 "lacks sufficient consideration of the specific challenges in regional areas". Can we give you that question as a question on notice? Perhaps you could respond by explaining that in a bit more detail. I'm sorry that our time has now concluded, but I want to thank everybody for appearing today. We may send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

CHRISTINE AHERN: Yes.

VICKI FLOOD: Yes.

MEGAN SMITH: Yes.

JULIAN GRANT: Yes.

MICHAEL CURTIN: Yes.

(The witnesses withdrew.)

Ms JACQUI EMERY, Chief Executive Officer, Royal Far West, affirmed and examined

Ms CLAIRE TAYLOR, Head of Strategy and Partnerships – Child and Family Services, Royal Far West, affirmed and examined

Dr MARCEL ZIMMET, Chief Medical Officer, Royal Far West, before the Committee via videoconference, sworn and examined

EMMA PHILLIPS, Executive Director, Can Assist, affirmed and examined

Ms MAJELLA GALLAGHER, Advocacy and External Relations, Can Assist, sworn and examined

The CHAIR: I welcome our witnesses from Royal Far West and Can Assist. Can you each please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

JACQUI EMERY: Yes.

CLAIRE TAYLOR: Yes.

MARCEL ZIMMET: Yes.

EMMA PHILLIPS: Yes.

MAJELLA GALLAGHER: Yes.

The CHAIR: There is an opportunity for each of your organisations to make a very brief opening statement with a maximum of two minutes. We've got a timer on here. Royal Far West, would you like to start?

JACQUI EMERY: Thank you. Royal Far West acknowledges the traditional custodians of country throughout Australia and the ongoing and important wisdom shared through their continued connection with the land, waters and community. We respectfully recognise the Elders of the past and present, and walk with the children who will become future Elders. Royal Far West is a 99-year-old national charity dedicated to the health and wellbeing of country kids. Last financial year, we supported 21,000 children, care givers, educators and health professionals. Our team of over 150 paediatric clinicians offer multidisciplinary health, education and disability services. We spend nearly $30 million per annum to deliver these essential services to country families, comprising over 10 State and Federal Government grants, service contracts, partnerships, Medicare, NDIS, fundraising from individuals, branches, groups, bequests and other income streams.

The key issues faced by our families are increased complexity in children and their environments. Royal Far West clinicians are increasingly supporting highly vulnerable families, children who are struggling in their school and home life, and who often experienced early life trauma. Children are displaying challenging behaviours younger. Compounding this, there remains a serious shortage of allied health professionals in country New South Wales, along with a lack of paediatric and diagnostic services. Paediatric waitlists are an ongoing and worsening situation in many rural centres. In some communities, children are on waitlists for up to five years or declined altogether. Outpatient clinics across the State have had to make the difficult decision to prioritise medical appointments and waitlist or decline children with behavioural concerns. However, we would like to challenge the notion that behavioural children are not in the most at-need category. Many of the children we see are, in fact, at risk and in desperate need of ongoing support to avoid poor lifelong outcomes. There are many long-term solutions to address workforce shortages that have commenced, but there needs to be further consideration of what is going to work in the short to medium term. We all know there is money in the system.

The CHAIR: Thanks, Ms Emery. Can Assist?

MAJELLA GALLAGHER: I speak here today on behalf of Can Assist's 3,000-plus volunteer members across country New South Wales. Whilst we do not work in the New South Wales health system and do not claim to be experts on it, we do work closely alongside it, sourcing our clients and distributing assistance. The feedback we share together is sourced from conversations we have had over the last six to eight months with healthcare professionals and our members across all rural and Local Health Districts (LHDs) . There are various issues raised in our submission. I would like to highlight here that the bonus scheme is not working as well as it could be. There are hospitals in dire need of staff that have either had multiple bonus applications rejected or who have simply just not applied. Other workplaces have actually voted against using them altogether. There is much confusion around the finer detail, and in some cases the scheme has alienated the very workers it is designed to retain.

Additionally, whilst not raised in our submission but relevant to the terms of reference under recommendation 1, we would like to raise two further issues. First, it is the travel and accommodation rebates for isolated rural patients. In line with the recommendations of the 2021 inquiry, Isolated Patients Travel and

Accommodation Assistance Scheme (IPTAAS) reforms have been rolled out swiftly and are creating better patient outcomes. Across our client base and across our branches, more and more people are availing themselves of IPTAAS, and in some cases no longer require the support of Can Assist.

However, whilst an important part of getting isolated patients to treatment, community transport has been left out of the reform process. Patients who use it are ineligible for IPTAAS. In opposition to the philosophy of IPTAAS, patients travelling for non-emergency treatment via community transport are subsidised less per kilometre the longer they need to travel and charged the same rate as a passenger travelling for a shopping trip. Further, with the Cancer Council NSW now consistently applying that eligibility criteria for their much-needed travel to treatment service, Can Assist has been receiving a higher rate of referrals from patients unable to find or afford transport to treatment. We are now funding an increasing amount of community and transport trips. Reform of this sector is needed more than ever.

Secondly, it is radiotherapy. Radiotherapy is uniquely expensive for patients not living close to treatment. Cancer patients travelling daily from Bega to Canberra—460 kilometres return, for example—would face a charge of up to $1,800 a week in community transport fees to access it. Since the 2021 inquiry, the state Government has utilised two more of the federal government grants that have been on offer since 2019 to build much-needed radiotherapy services in Tweed Heads and Nambucca. Two sizeable grants for Armidale and Eurobodalla remain left on the table. These communities have been promised these services and need them.

The CHAIR: Thanks very much for that. We'll now proceed to questions. I will start the questioning, and it's to both organisations. Can Assist began to touch upon this. I'm interested to get your observations about any improvements that you've seen in the regional health system since the upper house rural health inquiry, in particular, in relation to workforce issues, workplace culture and funding which are the issues of this inquiry. I might start with Royal Far West.

CLAIRE TAYLOR: Not necessarily an improvement to start with, but the paediatric waitlists are growing and that's something that concerns us; those numbers continue to grow. We know that some children just are not able to see a developmental paediatrician altogether unless they can afford to pay for a private service. But something that is promising that is a recommendation that's come out of the original committee is the work that NSW Health has committed to do to work more closely with the charity sector. We've been told by NSW Health that we will be involved in a process next year, which will be attempting to bring us closer to the LHDs that we work within, and that's a process we're looking forward to being involved in. Although in terms of workforce within the LHDs, it's not something that we've seen improve particularly in terms of paediatrics. It's something we've seen worsening post COVID.

The CHAIR: There has been an indication that you will be more involved at LHD level, is that right—as a charity?

CLAIRE TAYLOR: I guess at that strategic level we have very good grassroots relationships with the LHDs. People like Dr Zimmet, our paediatricians, all of our managers of our services on the ground have great relationships with the LHDs. Where that's probably been lacking to date is in the high-level strategy, working together on co-design, planning our models, service delivery planning. NSW Health have indicated to us that they want to bring us more into the tent, which we're really grateful for. That work that should be happening next year.

MAJELLA GALLAGHER: I would say the improvements that we've seen in terms of the workforce haven't been anything to do with the inquiry. We've had some communities, for instance, that have had increased GP services or increased doctor numbers, but they have not been the result of the inquiry. I would say social workers and nurses who we deal with regularly—if anything we've seen a reduction in those numbers and an increased volunteer workload. More generally, in terms of improvements since the inquiry, like Royal Far West, we've been a bit more engaged with NSW Health via the IPTAAS forum that we now co-chair. That's been great, having a great voice into NSW Health. There are another 20-odd members on that committee all through grassroots. It's a well-represented committee, and I think we get to raise a lot of good issues.

EMMA PHILLIPS: I think they're very willing to hear from us, which has been a real bonus from the inquiry that we hadn't witnessed prior to that.

Ms JANELLE SAFFIN: Following on from what you said with that forum, are the Aboriginal medical services (AMS) in that forum?

MAJELLA GALLAGHER: They are, yes.

Ms JANELLE SAFFIN: How are they represented there?

MAJELLA GALLAGHER: There's one person. I think there are about 20 people on the committee. I think there's an Indigenous health worker on there as well.

Ms JANELLE SAFFIN: Thank you. I do have a few other questions. That was just arising from what you said. Firstly, you talked about the issues with rural health workforce, and you mentioned the incentives scheme. We have heard quite a bit about that—some of it where it's working and some of it where it could work better or it might skew things. So we're interested to hear from you what you think about it, and how it could work better or what needs to change, if anything.

MAJELLA GALLAGHER: I think that healthcare workers saw the headlines, like all of us—bonuses doubled to $20,000—and people expected to get retention bonuses and recruitment bonuses, and it just hasn't happened in that order. I think the key issue with the way it has been rolled out is that you can have the same job, in the same location, with the same qualifications and not have the same access to the bonus. That creates a lot of resentment. People are expecting to have the bonus, and then they find out retrospectively that they didn't. Often in our conversations, people still don't know why they didn't get it.

Ms JANELLE SAFFIN: There is no rationale given?

MAJELLA GALLAGHER: No rationale. They will talk about loopholes or some finicky thing that they have been rejected on in their application. I think the general tone is one of cynicism and resentment. I've had dozens of conversations with health professionals about those incentive bonuses, and it was actually only one person who pointed out to me that the reason why we are getting those disparities is that the bonuses are actually allocated via the cost centre, as opposed to the nature of the job. So in a district like the Western NSW Local Health District, where you have three cancer services cost streams, they are all basically doing the same thing but they are not all equally eligible. The social workers over in Hunter New England tend to have less streams, so it has been more successful there.

Then, of course, you will get a social worker who works on their own in the hospital—they are the only social worker—so there is no opportunity to get a retention bonus because no-one else is going to be hired, and she or he might see a whole lot of people getting retention bonuses around them. I think the final thing that I've heard frequently is the bias depending on where you are actually located. I think, for instance, in Moruya the retention bonus might be, say, $10,000, but if you're in Batemans Bay it might be $5,000. But the reality is that the health workers between those two locations are moving back and forth a lot and they are actually spending as much time in both of those places. So there is a real inequity out there that has created resentment, and it is not surprising. I've spoken to some major hospitals that might have 10, 11 or 12 headcount for nurses, they've got five or six unfilled and they haven't even applied for the bonus yet. So, yes, I think they are the key issues.

Ms JANELLE SAFFIN: That was good detail because we have heard a lot about it, but you were able to describe it very well. It is a good idea, but its implementation—that's what we are hearing about—leaves a lot to be desired. That is a nice way of putting it.

MAJELLA GALLAGHER: Yes.

Ms JANELLE SAFFIN: I've got one more question for Royal Far West about the telehealth and the virtual supports in children's health services. Because, again, we hear different things about telehealth, so we are interested in what you think about the benefits or the advantages and any disadvantages.

JACQUI EMERY: I think, like most services, there are varying levels of quality for a service. We have been delivering telehealth services since 2014, and I think for families in rural and remote areas, it presents a number of benefits. Most families, if they couldn't avail themselves of telehealth, would have to travel up to 200 kilometres round trip, in some cases, to access a specialist appointment or an appointment with an allied health or even with a GP in some cases. Trying to take a child, number one, out of school, taking the day off work, perhaps even having to take all of the kids out of school for the day, and then actually driving that distance with a child with a developmental challenge can be a struggle in itself. You get to the appointment and there is not much value in that appointment.

So we have found that by embedding, in a sustainable way, telehealth services inside of schools, that allows not only the benefit for that child directly, but also for those supporting that child—ideally a parent or carer who can make the decision. But the benefits we have seen in building the capacity of educators, not only to identify developmental challenges in children, but primarily to support them with strategies—we know for educators that their biggest concern is actually supporting children with developmental challenges, particularly as those numbers grow, which is what we are seeing over recent years. So there are some really practical advantages of telehealth, but also we have seen that the advocacy has been proven time and again. By delivering weekly frequency of therapy into these environments, we are seeing great outcomes in children and their ability to overcome some of those challenges if we go to them as early as possible.

Ms JANELLE SAFFIN: So you're saying that it needs a proper design?

JACQUI EMERY: Yes.

Ms JANELLE SAFFIN: And in a proper program, not just, "We are on the phone" or "We are on the video talking to you", but some real design and working with the others, like teachers and that.

JACQUI EMERY: Yes, absolutely. We have evaluated this program. I think one of the other key elements to its success is the coordination of the service. We have what we call telecare coordinators that do all of that background work in terms of supporting the access to the technology. When you think about it, it is actually a child or potentially a parent or teacher scheduling the clinician, so that does require some coordination, but that ensures that it is sustainable and it ensures that the communication between all of those parties works very effectively.

We have refined this model and evaluated it over time, and we find that over 90 per cent of children last year reached their goals that were set jointly by both the parent and the teacher and Royal Far West to support that child's particular needs—each child's particular needs. We are getting great traction. We report all the time from schools and teachers that we are seeing explosions in learning for children, that we are seeing much better classroom behaviour, and teachers actually understand regulation strategies and how to engage their whole classroom to engage in some learning. Because where this isn't happening, there is no learning going on. So it is effective in the right setting, with the right support.

Mrs LESLIE WILLIAMS: A surprise to my colleagues—I'm going to follow-up on my Deputy Chair's question about telehealth. First of all, I want to commend both of your organisations because I know very well the work that you do and the positive outcomes that you provide, and you fill the gaps in our regional communities. It is just immeasurable. To the Royal Far West, I know that speech pathology was where we started in telehealth back in 2014, and I know about it intimately. Can you describe to us how it has such positive impacts in the right settings? What is stopping you from scaling that up? Is it because we don't have enough speech pathologists to be on the end of the phone, is it funding, or is it both?

JACQUI EMERY: There are definitely workforce issues. However, we have been able to scale our workforce pretty significantly. We started back in 2014 in one school in Gladstone in Queensland, and now we are operating in over 200 schools and early-year settings across four states. So we are scaling the program. We've been able to do that with the support of a grant from the Australian Government Department of Health and Aged Care. That acts as a subsidy to support this co-payment, if you like, which is matched by schools. By and large, that has been matched by Catholic schools that have seen this and embedded this into their curriculum as a way of supporting children with developmental vulnerabilities. We haven't seen that level of take-up by government schools in New South Wales. We see that there is a lack of coordination at a state-based level.

For us, we think that there certainly is the opportunity to continue to scale this service. How we have refined the service in recent years, and going to telehealth, what we have discovered through the work that we have done in communities that have been impacted by floods and bushfires is that we can get even quicker and better outcomes with children if we combine our telehealth with some community visits so that we can actually better understand community context. Our clinicians know what kids do in that community after school when they have finished school, so that engagement piece is really elevated.

Again, we see that there are opportunities, particularly around an allied health assistant model, which would help address the workforce issues. However, there needs to be really strong governance and guidelines around the development of allied health work models. For us, that would be the next stage in terms of actually scaling that further. But it is an answer to preventing children actually developing comorbidities and mental health issues because their developmental challenges have been addressed earlier. We know the benefits of early intervention and the long-term savings to government by actually putting that investment earlier.

The CHAIR: Dr Zimmet has his hand up.

MARCEL ZIMMET: Yes. I thought I'd just expand on what Jacqui was saying, which is that our model of care is very much a 360 model of telehealth care that goes to assessment but also working to use telehealth in a videoconferencing model with local schools and clinicians. We've been doing that well before COVID—we were having videoconferences with schools. We would bring kids to Manly, complete their developmental assessment and have a session through Department of Education web links at that time, pre-Zoom, to feed back our findings to work with the teachers to support these children with their ADHD or autism or what have you. In our assessment arm, if you like, of Royal Far West we go through everything from engaging the child online before they come to Manly and then providing post face-to-face care.

What are some of the gaps with that? I think that, on the other end of our care, often because of those shortages with local clinicians at all levels and allied health and paediatricians having the time at rural hubs, we often can't get them in on the conversation. Often if we have a very complicated kid, we're getting Department of

Communities and Justice (DCJ) online, we're getting maybe the school or we're maybe getting an NGO like the Benevolent Society, but it's very hard to get their local clinicians online to have a multi-service case conference and do that capacity building to really help their local care team being coordinated and work effectively. We rarely, if ever, can get the local paediatricians into either our team case conferences to help discuss their children or, in fact, if you like, the after care planning. That's a big gap that hopefully we can continue building on through closer work with the LHDs. It's more of a shared-care model so that we can use, if you like, the broader telehealth and not just the consulting or therapy aspect more effectively with those local teams to better the care.

Ms TRISH DOYLE: Thank you for, what needs to be said time and again, all the work you do and the gaps you fill and for being so honest with us here today about what works and what doesn't. I go to Royal Far West first. As a former schoolteacher, it's worrying to see that there is more and more need and less and less available help to access. I think what I'm hearing is that, when you don't have sufficiently trained teachers and you can't access the healthcare workers that are required, it's quite tough for you to try and find those solutions, and you've outlined a couple of them. Beyond these four solutions that you've pulled together—and telehealth because we've had some discussion about that—what else do we need to note down here is required?

JACQUI EMERY: One of the positives that we were quite excited about was the investment in the Brighter Beginnings initiative. Again, I think the strategy and the reform is really positive. I think the execution and the implementation may be really challenged. I was in Bourke a couple of weeks ago on an inter-agency meeting and we were told by western LHD in that meeting that the developmental health check—and we've been doing these health checks with the Healthy Kids Bus Stops for the last eight years, who have a lot of experience in this—would consist of one child and family nurse for the whole of the western LHD, doing essentially a blue book developmental check for the 3,000 children in that LHD. It's not really delivering what was promised with that initiative.

In addition to that, it will only take place with four-year-olds. Currently, our work with Bourke and District Children's Services (BDCS) allows us to do speech and occupational therapist (OT) assessments with children that are from three years of age, which then actually unlocks funding in those early years settings to provide supports for those children well before they start school. That service will not be replaced and, essentially, our funding to complete those services, which has been philanthropically funded to now, will end at the end of June this year. Bourke will not receive the services that they need to give the depth of developmental screening that's required to actually identify the specific issues that children need. On top of that, there is acknowledgement by the LHDs and, in fact, the ministry that there is not the allied health workforce to then support the treatment or supports for those children post identifying those developmental challenges. But it will give us better data on the scale and size of the problem, which we already know. After doing it for eight years, we know that 80 per cent of the 5,000 children that we screened needed a referral to another service, primarily speech and audiology.

Mr CLAYTON BARR: Did you say 80 per cent?

Ms TRISH DOYLE: That's ludicrous.

JACQUI EMERY: Yes, 80 per cent of three- to five-year-olds that we screened over the eight-year period across 430 rural New South Wales communities.

The CHAIR: How were they referred to you for screening?

JACQUI EMERY: That was really a large part of our role. Because of the relationships that we have on the ground, we were really charged with the coordination piece. We would work with the local AMSs, we would work with preschools and we would do a lot of work. Even though the bus stop was a week-long screening program, we were working for months beforehand with those communities to identify children, many of which weren't attending any kind of preschool or early learning setting.

The CHAIR: So the screening was for a group that was identified as at-risk at the start?

JACQUI EMERY: Basically, yes. How it commenced, though, was that we had MoU with a number of LHDs to do that work. It started as us actually doing that coordination piece and then having a bus stop there coordinating the week and then following up on the referrals. But the LHDs were supposed to provide their allied health staff. As time went on they didn't have the allied health staff so we had to bring our own. Again, this was philanthropically funded for eight years. Obviously we did a lot of advocacy that these developmental checks should be done by the State for every three- to five-year-old. When Brighter Beginnings came out, that was exciting.

Ms TRISH DOYLE: I just have another quick question.

The CHAIR: I think Dr Zimmet just put his hand up. We might hear from him.

MARCEL ZIMMET: I'm happy to hear the question first.

Ms TRISH DOYLE: I was going to go to Can Assist. If you wanted to build on that particular issue, go for it.

MARCEL ZIMMET: I just thought I'd add that another solution to bring out in this space is thinking about the coordination across the departments, in terms of that intersection of health education and child protection that we often see, day in, day out, at our service. I think that's critical coming from the Government because often we're the glue between those three departments, as I alluded to before. That is where we spend, in what's supposed to be an assessment service, a lot of our time doing psychosocial support work because the families can come to us and have time and space to open up and we can really explore things. But then we're often in a bind whereby we're left holding the family.

It's not just about medication or helping them to get speech therapy. We're doing a lot of the psychosocial support work with our vulnerable families, who are increasing. That's often because there's no-one coordinating the departments and the NGOs in those areas apart from us. That can be, for us, one to two years' work after we've completed an assessment. There's an example I can think of that I've presented in many forums like this. A child who waited two years for their local paediatrician—they didn't have NDIS access, and child protection services had capacity issues getting to them. We spent 18 months basically coordinating all of their child protection, health, and supporting the school with their education.

That's not something we're actually funded to do. I think that coordination across the sectors is always talked about but is just critical in this space. Also, the child protection services, particularly with really vulnerable families, can get in and provide early intervention in that space. We know the impact of developmental trauma and all of the risk factors before and after birth in stressed families that impact their development. We're really missing the boat on that because, as we all know so often, the services aren't there to do the broader psychosocial supports in the communities, and the further out you get, the more vulnerable.

Just the other point I wanted to make is the role of the state system next to the NDIS with kids with developmental mental health problems. I don't have a clear solution on this, but it is just to identify that gap, which will lead to a solution of children who don't meet NDIS criteria—despite having severe developmental disabilities, they're just not ticking the boxes; or they do meet the criteria, like the kid I just mentioned, but in their region in remote New South Wales, they can't access—there are no therapists there. Even getting the telehealth in is hard because the family doesn't have a wi-fi link because they can't afford one, and then they can't get to school easily or there's a problem with the school-parent relationship.

So there are a lot of kids we see who fall through that gap, and then there's very limited access, as you may all know, to state-funded developmental care obviously in the early intervention space but even once issues are identified. I think building that capacity through NGOs over time, using innovative modalities—we've talked about hybrid telehealth/face-to-face models—will really help that, but there needs to be an injection into the system to provide that architecture across the sectors.

Mrs TANYA THOMPSON: I have a quick question about recruitment for Can Assist. In your submission, you note that it can take eight to 12 weeks for that recruitment process to happen. What solutions do you feel could be implemented to streamline that process for staff recruitment?

MAJELLA GALLAGHER: I think the thing is my understanding is that each LHD has their own people and culture department, and it's really different. I think I said in the submission that the Murrumbidgee one, we get really good feedback there that that people and culture department works well, whereas Western NSW Local Health District is a completely different story. I think I spoke to one hospital who's desperate to recruit social workers, and she has been dealing with either three or four recruitment advisers there in the last three or four months. So there's a revolving door going on there.

I think the temptation with a lot of these issues is to try to umbrella the solution and say, "Look, this is what we need to do across everywhere", whereas, in reality, it's not always like that. So what's going on in one LHD isn't going on in another LHD. I guess the idea would be to say look at the Murrumbidgee and what are they doing there that's working so well, because that was the only one we heard good feedback on. It's not unusual at all for a person to be found and then not—to be onboarded under two months seems to be a rarity.

EMMA PHILLIPS: I also think that the issue is stepping back from even the onboarding, and it's the attracting and it's the respect to the allied health workers. That's what we see. A 0.2 to a 0.8 head, only having a 12-month contract—you're kind of failing before they even step up. Overhearing your previous conversation about attracting from university or education systems makes a lot of sense. Let's have respect for the industry.

Ms LIZA BUTLER: Dr Zimmet answered most of my questions around the NDIS. With the lack of funding, did you see a decline when Ageing, Disability and Home Care dispersed, with the introduction of NDIS? Especially around your early intervention, there used to be early start, early intervention money that would actually support a family from the birth of a child that was identified early or in very, very early years. Have you seen a decline in that? I'm a firm believer that the earlier intervention takes place, especially the whole of family, you save money longer because you've got families staying together instead of separating, depending on welfare and lots of other things. Is there any study? Did you notice a change in that funding when Ageing, Disability and Home Care NSW (ADHC) was dispersed?

JACQUI EMERY: There has been a lot of feedback for us that ADHC was more effective for those early inclusion supports. I think, however, the key issue in rural and remote in New South Wales is that so many children—it's estimated that 50 per cent of children are not accessing any kind of early education and care. That's the big issue. We know that there are childcare deserts. What we find with a lot of the children that turn up to our assessment and diagnosis service, they've been identified as having a challenge maybe in kindergarten, if they're lucky; more likely year 1. By the time they get to us, they're sort of eight or nine, and then it's much more difficult to address these challenges. This is sort of where some of the intersectionality comes into it. They don't generally go to the GP. Right now we're hearing reports of three months, even longer, just to get into a GP for so many of our families, let alone a paediatrician. So that early intervention piece is really difficult.

When there are early inclusion supports, actually trying to find, again, the workforce to support this or the right workforce—and this gets back to some of the challenges around the quality and the qualifications of some support workers in this space who are really not delivering the outcomes that are required. There are kind of multiple challenges there. Again, when I was out in Bourke, I heard that there is a—one of the recommendations around the royal commission is around looking at a direct commissioning model for remote towns, where communities are actually driving what the solution is around early inclusion supports. We would really strongly endorse that recommendation as a way of actually trying to create a market where there are no markets and also make it a more holistic approach in those towns, because the one-to-one family commissioning model is not working because the workforce just isn't there.

Ms TRISH DOYLE: Can I ask a question on notice, please, Mr Chair?

The CHAIR: Yes, you can, and I have a question. I have a question to Can Assist in the remaining two minutes.

Ms TRISH DOYLE: My question on notice to Can Assist—because I know it's difficult to speak to—is point 5 of your submission, "Fear of speaking out". That goes directly to part (d) of our terms of reference—the complaint handling, workplace culture. It's incredibly concerning. This is across the board, I'm sure, but you say that you can't provide more specific feedback about many of the issues that you've raised and you've talked to because there's this request for anonymity. Why? Perhaps you can pull together, anonymously, some of those comments.

Mr CLAYTON BARR: If you were to make something in writing, we could keep it in confidence.

The CHAIR: Yes. That's a request for a response on notice, because we've run out of time.

Mr CLAYTON BARR: Just to clarify, if we keep it in confidence, it means that it doesn't get published—only the six or seven people around this table would get to read it—and we don't want you to identify anyone. Thank you.

EMMA PHILLIPS: Can I just say, though, that we would need to check because of the feedback, and if they say no, we will just put that back to you.

The CHAIR: That would be a response.

Ms TRISH DOYLE: Just don't put any names to it.

The CHAIR: But we are interested in your further observations of workplace culture, and you've obviously alluded to that in your evidence as well. My follow-up question is just to request a bit more detail from you in relation to the observations you've made about general practice and the lack of planning to replace general practitioners in some facilities, in some places, and the fact that in other places there has been successful recruitment but it hasn't had much to do with the health system, frankly. I thank all the witnesses for appearing today. As we've indicated, we may also give you some questions on notice. There may be some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

JACQUI EMERY: Yes, we would.

EMMA PHILLIPS: Yes, we would.

MAJELLA GALLAGHER: We will.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms DEBORAH WILLCOX, Acting Secretary, NSW Health, affirmed and examined

Mr LUKE SLOANE, Deputy Secretary, Regional Health, NSW Health, affirmed and examined

Mr ALFA D'AMATO, Deputy Secretary, Financial Services and Asset Management and Chief Financial Officer, NSW Health, sworn and examined

Mr PHIL MINNS, Deputy Secretary, People, Culture and Governance, NSW Health, sworn and examined

The CHAIR: I welcome our witnesses from NSW Health. Can you each please confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

LUKE SLOANE: Yes.

DEBORAH WILLCOX: Yes.

PHIL MINNS: Yes.

ALFA D'AMATO: Yes.

The CHAIR: Would any of the witnesses like to make an opening statement?

DEBORAH WILLCOX: I would, if the Committee's okay with that. I would like to begin this afternoon by acknowledging the traditional owners of the land where we are, the Gadigal people of the Eora Nation, and pay my respects to Elders past and present. I acknowledge any Aboriginal people in the meeting today. I would also obviously like to thank the Committee for the opportunity to appear to discuss our submission and receive an overview on the work that's been undertaken. I am pleased to be able to advise that since the rural health inquiry significant progress has been made towards implementing the inquiry recommendations and, although we are well underway with the work, we know there is always more to do.

The New South Wales Government committed to implementing the 44 recommendations handed down by the inquiry. Sixteen of these recommendations have been completed in full, including a review of the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) —recommendation 2. All remaining 26 recommendations are on track. In its response to the inquiry's report, the Government committed to implementing 68 actions aligned to these recommendations. Of these, 30 have been completed, including the development of our *NSW Regional Health Strategic Plan 2022-2032*, which publishes the Rural Nurse Practitioners Framework which provides the training and development pathway for rural generalist nurse practitioners, and a review of the local health committees to strengthen connection and engagement with local health communities. The remaining 38 actions are on track.

We continue to work closely with clinicians, staff and our management teams across NSW Health to ensure that communities in rural, regional and remote parts of New South Wales have access to the best possible care available and optimal health outcomes. Our staff, as you well know, have strong connections to the communities in which they live. We acknowledge the work they do and their dedication and commitment to providing care to those local communities. Around 3 million people live in regional New South Wales and have access to more than 170 NSW Health facilities, ranging from major tertiary hospitals like the John Hunter to neighbourhood multipurpose services and HealthOne centres. These health services are crucial to our communities and provide, I believe, great care, and play a crucial role as part of the broader health system.

The effective networking of services between our larger and smaller health facilities is also an important element to the provision of care across New South Wales, as well as the latest technology to deliver world-class virtual care and the support of major metropolitan hospitals and clinicians, who are all contributing to this network of health services across the State. One example, the partnership between Sydney Local Health District and Far West Local Health to support the Broken Hill virtual intensive care service, demonstrates how effectively the system can work together and collaborate to ensure great patient outcomes no matter where somebody lives. The Broken Hill virtual intensive care service links critically ill patients and their Far West Local Health District clinicians with Sydney-based specialists. This model uses remote monitoring and videoconferencing to connect clinicians, patients and carers in Broken Hill with intensive care staff at Sydney's Royal Prince Alfred Hospital and the RPA Virtual.

It allows remote communities to prioritise treatment and provide continuous high-definition monitoring of multiple critically ill patients. Importantly, on workforce, which I know is a big issue for this Committee, a large amount of work is underway in relation to staff recruitment, retention, workforce management, planning, and staff accreditation and training. The Secretary of NSW Health, Ms Susan Pearce, chairs the inter-jurisdictional health workforce taskforce, a taskforce that includes all of the jurisdictions around the country, including the

Commonwealth, and reports to health ministers. They are developing a range of short and medium-term actions and long-term strategies to support the health workforce, which has been so severely impacted as a result of COVID. NSW Health separately is working on its own workforce challenges and has a range of measures. No doubt the Committee will hear more about those this afternoon.

We appreciate the value of incentives available to recruit staff to remote communities, and have really doubled our efforts to try and fill the most critical positions in the most critical locations. Funding has been provided to increase the number of nurse practitioners and for the training and placement of rural generalists, and we're also working on the single-employer model, which will be well known to the Committee. A strengthened regional health workforce will provide for the foundation of an equitable and integrated health system delivering outcomes that matter, and we know that we can't do it without those staff. We're committed to nurturing a positive workforce culture focused on consumer experience and safety, and we've progressed a number of actions in this regard. The NSW Health workforce culture framework is currently under development, and the core values of collaboration, openness, respect and empowerment are central to this work.

The framework will be an overarching system guideline that local culture frameworks can anchor to, ensuring consistency and connection. The delivery of high-quality healthcare services enhancing access to care for the people living in rural, regional and remote areas of New South Wales is a key investment focus of NSW Health. Consideration has been given to the funding for agencies' programs and incentives to support them. I want to assure the Committee and the people of regional New South Wales that NSW Health is listening to, engaging with and talking with communities, staff and our many partners in health care, including local government and many peak bodies. Again, this is a real partnership and something we know we can't do alone. The Regional Health Division, led by Deputy Secretary, Regional Health, Luke Sloane, continues to work with Local Health Districts. He has clocked up many kilometres travelling around the state meeting with health districts, communities and clinicians. I thank the Committee for their time this afternoon.

The CHAIR: Thank you, Ms Willcox. Mr Sloane?

LUKE SLOANE: Thank you, Dr McGirr.

I would like to acknowledge that we are meeting on what always was and always will be Gadigal land. I recognise the people of the Eora nation and their continuing connection to land, water, culture and learning as we give evidence and truth-telling today. Thank you to the Committee for the opportunity to speak this afternoon. I'd really like to thank all the witnesses—not only from this morning and Friday—for preparing and sharing their input and their experiences really candidly. It's not something we take lightly, nor did we take it lightly with regards to the inquiry as it was two years ago. I would like to reassure the Committee and the community of our unwavering commitment to ensuring that the people of regional, rural and remote New South Wales have access to safe and high-quality care, and that we work together to achieve the best health outcomes possible.

Through the rural health inquiry we heard the deeply personal accounts of people whose healthcare experience did not meet the standard of care that we strive for in New South Wales. To that end I would like to acknowledge the 51 submissions that individuals and organisations have made to this inquiry as well. We welcome the opportunity to provide an update on the recommendations from the inquiry, in particular the challenges and opportunities relating to workforce, workplace culture and funding for rural, remote and regional health services and programs. I acknowledge that the Special Commission of Inquiry into Healthcare Funding is conducting a review of the funding of health services in New South Wales as a whole. NSW Health has provided information to the commissioner of the special commission of inquiry regarding the progress of actions relating to the rural health inquiry and the recommendations progress.

NSW Health has been monitoring and reporting on the progress of the implementation of the recommendations, and in April 2023 an independent review was undertaken into the implementation of NSW Health's actions. This review showed that NSW Health has already completed or made progress on most of the recommendations from the rural health inquiry and 16 recommendations have been completed in full. At this point I'd just like to note that even though we are completing and implementing these recommendations, that doesn't always translate to how it's ground-checked for the people living in these communities and those people working in not only health service delivery but our partner organisations. I think that's part of something that we need to think about as we go through the implementation.

NSW Health is responding to challenges relating to attraction and retention of healthcare staff by focusing on a whole range of measures such as doubling the value of incentives available to help recruit staff to remote communities with critical staff vacancies for the hardest-to-fill and critical locations. Staffing numbers, recruitment and retention-related workforce management and planning issues and staff accreditation and training are a key focus for us, and that is definitely being driven hard out of Deputy Secretary Minns' portfolio. The Regional Health Division is building on work already undertaken to improve health outcomes. The work includes

working with stakeholders to address their priorities, as Ms Willcox said, through the *NSW Regional Health Strategic Plan 2022*-2032, published in February of this year, which includes recommendations, builds on those and the recommendations made by the inquiry, then goes beyond that into the next 10-year period.

The *NSW Regional Health Strategic Plan 2022-2032*identifies those six priorities to strengthen regional workforce; enable better access to safe, high-quality care; keep people healthy and well through prevention and education; and keep communities informed—we know that's extremely important in regional, rural and remote areas, and build that engagement and make sure we're seeking that feedback, and then working with the Commonwealth and other partners in the expansion and integration of primary care. Expansion of the Single Employer Model is just one of the many initiatives that will allow Local Health Districts to employ rural generalist trainees to work in local hospitals and GP practices while completing their training. In May of this year the Commonwealth accepted New South Wales' proposal for two trial sites of the Single Employer Model which will integrate the Murrumbidgee Rural Generalist Training Pathway pilot and essentially cover off the north and the south, or the entirety, of the state.

The New South Wales collaborative trial model will offer up to 80 trainees at any one time over a four-year period. We're currently recruiting trainees for these roles to kick off in February of next year. Most importantly, developing place-based solutions to primary healthcare challenges impacting our regional, rural and remote communities is the essence of the NSW Rural Doctors Network's (RDN) collaborative care program. Part of us working with the RDN is how NSW Health both supports and then leads on collaborative care models being delivered all the way across New South Wales. The RDN model is truly the essence of making sure that communities engage. It helps push new models of care in areas where we know that the market is under a lot of stress or crisis and moves that forward, concentrating on not just one particular part of the healthcare team but rather all aspects of healthcare and wellbeing that are delivered to a community.

The program is currently operating in communities such as the Far West and Western Murrumbidgee areas and the Regional Health Division is working closely with the RDN to expand to further sites this year. NSW Health has embarked on further work to address health workforce issues in regional New South Wales. For example, we've committed 2,480 full-time equivalent positions towards minimum nursing and midwifery staffing levels and have established rural doctors employment arrangements working group—which we've come from this morning—to review the working conditions, contracts and incentives of general practitioner Visiting Medical Officers (VMO) in New South Wales. We're also building the Aboriginal workforce in rural and regional areas. This workforce has increased by 0.15 per cent to 4.52 per cent from 30 June of last year, 2022, to 30 June of this year. We continue to grow and it's even higher in some specific areas.

NSW Health offers a range of scholarships to support NSW Health staff and students living and working in rural and regional areas. Education and study leave for nurses and midwives has also increased in the 2022-23 financial year and work is underway to convert more than 200 paramedics to Intensive Care Paramedics (ICP) in regional areas. We acknowledge challenges relating to workplace culture and highlight work already underway, including forthcoming reviews of workplace culture and complaint handling mechanisms and funding for agencies, programs and changes to the incentives. NSW Health is developing—

The CHAIR: Have you got much to go?

LUKE SLOANE: Maybe two or three paragraphs, max. I will be concise. NSW Health is really developing that refreshed culture framework and all health agents have developed the NSW Health mental health and wellbeing framework to ensure that staff are engaged and well-supported and experience a safe and mentally healthy workplace. We're committed to our key investment focus, which includes new or upgraded hospitals in regional and rural areas; investment in NSW Ambulance across the State with new ambulance infrastructure at Warilla, Lisarow, Gateshead, Swansea and Kincumber; the expansion of access to and, as Ms Willcox pointed out, eligibility for the Isolated Patients Travel and Accommodation Assistance Scheme—or IPTAAS, as we refer to it going forward—and allowing more people in remote areas to access critical health care via travel or other means over the next four years. It should be pointed out that the point-in-time review for the IPTAAS policy is not going to be the only review we do. We will continue to review that as time goes on and we know we can make it work better for communities.

The New South Wales Government is investing funding over two years to deliver 25 urgent care services by mid-2025. Seven urgent care services have been announced already, including Long Jetty urgent care and Tweed Valley urgent care response team in northern New South Wales. As we continue to advocate for regional communities, we are guided by the vision of the regional health strategic plan. We do convey that to everybody that's partnered with us in this area to provide a sustainable, equitable and integrated health system that delivers outcomes—and improved outcomes at that—that matter most to patients and communities in rural, regional and remote areas.

The CHAIR: Thank you again for coming today and also acknowledging the work that has been done. Certainly there has been a significant increase in focus from the department on rural and regional health, and that's been reflected in feedback that I have received. I want to thank you for your efforts in that regard. I'm going to start the questioning, and my area is going to be around primary health care. I will begin with the observation that primary health care in rural and remote areas is probably in worse condition than it was at the time of the inquiry. It has been made worse by a range of factors, not least being changes in the training program structure, for example. We have heard and seen evidence of hospitals frequently without doctors and the use of virtual care to support them and the fact that, for many reasons, rural general practice, which is a critical part of small community health services, continues to decline. We've also become aware of the pressure that puts on NSW Health and the steps NSW Health has been required to take to fill the gaps in that area. I'm interested to hear from you about the impact of the decline in general practice on NSW Health and what steps NSW Health is going to take to address that issue.

DEBORAH WILLCOX: Dr McGirr, I might just commence, then I might throw to colleagues, into some of the specific employment and recruitment activities that are under way. As you rightly point out, primary care is under a significant strain across various parts of the state. As part of my role, I work closely with the Commonwealth, looking at what we can do around thin markets in both primary care, and aged care is also another area of significant concern. You will recall that the Commonwealth released the Strengthening Medicare Taskforce Report, which included a number of initiatives to assist with the care of people in primary care and to support GPs by enabling them to recruit nurses and allied health, voluntary registration of patients with chronic disease and the like, and some really worthwhile initiatives. But in terms of actually attracting general practitioners and training of medical students in general practice, that remains a difficulty.

We use a number of workarounds in NSW Health to try and support communities in rural and regional, the subject of this inquiry, but this is also occurring in metropolitan Sydney as well, where there is a dearth of general practitioners in various locations. The single-employer model is probably the most obvious one that we're doing, and I know you understand the role of that. And we're also working with aged-care facilities and our community-based teams to see how we can better maintain our connection with primary care and to support and to avoid patients coming into hospital and working with general practice to enable that to occur. It has been particularly difficult in the regions, and I know you understand those circumstances much better than I do.

Virtual care has been a real boost to this and I think some of the recruitment strategies are under way. I would like just to emphasise how closely we're working with the Commonwealth on this, and how strongly we are advocating. I belong to an interjurisdictional committee on primary care where we're looking at recruitment and retention and how the Commonwealth can better support primary care. But in the interim, as the State provider of health care, we have to, I guess develop these workarounds to try and support communities and to support those general practitioners, because they're a very important part of those local communities as citizens as well as healthcare providers.

PHIL MINNS: Chair, to your question about the relative position now compared to when the upper house committee occurred, we can tell you that the decline in people entering GP training in Australia is now 19 per cent between 2016 and 2023. In New South Wales, it's a decline of 15 per cent across the same time period, from 519 doctors entering training to 440 in 2023.

The CHAIR: That's in general practice overall?

PHIL MINNS: General practice New South Wales. And in 2023, 83 per cent of first-year GP training positions were filled, and that is down from 88 per cent being filled in 2022, and 99 per cent in 2021. The performance in 2021 probably had a bit to do with COVID and international borders and how that affected people's decisions post their university education. But it is a decline. It continues, and hence the focus that we've been trying to bring to discussions with the Commonwealth.

The CHAIR: Do you have any data in relation to entry into rural general practice training?

PHIL MINNS: I may have it. It just might be something that someone will contact me on while we're in the Committee today and I will be able to provide it.

The CHAIR: Otherwise, could you take that as a question on notice?

PHIL MINNS: Absolutely.

The CHAIR: Mr Sloane, did you want to make a comment?

LUKE SLOANE: Yes. I think, once again, what we heard from the inquiry is there is a bit of a divide between Commonwealth and state and I think we've done a lot of work to make sure that that now-collaborative tone continues on with how we interface. I participated in a piece of work a couple of months ago in relation to

how they're going to target thin markets—the Commonwealth, when I say "they"—and markets in crisis at the moment, for primary care across the State—not only seeking our input but all jurisdictions, because it is much of a primary care problem for New South wales as it is for all of the country.

We're exploring other innovative models, as I touched on. None of these are going to solve all of our problems all at once, but the collaborative care model, which we've seen piloted in five areas within New South Wales, looks at innovative ways to keep primary care alive and help communities or groups of communities serviced from a primary care model, working with the Local Health Districts. We've got the four Ts models, which took on a single approach to a single employer model, making sure that there was a GP available to the communities, as well as linked in for not-for-profits or non-government organisations and the Local Health District to provide wraparound, holistic care, both from a primary care point of view but also that segue and that connection to the Local Health District. We've seen a similar thing happen in Snowy Valleys around connecting those that are providing primary care to each other in the community and allowing the community to have a say in how that's going to work for them.

Whilst I'll probably put the caveat around, that we know not all of that is the silver bullet that's going to fix primary care for a certain community or region, but it does go to address some of the ways or things that we've heard from the inquiry around communities making sure that they're involved in their health care, that they're communicated with around what's actually happening within health care, and they're able to articulate their needs, as well as have data and information on what healthcare issues are affecting their communities. We've seen other models take off, like the model in Finley, where local health advisory committees are very well connected to primary care, preventative care and health promotion, and that is linked in back through their Local Health Districts.

On top of that, touching back on the single-employer model, we knew that the Murrumbidgee Local Health District model was very successful. Jill Ludford, the chief executive down there, and the team really worked hard to set up quite an innovative model in agreement with the Commonwealth with regards to exemptions for trainees entering that program, so they could employ them as well as facilitate their training in private practice, and now we've made the commitment to expand that across New South Wales. Again, I don't see that being one of those things that's going to reverse 19 per cent decline in people entering GP training. However, again it is one of the things we heard through the inquiry around what was putting people off going into GP training, but also, give them a very supportive connection to not only the Local Health District but private practice where we know that the interface is extremely strong in these small communities.

The CHAIR: Could I just follow up, because I think this is a really critical point? I do want to acknowledge and recognise those different initiatives that have been undertaken, and the requirement to work with the Commonwealth. We have seen examples of general practices that are able to attract practitioners. They're practices with good culture and a range of initiatives, and we are aware also of other practices that have a critical mass. Unfortunately, it seems that there are circumstances in which it's pretty clear in a community that a practice is declining, that people are retiring. People will know two or three years ahead that that's the case. And yet, there seems to be—well nothing happens to proactively to shore up that practice before it gets to the point where workload becomes unsustainable. I accept that NSW Health is not responsible for primary care, but you bear the brunt of it, frankly, when the hospitals close and patients are moved to other hospitals; where chronic care is not implemented; prevention is not implemented; aged care, where you have to go into aged-care facilities, for goodness' sake, to provide primary care because it's not available. You suffer the ill effects of it.

It's not traditionally an area that NSW Health is involved in, but it seems to me that in rural and regional areas, NSW Health does need to be increasingly involved in it. You have mentioned work with the Commonwealth, and I'm keen to hear a little bit more detail about that, but recommendation 11 talks about a rural, remote, regional medical workforce plan over 10 years. It just seems to me that that's the missing piece here: that when it comes to rural primary care, frankly, no-one is doing the planning in that area, and that's fine when lots of GPs are coming into practices, but we don't have that now. And actually it needs someone to intervene in that space. I guess I am putting it back to you. In regard to recommendation 11, what is happening with the 10-year Rural Medical Workforce Plan? And number two, do you see an increased role for NSW Health, perhaps in conjunction with the Commonwealth, actually proactively regarding this sort of workforce planning?

DEBORAH WILLCOX: Dr McGirr, would it be okay if I answered your second question first and then throw to Mr Minns on the workforce strategy?

The CHAIR: Yes.

DEBORAH WILLCOX: Your summary is a good one, and you're quite right. Obviously it's not for us to be recruiting general practitioners, but it's in all our collective interests to be working together because the citizens are the citizens, and they don't care about whether we're Commonwealth or state. The work with our

Primary Health Networks (PHN) counterparts in some way assists these needs. We have a joint statement of intent with the statewide PHN group and increasingly strong partnerships between the Local Health Districts and the PHNs. That is an opportunity where advocacy around a particular practice or a community that is at risk of losing a GP—at least those discussions can be had, and there's an opportunity then to escalate that through the Commonwealth. While we can't actively do the recruitment, we can certainly stand alongside our PHN colleagues and community leaders to assist. There was a second point I was going to raise and it just left me.

The CHAIR: On that issue, would you be able to provide us, as a question on notice, some detail around where those partnerships of the nature you've just outlined are happening? It's not my impression that PHNs are particularly active in proactively planning. Secondly, our feedback has been that relationships between LHDs and PHNs do vary in quality. I definitely agree that there's an opportunity where they work well together, but I think there's a variation. Any particular information on where they work together to address it—if you could come back to it.

DEBORAH WILLCOX: Most definitely. The second point I wanted to add was in terms of the workforce planning. As part of our interjurisdictional discussions with the Commonwealth, issues around workforce planning have been raised because there isn't any national body or any agency that's responsible for looking at this. We all agree at a jurisdictional level—Mr Minns and his team, with the university and TAFE and other sectors, are looking at workforce needs and doing that local planning but nothing at a national level. That's the subject of some discussion in our Commonwealth-state interjurisdictional meetings at the moment to try and get ahead of this planning need so that we can support communities a little earlier than we currently are. Thank you.

The CHAIR: Mr Minns?

PHIL MINNS: Chair, I'd make the observation that the work that has been occurring with the Commonwealth on workforce has probably tried to go after the immediate challenges—looking at the visa system, the arrangements for people qualifying to be able to practise in Australia. It's referred to as the Kruk review. It's got an interim report. We're expecting a final report to arrive before the end of the year for consideration by the health ministers' meeting. That's where the energy has gone at the moment, into those sorts of initiatives. If we're going to get to a point where we have a national 10-year rural and remote medical and health workforce recruitment and retention strategy, we actually need all of the health ministers to engage because we can't do it from New South Wales alone. We definitely need the Commonwealth involved and playing a leading role. We're happy to co-lead on things like that, as we have been so far on the immediate responses to shortage. But I think it has to be a focus for next year in our deliberations with the Commonwealth.

The CHAIR: Before I hand to Ms Saffin for the next question, could you take this as a question on notice? What do you see as the implications of the Kruk review for NSW Health in terms of both rural primary care and rural specialist workforce? That's quite an important piece of work. Secondly, can I clarify? The recommendation was for NSW Health to work with the Australian Government collaboratively to invest in the development of a 10-year rural and remote medical and health workforce plan. I don't think that requires the cooperation of all the other States—just New South Wales and the Commonwealth, doesn't it?

PHIL MINNS: When you involve the medical colleges and when you're dealing with aspects of Commonwealth health settings around workforce, it means that anything that we try to ask the Commonwealth to move on or to has an impact in all jurisdictions. The Commonwealth minister announced last week that they want to do a wideranging review to investigate how to more equitably distribute doctors and other health workers around the country. The review will look at Medicare's role in locating the workforce as well as the three main policy levers used to distribute the workforce: the Modified Monash Model, the District of Workforce Shortage concept and the Distribution Priority Area concept, and how they impact on the structure of Medicare. To some degree, that announcement reflects an intent to move in the direction that the recommendation noted. But we do have to try to move all the parts of the ship at the same time.

The CHAIR: Can I just make a comment on that? They are the levers that they've got. It's good to hear that they've finally recognised they have to pull some of them to sort this out. My observation would be that I'm not sure we can wait for the Commonwealth to sort all that out in the next two to three years. Even despite that, I would have thought that there's an opportunity for NSW Health to do its own rural and regional medical workforce planning. I'm conscious that, of course, you have to cooperate with the Commonwealth. Nevertheless, at the end of the day, it's a problem we have in this state. Waiting for the Commonwealth and the other states—I make the observation that we may not have the time to wait. I offer the suggestion that perhaps we should be a bit more proactive in that planning.

PHIL MINNS: Noted, Chair. But I would say that the work that occurs between my branches and Luke's are very much focused on the bits that New South Wales can bring to the table. There is an incredible focus at the moment on workforce strategies that are either enhancements of what we've tried in the past or are new

opportunities to think about the problem. We keep doing that, but some of the levers that we need to influence—we have to have the Commonwealth at the table with us.

The CHAIR: I understand that, and I've taken up enough time talking now. I note that Ms Williams will be leaving at a quarter past two. I wonder whether we could go to Ms Williams next because she has obligations. She's not storming out; she just has another obligation. She was at pains to make sure I knew that.

Mrs LESLIE WILLIAMS: Thank you, Chair. I have two questions and they're not related to each other at all. First of all, I welcome the news that 16 of the recommendations have been fully implemented. I am going to ask about one of them, and that's IPTAAS. We have heard from other witnesses that they've welcomed the significant increase in funding. Mr Sloane talked about ground-checking the changes, and that's great. Are you, and how are you, going to evaluate whether the changes that you've made as a result of the recommendations are enough? We've heard from witnesses as early as this morning that there is a lot more we can do with IPTAAS rather than just increasing funding. How are you going to evaluate whether or not you've done enough in terms of the recommendations? That's my first question. I will leave that one with you first.

DEBORAH WILLCOX: Thank you. If it's alright, Ms Williams, I might defer to Mr Sloane on that one.

LUKE SLOANE: Thank you for your question, Ms Williams. We have a full measurement and evaluation framework for the implementation of the new policy proposal, which saw us increase IPTAAS up to $200 million over the forwards, which was a substantial increase. We've had an upswing from the usage of it already tracking on a monthly dashboard of upwards of 40 per cent, I think it was, with regard to uptake and usage of IPTAAS. We know that it's not just the payment or the ability to access payments, so we've increased those things that are available to the end user, such as high-risk clinic, specialty dental surgery and a few other items that they can access. But we also know that the filling out of the forms and the usability of how people access it is very important as well. There has been substantial change to not only the paper form but also the online version of how people apply to it. We're working on further improving Part C, which is the GP validation of the IPTAAS application.

In reality, it comes down to a financial question of how or where we draw the line and how we do governance around people accessing IPTAAS schemes, trying to balance those people applying versus what the eligibility criteria is for it. We've given many based on a very sound process with EnableNSW from HealthShare, who administer the program for us. If someone does question their application or the validity of their application outside of it, we have a process of working through where that can be discretionarily granted to fund the IPTAAS program as well. That's why I said in my opening statement that it's not going to be one of those things where we go, "Right, we've reviewed it once and we're going to leave it there for a while." We're going to continually work on and improve it. But it will be measured and evaluated across all aspects of it, not only the financial aspect but the user experience aspect and the end-user experience. We've already seen it enveloped into some of our experience surveys with the Bureau for Health Information about how people experience applying for it and/or the use of travel to and from appointments.

Mrs LESLIE WILLIAMS: That's good. I'm pleased to hear that there is feedback on it. That's great. My second question is in relation to nurse educators. I noticed that it was mentioned. I think you mentioned that there was increased funding for nurse practitioners. Is it the same for nurse educators? And how do we know that a nurse educator in a hospital setting is 100 per cent focused on nurse educating and not being used to backfill positions?

DEBORAH WILLCOX: Ms Williams, I would have to take that on notice, unless other colleagues here have—

Mrs LESLIE WILLIAMS: I'm happy for you to take it on notice.

PHIL MINNS: I could make one remark. We did see quite a significant increase in the number of Certified Nurse Educators (CNEs)—nurse educators—across about the last six to eight years. I've seen that table. I can't recall its numbers, but we can get that for you on notice. The situation within a ward or a facility with an educator is ideally that they get to do the education work. But there are likely certain circumstances where late withdrawals of staff through illness, et cetera, and the inability to get someone for agency or casual shift basis does present challenges. That would be occurring in some of our smaller facilities. But it's not the planned intention; it's when the labour supply fails us.

Mrs LESLIE WILLIAMS: I totally understand that after working in a very busy hospital. But my concern is that we're hearing that nurse educators aren't actually getting to do much nurse educating. The knock-on effect of that is that those post-grad students or their colleagues aren't getting the professional development that they should be getting with those CNEs in those positions. I will leave that as a comment.

The CHAIR: Which then, of course, makes the recruitment retention much more difficult because they're not getting the bonus of the professional development.

Mr CLAYTON BARR: Could I just add one more comment to that? What we heard this morning also was that because the nurse educators don't have the time, or they've been pulled away to do other stuff, some of the policies and ideas and initiatives that are coming down from your level hit the nurse educator and then don't get rolled out because they don't have time to roll it out, which was really challenging to me.

Ms JANELLE SAFFIN: My question is to do with the reviews of the small hospital funding models. That was recommendation 1. Can you give some report on the key findings from the reviews and also comment on any changes that might come with the block funding model in upcoming reviews? Who wants to do that one?

LUKE SLOANE: I'm happy to. In line with the Special Commission of Inquiry into Healthcare Funding, no specific reviews with regards to healthcare funding have been kicked off, from NSW Health's point of view, since the inquiry recommendations. However, we have a continuing and ongoing focus on financial oversight and which model works best. I don't know whether Alfa wants to comment around the switching between models or which model suits best for small sites or otherwise. But, at this time, we haven't embarked because there has been a significant amount of information pulled and a commitment to participating in the special commission of inquiry. It's not to say that we don't focus on and/or keep an eye on finances for small to larger regional sites as we go on. I don't want know whether you want to provide any more comment, Alfa.

ALFA D'AMATO: If I may, in respect of the small hospital funding model, I think we have to acknowledge that it has been evolving over the years. What I mean by that is that every year—I probably need to acknowledge, before COVID—we used to engage with the districts in respect to the feedback around the funding model, purchasing arrangements and the like. This kind of cycle started around November or December, but we had an opportunity to then reflect and strategise in respect of ways that we need to make modifications. The modifications were more around the fact that the national model is relatively rigid. It has to accommodate for all rural hospitals, not only the rural hospitals in New South Wales but also for Western Australia. At that point, probably six years ago, Murrumbidgee raised with us an opportunity to create a better link between small hospitals and ABF hospitals so that we could encourage local districts to determine where would be the most appropriate and efficient way to deliver care.

At that point we introduced a model whereby, when we engaged with the purchasing activity in regard to the activity growth for the future years, we tended to allow districts to also determine whether they want to do it in small hospitals. What this means is that, yes, there is a small hospital funding model which is predicated on a fixed and a variable component. But, on top of that, we also acknowledge that if districts want to move activity, we fund on top of it. We don't necessarily penalise the small hospitals or districts that are willing to make some changes in the way that they determine to deliver care. As I say, it's an evolving model. I think that so far we have evolved based on the feedback we've received, acknowledging that during COVID we pretty much paused the conversation in regard to the funding model because of the circumstances.

Ms JANELLE SAFFIN: You said it was rigid and evolving.

ALFA D'AMATO: The national model, yes. We evolved locally based on the feedback from the districts and we paused during COVID.

Ms JANELLE SAFFIN: I'm not sure what you're telling us. Anyway, I'll think about it.

ALFA D'AMATO: Okay.

Mr CLAYTON BARR: Can I just clarify? Ernst and Young marked that down as complete—all done.

LUKE SLOANE: That's part of us collaborating and committing to participating in the Special Commission of Inquiry into Healthcare Funding across the State.

Mr CLAYTON BARR: So it's complete but not done?

Ms JANELLE SAFFIN: That's why I said I'm not sure what you're telling us.

The CHAIR: Yes. If you look at the specific recommendation, it's that NSW Health review the current funding models for all Local Health Districts, rural and regional, in order to identify service delivery gaps and provide a recommendation for funding increases. There are two actions associated, both of which are rated as "completed". Essentially the commentary is that, according to this, you have embedded it in an annual review process. The second one is that block funding is in scope for the National Health Reform Agreement. Neither of those commentaries really outline what happened in terms of the review process and what the implications of that have been. You partly alluded to that in your reference to something that Murrumbidgee did, but there's no detail on that here. It would be good to understand that a bit more. It would also be good to understand what, if anything,

happened as a result of that review process in terms of the small hospitals. I think that's what Ms Saffin is getting at.

Ms JANELLE SAFFIN: That's what I was getting at. You didn't answer the question I asked based on recommendation 1, so I wasn't sure what you were talking about. I was quite specific with what I was asking and recommendation 1 was a clear recommendation. That was something different, I think, that you were speaking to.

LUKE SLOANE: Every year, NSW Health goes through a purchasing review and agreement with each one of the Local Health Districts, which incorporates all of their activity across all of their sites and includes population and planning data with regard to the health care that's purchased off the LHD. Every year, we go through a review process with each one of the districts to look at and assess their annual spending, the activity performed and how they've performed against a whole bunch of key performance indicators for the previous years to advise and inform changes to and/or the evolution of their funding for the next year going on.

Ms JANELLE SAFFIN: But what did you find? You haven't implemented recommendation 1. Is that what you're saying?

LUKE SLOANE: No, I'm not saying that. I'm saying that's part of us reviewing all of the different parts of funding for all of the LHDs, including participating in the new Special Commission of Inquiry into healthcare funding as well. As I did say, we did no specific review into funding for smaller sites and recommendation 1. We do it on an ongoing basis.

Ms JANELLE SAFFIN: You didn't implement recommendation 1 even though the Ernst & Young (EY) report says you did?

LUKE SLOANE: I think we've stayed true to the intent of recommendation 1, with all of the processes that we have in place to review that funding on a per annum basis.

Ms JANELLE SAFFIN: That's not what I'm hearing. If it's not done, it's not done.

The CHAIR: Ms Saffin, I think what you're saying is that if the review was done, as recommended, what was the outcome of that review?

Ms JANELLE SAFFIN: That's the question.

The CHAIR: Perhaps you might provide us with some information on that. I accept that you've just also indicated that there's work taking place with the Special Commission of Inquiry.

Ms JANELLE SAFFIN: That's a separate issue, though.

The CHAIR: Yes, but it may be relevant to our considerations.

Ms JANELLE SAFFIN: It may be relevant, but it's separate to recommendation 1. The EY report, which you commissioned, says it is done. That was the question I was asking. Maybe you might want to take it on notice.

LUKE SLOANE: I am happy to take it on notice and give further information. But, again, I think the evidence that EY have been taking—and/or, again, just noting it was a completely independent review of how we were progressing against it—was more than likely referring to that periodic review of activity-based funding (ABF) and small hospital funding models on a per annum basis, including Multipurpose Services (MPS) and other small sites.

Ms JANELLE SAFFIN: That's quite unsatisfactory.

DEBORAH WILLCOX: It is an annual process. I would probably just add that, slightly off the point of the actual recommendation, it's part of the midterm review of the National Health Reform Agreement. The funding models for health in general, but certainly small rural, are incorporated in that review. Obviously the Commonwealth is a critical partner in that as well, but I think the recommendation says "a review". From what I'm understanding from our colleagues, every year we do a review of Local Health District funding and that would meet the intent of recommendation 1. But we'll take that on notice and get you some further detail. I understand your point.

Ms TRISH DOYLE: That's recommendation 1. My question is a little more broad. We know that the New South Wales Government established a Special Commission of Inquiry into healthcare funding, and that obviously means there is some crossover. How are you managing that crossover with the recommendations?

DEBORAH WILLCOX: Ms Doyle, if I may, the Special Commission of Inquiry just started receiving submissions and literally just commenced the hearing process today. My advice is that we're unlikely to receive any recommendations from the commission until September next year. We'll continue to work on the

recommendations out of the rural inquiry. If anything additional comes out of the special commission that relates to rural and regional health, we'll work to ensure that is equally implemented.

Ms TRISH DOYLE: I'm going to turn to a completely different question now. In your submission, there is reference to community paramedicine and that it's not currently fully defined in the New South Wales context. There is a broad understanding in the community that paramedics with extra primary care training working in community settings would assist where we have gaps. Working in large GPs, urgent care centres, people's homes—aren't on an ambulance. It doesn't exist in New South Wales, but where are we at? You say that it is progressing in line with related work. Can you elaborate on that?

PHIL MINNS: The government asked us to reconvene the paramedic workforce forum, and I think we did that from about the middle of the year. It has met several times and it has tried to develop two higher levels of paramedic specialisation, a level three and a level four. The broad framework for that is in place. It has resulted from the discussions in the forum. There are lots of logistical questions then that flow on. How do you deploy that model or those paramedic skills in the community setting? There is a plan to conduct a pilot in western New South Wales. The pilot has a potential commencement date early in the new year, subject to consultation. The progress has probably stalled a bit in recent weeks, in connection to other issues associated with the paramedic workforce.

Ms TRISH DOYLE: That's a positive response, Mr Minns. I'm pleased to hear that's where we're at.

The CHAIR: You said it has stalled. I just want to check that it has not stopped.

PHIL MINNS: It has not stopped, Chair, but there is quite a lot going on in respect of the paramedic workforce and the Health Services Union.

The CHAIR: Indeed.

Ms JANELLE SAFFIN: It might be paused.

Ms TRISH DOYLE: I'm told in the community that this would take some pressure off our EDs—potentially take pressure off our emergency departments—and take pressure off our on-road paramedics, because we could treat people in their homes. It would recognise paramedicine as its own profession with its own specialists. For the purposes of the Committee, I'd like to note that I'm told the Australasian College of Paramedic Practitioners has put together a very good opinion piece on this that could inform how we move forward here. Dr Joe, our Chair, just referred to this stalling, but there have been several discussions. Do you expect that there will be a trial at the start of next year?

PHIL MINNS: Subject to consultation and agreement from all the parties.

Ms TRISH DOYLE: Which is a tough one. I'll leave that for a moment.

Mrs TANYA THOMPSON: My question revolves around the initiative schemes that were rolled out. Given that we've had many opportunities to talk firsthand with staff across the board and read it through submissions—even this morning, we've heard feedback ourselves—I'm interested to know and to hear how you feel the scheme has been received by staff and if you feel that the incentive payments were allocated fairly and rolled out effectively. Given Mr Sloane's referral to ground-checking, do you feel that it has, in fact, been effectively rolled out across the board as it was intended to?

PHIL MINNS: I'll just give you some data points that I think go to the question of effectiveness. The first one would be that the new full-time equivalent staff that have been recruited with incentives, as at last Wednesday, is 1,347.95. If we reflect that as a headcount number, it is 1,566 people who have been recruited newly into a role in NSW Health with an incentive.

Mrs TANYA THOMPSON: Is that in remote and rural areas?

PHIL MINNS: Yes, it only applies to rural areas. If we talk about the number of positions that have had an incentive allocated to assist in retaining staff, the existing FTE retained with incentives is 7,105.13 and the headcount of that same concept is 9,950. We can show time-series graphs that show that we are past the worst of the separations we were experiencing in some of our smaller rural and regional facilities. It's still not universal across every one of those facilities. The point of the change in policy to increase the amount available as an incentive, particularly to attract and recruit up to 20,000 across a three-year period, is derived from the fact that we've still got aspects and areas where the incentive offered has not generated the solution needed. We are in the process right now. I think we received the feedback from unions last week. We gave them a month to look at a revised policy for the operation of the scheme that reflected the feedback that they had given to us after its first eight to 10 months of operation. We'll be considering that feedback now and moving to a second iteration of the policy.

LUKE SLOANE: In addition to Phil's comments, it would be remiss of us to not respond to the entire question, Mrs Thompson. As I've travelled around—as all of us have travelled around—there have been some variable positive and negative comments around the incentive scheme. We know and we acknowledge that it's affected some workplaces with regard to how it's been applied in some of the Local Health Districts. I know the chief executives from all regional, rural and remote Local Health Districts are coming together at the moment to try to work together with regard to how it can be more equally distributed across, keeping in mind that one of the things is it that needs to be place based.

The critical workforce shortages in some areas are very different to other areas, right down to specific professions. We also know that application to some areas of where or what type of workforce the incentives apply to—it's not applied to the person that works in the office next door or in the clinical area next door because that hasn't been seen as a clinical workforce shortage. We also know some of the jobs or roles that are perhaps more appealing—we've talked about clinical nurse educators or nurse educators—in some areas haven't attracted the incentives payment because they have not been critical shortages. All models are wrong, some bits are helpful. As we work through this progress, and Phil and his team work together with us in the Regional Health Division and across the system with all of the districts, it's what will work best for the greater good of the workforce and making sure that we can keep and retain people in these areas.

I want to acknowledge that we have heard that as we've travelled around. It's not lost on us that it has affected people and has caused, in some places, schisms within the workforce around why someone has received it and others not, and also the notice and the communication around when they have and haven't received it. Some people have received it as a bit of a surprise and haven't been consulted. We know that all the districts now are working very hard to remediate that. As we work through this policy consultation and review, we can do it better into the future.

The CHAIR: That's good to hear. Can I just feed back? Part of what we heard was the suggestion that the funding for the incentive scheme would have been better—this is a suggestion—targeting opportunities for professional development. We particularly got feedback around people being able to travel away to develop their skills and get leave relief but also be funded to do that. The commentary was made that those opportunities may work more effectively. I make that comment to you. I don't know if you've got a response to that.

LUKE SLOANE: I definitely do, and Phil might like to expand on it. We know that the incentive scheme was there for the use of the employee and how they wish to do so—within reason, of course, not buying ice cream trucks to bring to work. However, there was the real remit that those incentives were there to use for further education opportunities and for other development opportunities that they could use. However, again, coming back to how we may have communicated that, we could do better next time in making sure it was explicit about all the uses that could be used.

I know that a lot of the workforce, from the people I've talked to—I'm not speaking on all of this. I remind everyone that we're talking about 60,000 or 70,000 people that work in the regions. Some of them just thought it was part of their new pay packet as part of working in a regional area. However, the option to use it as a scholarship for professional development or other mechanisms—to come to the city to train or to go to another rural area to train, which we know is happening more and more—was on the cards. Phil, I don't know whether you want to elaborate on that. But I think that's the crux of the matter, and it comes down to communication.

The CHAIR: Okay. Mr Minns, the numbers that you gave us—it might help us understand their impact if we saw the time-series graphs. I think what you're painting is a picture in which this has stabilised, if you like—a decline in the workforce—and it's been effective at that. It doesn't address entirely rebuilding it, but it does seem to have been effective. For us to make sense of those figures on their own is a bit hard. There have been 1,347 recruited with incentives. I presume what you're saying is that in the six months or whatever the year prior to that, there weren't as many recruited and that recruitment lifted. Likewise, the retention figure—how do you know someone has been retained? I presume, again, that you're comparing a figure to something that's gone before, a decline that's happened before. Would you be able to provide those?

PHIL MINNS: Yes. Rolling retention graphs show an average curve for just about all disciplines, where we've got a classic U reflected in the data. I'm happy to make that available.

The CHAIR: I think that would be helpful for us to understand the impact of it. We might move to Ms Butler.

Ms LIZA BUTLER: Thank you, Chair. My question relates to obstetrics and recommendations 11 and 20 around the midwifery workforce. Can you tell the Committee more on what you have done in those regards and what that has meant for women in rural, regional and remote areas to access any natal and obstetric care?

DEBORAH WILLCOX: We'll just get some figures for you. I should probably open with the inquiry into birth trauma. As you would be well aware, we've been actively participating in and are very mindful of some of the experiences that women have bravely shared with that committee. We've been working particularly in Wagga and Wollongong, where we've had some particular concerns. Wagga was really the beginning of that inquiry. The consumer network raised a number of complaints from women. We most recently briefed Dr McGirr on some of the initiatives there, but we're deeply focused on improving the experience and continuity of care with a midwife or an obstetrician. Giving women choice, continuity of care, informed consent and communication are really paramount. They form the foundational elements of our blueprint for maternity action. We're just starting an implementation program. We have a peak clinical group of obstetricians and midwifery leads from every local health district, as well as a consumer council with representatives from around the State, to help guide us in that statewide process.

Ms LIZA BUTLER: Is that just looking at where women can deliver babies now, or is it about expanding? They're two totally different things.

DEBORAH WILLCOX: It won't specifically go to identifying different facilities or hospitals where birthing could be occurring.

Ms LIZA BUTLER: That's in birth trauma. We're talking about this recommendation of workforce. They're two separate things.

DEBORAH WILLCOX: I'll get Mr Sloane to give that background while we prepare.

LUKE SLOANE: We continue to work through some of the workforce challenges with regard to obstetrics as a whole, not only recruitment and retention of midwives, which we know is not our new statewide shortage but a whole interjurisdictional and, some would say, global shortage at the moment. We're working with universities about how we can increase graduates through there. But, once again, that comes back to some of those experienced workforces and how we're actually applying them. Through the tiered perinatal network I know that there are strong networks and/or supportive mechanisms in place in order to provide some of the smaller sites with the support, but it doesn't come through a workforce lens or angle because we need the bodies on the ground. We're working with the Chief Nursing and Midwifery Officer to make sure that we are funnelling those graduates, where we're able to, to the places that we need them to be. However, that's not without taking their choice away or providing some sort of social conscription-style service of placing people where we need them to be, rather than where they have anchored themselves with their family or otherwise.

On the medical side of things, there's a bit of a dichotomy at the moment where we might have a lot of GP obstetricians in a small town but they're unable to do higher-risk or higher-acuity interventions because there's no GP anaesthetist in town. We're working with the college and some of the districts around identifying exactly where the hotspots are or the need is most for either GP or VMO obstetrics, anaesthetics and proceduralists to make sure that we can do some of these procedures, specifically with relation to the maternity and obstetrics workforce. The midwifery pipeline—for us, we know we've got three ways to get midwives through the system, one being the degree training. That's a degree in midwifery only. The MidStart program is registered nurses embarking on an full-time equivalent (FTE) and training at the same time in order to become midwives. But we know that that pipeline at the moment—because of the changes and nature of workforce post-COVID, people are not working a full FTE.

Now we're looking at replacing some of the full-time equivalent staff, or one-headcount staff, with two or three to be able to make up the full quotient of hours. That goes all the way from some of the larger regional sites through to the smaller. With some of the sites around birthing and very much smaller sites or low-risk birthing with regard to support to GP obstetrics—I've got a few examples of locations—it's really walking that fine line of ensuring there's a safe, good quality service for those mothers who are giving birth or looking to have antenatal and perinatal services in these regions and making sure we've got the staff to match whatever that service looks like at the moment, from a safe and good quality of care delivery point of view.

Ms LIZA BUTLER: We haven't got anything measurable so far to see improvements for women in regional areas?

LUKE SLOANE: Improvement for women in regional areas—I think the connected nurse and the support across the different tiered perinatal networks is there. However, we do need to still continue to build on the workforce in a lot of these places. Again, coming back to comments—I can't remember who made it earlier—we have seen sites where they have a full quotient of midwives and GP obstetrics at one place. Then you might drive 45 minutes or an hour down the road and they don't have the access or the same amount of workforce and have been struggling to recruit. We're trying to figure out the exact cause of that or how we can redistribute the workforce so that we have both those sites humming, especially where there is a need from an activity. We're

certainly not going to do it if there's less than one birth a month there. We want to make sure there's a safe, good quality service in place. But there definitely is, and has been for a while—the ability for us to get midwives to put in a lot of these regional remote areas has been very challenging.

The CHAIR: Is there a map or a plan of current maternity services in the State with their staffing levels and identification of ones that are operating well, ones where it's precarious, ones where there has been a temporary halt or there's bypass and, to accompany that mapping of the services, a plan with each service as to how they'll be restored if they're in a difficult position?

LUKE SLOANE: The districts manage that within their Local Health Districts. Whilst that would be a liaison with the maternity unit in the NSW Ministry of Health, the districts themselves would have that information around what's happening in their own districts and all the different services there involved. At any one time, if push comes to shove, there do need to be business continuity plans in effect.

The CHAIR: We heard this term "business continuity plans". I was pretty distressed to hear that there were business continuity plans for obstetrics in a place like Armidale, for example, that has a barely sustainable specialist obstetrician workforce. In fact, I think at the moment people are on leave and so on. There are locums that are not always available and so on. It struck me that this is such a global problem in NSW Health and is probably beyond the capacity of any individual Local Health District to tackle. Ideally for the rural health division, we should actually take a strategic view to this and start mapping these gaps, because it's not just the rural generalist workforce and the midwifery workforce. It's actually the specialist obstetric workforce in some places.

I don't get a sense that the health districts have the capacity to long-term plan to sustain those services with the workforce they need. I'm not actually sure the college of obstetricians is producing graduates, for example, who could go straight into a rural practice without mentoring. There's a degree of involvement of overseas recruitment. Any reflections on that? I have to say, it's quite a distressing aspect to think about that. I put it to you that I'm not sure that the rural Local Health Districts have the capacity to solve this problem—each of them individually.

Ms LIZA BUTLER: Dealing with my own local health district, it's like they do not want to even think about how to restore. They're actually putting the brakes on it. I think that is a cost-saving measure. How do we break that?

DEBORAH WILLCOX: I might just make a general comment. In a devolved system, which is NSW Health, as Mr Sloane indicated the districts do look across their hospitals and their services and manage their recruitment and monitor their service delivery. I agree with you. In some of our rural LHDs this has been an irretractable issue in a number of services, including maternity. There is strong communication and escalation from the Local Health District chief executives and hospital management into the Ministry of Health. We network across districts, as well, to try to support various locations and put in contingency measures for services that require clinicians to enable them to have a 24/7 service, such as maternity. In terms of managing the development of a workforce pipeline, that work is done through Mr Minns' division and works with the colleges and universities. We would not leave a district alone to try to manage a chronic shortage of workforce. Generally their job is to try and sustain and maintain their services with our support. But in terms of retention—

The CHAIR: What is the pipeline for the specialist obstetric workforce into rural New South Wales?

PHIL MINNS: I'd have to take that on notice, Chair.

The CHAIR: I'm going to make the suggestion that I'm not sure there is a pipeline for it. I understand the concept of devolved authority—I appreciate you taking that on notice, Mr Minns. Mine was more in the way of a comment. I understand the concept of devolved structure, but it strikes me this is something that needs a statewide approach. Otherwise I think we'll have maternity services continuing to slowly disappear, frankly, and even specialist high-volume services. It is a concern, so I just put that out there.

Mrs TANYA THOMPSON: On Friday we did hear from Inverell representatives, who advised that Armidale was on bypass. Therefore, people are now travelling to Tamworth, which is 2½ hours, and that is if all is going well, they can have a normal delivery and there's no complications.

The CHAIR: And Tamworth is intermittent. There are some weekends where Tamworth—

Mrs TANYA THOMPSON: It also doesn't have obstetrics.

The CHAIR: That's a big regional centre with a specialist obstetric workforce.

LUKE SLOANE: Absolutely. From a Regional Health Division point of view, we've very much put them in the limelight with where we want to concentrate because we know that the tablelands is a very vulnerable place at the moment with regard to the medical and other clinical workforce as a whole. It's a wicked problem, which

I've probably said to the Committee a couple of times, in how we unpick this. Even if we had 18,000 people going through the college of obstetrics, asking them to go and work in regional areas still comes down to their choice. But we do need to work with them to make sure that, from a community and liveability point of view, it is very appealing to work and function in these areas.

We know that if someone who is a specialist goes and works in a smaller site—a smaller regional or remote, or even somewhere like Armidale referral hospital—they will still need to be able to perform the clinical interventions or procedures necessary to maintain their fellowship with the college. This is ongoing work that we will do and continue to talk to the colleges about. How we make sure that we maintain that balance between exposure to clinical skills; safe, good quality care; and their ability to function in these very small, exceptionally liveable towns. As we heard from Inverell the other day, the community is extremely passionate and they want to wrap around anyone that comes to the towns.

I will draw the Committee's attention back to—there is a National Medical Workforce Strategy through to 2031. Priorities two and three talk about distribution of the medical workforce. This is from a Commonwealth level. They also talk about the right people and the right distribution of what specialists and what workforce we need to put where. The main thing to come home with is that we can have all these plans working. It's about brokering that relationship not only with the colleges but with the workforce team at the Ministry of Health and with the Local Health Districts. I probably won't be contrary to your statement, Chair. But I think some of the regional Local Health Districts, if not all of them, have extremely good capability in planning. However, some of them are limited with what they can do—blood, sweat and tears—trying to attract people not only to the community but to work in their service with some of those role delineation problems or barriers that they face.

The CHAIR: I think that when it comes to dealing with the colleges, that's beyond Local Health District capacity.

LUKE SLOANE: Absolutely.

The CHAIR: I think that's a necessary discussion that has to be taking place. I would be interested to see the mapping of obstetric services and what their current status is in terms of viable, precarious, temporarily closed. I accept that there's a national strategy and I accept that there's capacity at the local districts. For a number of years they have managed this issue. But it's such a global problem, and we're in the midst of such a difficult situation. Frankly, it's becoming urgent. I think the state should be considering that from a global perspective.

LUKE SLOANE: Look, I think we have. I refer back to the NSW Regional Health Strategic Plan which we've covered off, linked up with Phil's workforce plan, in order to put these actions in place as part of the road map to work on this. I cannot guarantee I'll deliver it yesterday or tomorrow, but we will continue to work with all of the stakeholders to get this done.

Mr CLAYTON BARR: I had a bit of a smile because we're running out of cemetery space as well. We're not planning for them coming in. We're not planning them for going out. We're just living life in the middle. I like to think I'm a fairly reasonable person. I'm also 52 years old. The large part of my life is behind me instead of in front of me, so I'm going to be pretty blunt and abrupt, and respectfully honest with you all. Is there any chance you can get your money back for this Ernst and Young report? I want to go to the point that was being made earlier by my good colleague Ms Saffin. Recommendation 1 is marked down as complete. We had a bit of backwards and forwards. But when I look at the progress markers, essentially the progress is, "We already do that review, so it's complete." Then the effectiveness that Ernst and Young notes is that evidence has not been provided to assess the effectiveness towards this action, but it's complete. I also want to make the point that if the annual review of that funding was working well, then it wouldn't have come up in the inquiry that took place. How do we progress when we get an independent report like this that is just not up to it? How do you guys work through this?

Ms JANELLE SAFFIN: It's a qualified audit report. That's how I read it.

Mr CLAYTON BARR: It's a qualified audit report. Fifteen out of the 71 have blue lights. If you guys take that on face value that they're done—have we listened to what the upper house inquiry found and the context in which those recommendations and actions were made? We can't explain it away and say, "We already do that."

Ms JANELLE SAFFIN: Can I just add that we'd rather hear from you how it was done, not Ernst and Young. Forget Ernst and Young.

DEBORAH WILLCOX: The first thing to say is that we take the inquiry and the recommendations incredibly seriously. I would impress upon the Committee that an inordinate amount of work has been done and continues to be done. We come to work to serve those communities every day, as do our colleagues out in the Local Health Districts. I accept the Committee's discontent with recommendation 1. My understanding—others

could be closer to this—is that the review of our work in relation to recommendation 1 is because every year, as we step through the purchasing and budget cycle with every Local Health District, there is a review of their funding. The complexity in our rural and regional and remote Local Health Districts is that there are many, many small facilities, and activity funding is not a suitable funding mechanism because of the low volumes. I appreciate that the Committee understands that. It's a combination of block funding and activity funding.

We have a capability within the finance team and through NSW Treasury to alter that funding model to accommodate the needs, because clearly there are changes within those hospitals and services. They provide an activity and serve the community in those Local Health Districts. The intent of recommendation 1, a review mechanism, has occurred and happens annually. I understand, too, that the Committee would expect that it would be a review with another set of recommendations. But, clearly, the EY work has indicated that, for the purposes of recommendation 1, that work is undertaken to a level of satisfaction from their perspective. In terms of, as I briefly mentioned before, issues around the funding of our rural and regional and remote hospitals, we do have to deal with the Commonwealth. I know it's a little like a broken record. But as part of the midterm review, that is definitely a feature that's come up across all the jurisdictions. Many, like WA, South Australia and the NT, have large remote communities. It is, to use Mr D'Amato's word, a fairly rigid funding measure that we're hoping the Commonwealth will come to the table and make some more practical change to.

LUKE SLOANE: Whilst Ernst and Young was a report at the point in time, by no means do we take that as gospel. We embarked on that to give a pulse check of where we were up to with regards to recommendation implementation, not passing up the fact that we also have the 10-year strategic plan, which not only incorporates recommendations through about 600 actions but also takes it further to where we need to be in the next 10 years. On the funding model, when we did examine it—it's not by any means a review, that's for sure. We do have the small hospitals funding model that provides that examination of funding models on a per annum basis with the basis of the actual cost of the previous years running, plus escalation. It's never a backwards thing with any of these small hospitals that we look at on a per annum basis.

That model enables the facility to participate in any growth funding for that activity increase on a year-to-year basis. It doesn't reduce the funding at all where activity reduces against the prior year. None of these small hospitals are taking a step backwards. That's why we felt somewhat assured by that small hospital block funding, but that doesn't cover off everything. Some of them teeter on the difference between that small hospital block funding and being slightly larger, where they might tip into, and the LHD might choose to go into an activity-based model of funding. Mr Barr, to close on your comments, that's one point in time. We knew Portfolio Committee No. 2 was also going to review our process into the implementation of the recommendations at the two-year mark, which is coming up. I think there has been considerable work done, not only by the Regional Health Division but by the Ministry of Health and the districts as a whole, as part of these recommendations within the 14 or 15 months since they've been handed down.

Mr CLAYTON BARR: Mr Sloane, do you understand what I'm saying? This issue is something that already happens in NSW Health—this review, annual review, 12-month review. If it had been happening well and happening effectively, then it should never have arisen as a problem to become a recommendation in the upper house report, should it? If it was going well, it wouldn't be a problem. Doesn't the fact that it became a recommendation suggest that all is not well and we might need to do something differently? To your point in time thing, I really struggle with "complete" as one of the words in the Ernst and Young report because it is a snapshot in time on a longer journey.

LUKE SLOANE: Yes.

Mr CLAYTON BARR: But do you understand what I'm saying? If it was working well, it shouldn't come up in an inquiry.

LUKE SLOANE: Yes. Look, also things like Ms Willcox has talked about with regard to participation in the National Health Reform Agreement—our contribution to that, to make sure we are participating in the Commonwealth review into funding as a whole. Alongside that, my involvement in the multipurpose service advisory committee with regard to review of funding and/or funding models for multipurpose service advisory as well—they all come into it. We recognise that we always need to be examining this as part of making sure that all sides are funded according to the activity and the population that they serve. We'll continue to do that.

Mr CLAYTON BARR: That was all just introductory remarks. I wanted to talk about culture, which is recommendation 40. It was specifically around—I'll read it:

> … an independent review of workplace culture including complaints management mechanisms …

The third one is:

> … commission the conduct of independent and confidential staff satisfaction surveys …

These things have arisen in an inquiry, which means that whatever we're doing at the moment isn't doing real good. The fact that they came out as a recommendation suggests that we need to do something different, and I think there's a pretty clear outline there. But when Ernst and Young went to speak to the stakeholders, who are essentially employees of NSW Health, they just kept bouncing back to the things that already happen inside of NSW Health, which have already been happening for a long time, so they're just going to keep doing what they've been doing. That doesn't really match with the fact that there's a recommendation here. How do we balance that?

The CHAIR: Mr Barr, are you talking about recommendation 40?

Mr CLAYTON BARR: Yes.

The CHAIR: That is actually red.

Mr CLAYTON BARR: Sorry?

The CHAIR: That is incomplete.

Mr CLAYTON BARR: Yes, it is incomplete. But if you read the progress dot points, the staffing side of NSW Health, who were talking about what they might contemplate doing to address this, are essentially saying, "We're going to keep doing what we've been doing."

Ms JANELLE SAFFIN: "It wasn't good to start with, but we're going to keep doing it."

Mr CLAYTON BARR: "We're going back to the People Matter Employee Survey, which we always do." That's not what the recommendation is asking for. It's asking for something else. "We've refreshed the e-learning module Respecting the Difference." That's already in place. We keep on hearing from every person who comes to this Committee inquiry that the workplace culture is still not okay. So why do we keep going back to the People Matter Employee Survey if it's not giving us the answers or insights that we need? What did NSW Health staff hear when they read recommendation 40 and looked at what informed recommendation 40? Are we going to do something different?

PHIL MINNS: We are doing something different, Mr Barr.

Mr CLAYTON BARR: Excellent.

PHIL MINNS: I can't comment on what led the upper house inquiry to reach the views that they did.

Mr CLAYTON BARR: It's in the report.

PHIL MINNS: Well, no. The reasons they reached those views are not disclosed, and we didn't see most of the submissions that were made to it. We can work with what we've got, right? We're in the process of trying to refresh the cultural framework that we have in place. It's been the subject of consultation extensively. We hope to have a draft approach ready in December that will then be formally consulted on with groups throughout the workforce, as well as unions. We've been doing that as—how to think about the problem differently is the simple way of describing it. Our results in the People Matter Employee Survey (PMES) are slightly below those of the sector as a whole. What you'd say about the results of the sector as a whole is that they're probably not where all of us would like them to be.

Our engagement score this year is 63. The highest it's been is 65. It started to recover a little bit following COVID. But if you look at the model of measuring engagement across industry, if you score above 70, you're doing pretty well. The bigger your organisation is, the harder it is to get above 70. If you look at the New South Wales sector results, some of our smaller organisations will have great results on engagement, in their 80s and above. But when you have 170,000 headcount staff, your enemy is consistency. You're only going to score more than 70 per cent if the practice in every workplace is largely consistent with what good looks like. We have many, many hundreds of workplaces. We have workplaces where the culture changes from afternoon shift to day shift because of the configuration of people in that workplace.

How do we fix that? We fix it slowly, unfortunately. I have never worked anywhere on culture, including the defence department, where something happened immediately because of an inquiry and a set of recommendations. I remember a conversation where the Chief of the Defence Force (CDF) at the time asked me why it is that a CDF's declaration or directive, where it's sent to everyone in the training command in uniform and they sign it and send it back—he said, "How come that hasn't fixed our issues with training and the culture in training?" I said, "Well, because it doesn't work that way." You've got hundreds of people in middle management and other positions of authority. What they do and don't do—what they approve and disapprove formally on a daily basis—is creating the local culture.

How you shift that is with multiple points of intervention, persistently, with as much consistency in the message from leadership as you can manage. The new framework is part of doing that. We have done an incredible

amount of work. I've got some statistics—if I can find them in a tick—on how much engagement we've got with the portals that we've introduced: the manager portal, to explain how to deal with workplace grievances, and the employee portal. Recalling from memory, we've got about 600 people a month accessing those sites. They are having 1,000 interactions with the sites. People are going back to it multiple times in a month. The average engagement time is more than eight minutes, and the drop-out evidence—people go to one slide and then leave the site—is less than 20 per cent.

We have resources out there that are new, that were built despite COVID, and reflected my assessment when I arrived in NSW Health that things were not as good as they needed to be on culture. That was the assessment of the Secretary of NSW Health at the time, Elizabeth Koff. We started on some strategies that were quite hard to design and implement, and they're starting to move into operation in the system. I think we're starting to get some better traction. I would say to you that 44 per cent of the staff who make a complaint about bullying in the workplace—the highest proportion of who was the perpetrator of that is a peer employee. There's often an assumption made that bullying is something that happens down an organisation, but 44 per cent of our bullying instances reported in the 2023 PMES say, "It's a peer worker who is the source of the bullying that I'm experiencing."

So that's the nature of the problem we've got to work on. We are working on it. One of the things that we wanted to do—we were a little bit affected by COVID to ever get the clear air to do it—was to pilot some interventions in a site where we say, "The PMES information suggests that there's some issues there. There's some noise in that workplace." We provide the districts with about $4.5 million every year to focus on areas where they might have cultural issues. What we wanted to do is say, "Periodically, we're going to intervene because we're going to look at a suite of indicators and say, 'We think you've got more of a problem there than you're recognising.'" But we don't want to intervene like a hammer. We want to go in with an assistive resource. That is occurring in one of our LHDs at the moment where we've got a resource available. We've provided it, and its purpose is to try to unpack the issues that are the source of concerns in that workplace and to let the workplace bring forward some solutions to their current situation.

I would say that the PMES is the best instrument of its kind in Australian government, so I don't support reinventing it. But some districts, in response to what they learn in the PMES, then go that extra leg. They do that local assessment of what's going on. Either they get someone in to help as an intervention or they do a further survey to try to unpack what the issues are in their own workplace. So it is being worked on. I just can't see the sense in saying—we've got this annual PMES. It gives a comparative to everybody else in the sector. It gives a time series, which does show that witnessing bullying is down for us. It's still higher than the sector, but it's down this year to 26 per cent of staff reporting it. Experiencing bullying is down, I think, to 15 per cent of employees saying they've experienced it personally. It's still a little bit higher than the sector, but it's heading down. We work on this. We're working on this all the time.

Mr CLAYTON BARR: To clarify, you made reference to an inquiry and things changing shortly after that. I think it's fair to say that your health district scores have been in the low 60s and even into the 50s for quite some time, not just around the time of the inquiry. Is that accurate to say?

PHIL MINNS: Just about all, bar two, had some improvement this year. But our results tend to be lower in the districts than they are in other pillar organisations—not exclusively everywhere but, on average, yes.

Ms TRISH DOYLE: I'm just going to stick with the theme here. I want to acknowledge that you've had—this is what the general observation is—more than a decade of under-resourcing and difficulties that cannot be solved overnight and cannot be solved with implementing a whole range of recommendations. I just want to acknowledge that. You've been very diplomatic in your responses about what you can do and what you can't do and the approach you want to take. This is a bit of feedback, before I ask my question, from people just out beyond the Blue Mountains and the Central West:

> Workplace culture? How about we tell you toxicity has increased. The Committee should call in a random sample of random employees from each sector and hear about how much NSW Health view people or see that people matter.

I understand that there are those who have that degree of anger and cynicism still because there might not have been any changes. In fact, in some sites it might have deteriorated. You talk, Mr Minns, about a draft approach, September next year. You talk about interventions and piloting a gentle intervention, strategies and resources. What tangible and immediate actions can NSW Health take to improve the wellbeing and employee satisfaction for NSW Health staff? Give us some examples.

PHIL MINNS: We've recently developed a psychological safety framework that is being rolled out in response to the changes in the New South Wales law in that area. That is in the process of being engaged on with districts. We will receive requests from districts for funding to support initiatives to respond to their PMES results and we'll process those and send them the funding money. The Secretary of Health has issued, more than once, a

message to staff that she expects people to be able to make complaints and raise concerns and issues. The work we put into building the portal—and I don't know if the Committee has ever seen the employee or manager portal in operation. We would need you to get on the network to show it to you.

Mr CLAYTON BARR: Is that AIMS?

PHIL MINNS: No.

The CHAIR: I don't think we can access it, can we?

PHIL MINNS: No, we'd need to get you on the network somehow, so you might have to come to Reserve Road to do that.

Mr CLAYTON BARR: We'd love to do that.

PHIL MINNS: I think there would be some value in that because it shows the tools that we've built. One of the things that I noticed when I arrived is that at times the process of resolving workplace grievances takes too long. I know from my career that, once time is overlaid with workplace anxiety, you get all the worst outcomes. The reason that happens is that managers are not dealing with the issue sufficiently often to be adept at it, so you get missteps and that leads to a lack of trust. You can pretty much map this and I could do it for you in several organisations I've been in.

So try to make the system more accessible and try to make it full of tools and techniques. You're about to have a conversation to start a response to someone's compliant, so here's a template of how to go about it. We built the same resources for employees to ask, "What's happening to you in the workplace? Does this case study look like it, or is it this one, or is it this one?" They click on it and it says, "Well, here are your rights and here are the things that you should also be prepared to do at this point." We are trying to get a bias towards informal resolution. That is new. NSW Health, over time, had moved to a policy that was very formal and quite hard, I think, for people to follow. As a result, it's involved formality and sometimes legality way earlier than is helpful.

Mr CLAYTON BARR: Agreed.

PHIL MINNS: We're trying to reorient the system towards informal approaches where people just get to understand that if things are happening to you in the workplace that you don't like, you have the right to ask for them to stop and this is how you do that in NSW Health. We built those things. They weren't there until we brought them into place. They are tangible and they are getting use, from the data I shared with you.

DEBORAH WILLCOX: Could I just raise two other points? In terms of the People Matter Employee Survey, the action plans that the Local Health Districts, the hospitals and the community health and mental health services develop as a response to the results are all about local initiatives. There will be the broader ones that Mr Minns has referred to that have a statewide effect around grievance and complaint management and portals and the like, but many of the things—and I'm not diminishing the angst that particular staff may experience like the one you just raised with us. But often they are local things that are only in the gift of local executive or management to fix. One of the questions in the people matter survey is around, "Have you confidence that your local management will respond to the issues?" We watch that one very closely because if you've got confidence that things are going to be fixed, people feel more freed up to raise them and that just generally is a better working experience.

The second one is initiative that the Secretary triggered earlier this year called Time for Care and asked Dr Nigel Lyons, who you may know, to do this piece of work. That was to identify what are some of the things in the daily work of a clinician in a hospital service that get in the way, noting there will be industrial and award-like issues that are not things that can be fixed so simply. A suite of things have come back. I think around 4,000 staff contributed to that—I may need to correct that figure—and gave us a good list of things. The Secretary is driving this very strongly to make sure that we get and respond to all of these things, because they take the noise away for our staff on the ground. That's equally important but that's not to diminish that there are more deeper structural things that matter to them as well. But I think helping them with timeliness around recruitment, some of the reporting and recording things we request of them—there's a list that we could provide to the Committee if the Committee were interested in it. But it's actually happening. It's across the system and the Secretary is driving that one specifically.

LUKE SLOANE: Chair, can I just add one more thing? Ms Doyle, I think the tangible is probably the really important part of it, and leadership and culture is driven from the top. I think what we heard in the inquiry and through what I can only imagine—because, going back to Phil's comments, we didn't see everything that was pushed into these recommendations—is that there's staff that aren't feeling heard and definitely feeling disconnected from the Ministry of Health itself, in and behind the sandstone curtain. In that time I've been to

upwards of 144 of the 185 rural and regional sites across New South Wales. That doesn't include the Aboriginal community controlled sector, not-for-profits, local government and all those things.

The Secretary herself has accompanied me on many of the visits as well to make sure she's out there sitting down listening to staff so they feel like it doesn't matter where they go, they can actually talk to what's affecting them at the moment, whether it be good or bad. I think that sent a very strong message not only to the rest of the system but I know—not to speak on her behalf when she's not here—Susan Pearce does receive a lot of emails directly from frontline staff on the floor with stuff to follow up and she does so cordially. I think that it's very important for the staff to have seen us out there listening and paying attention, both managerially, frontline clinical staff and everybody else involved in regional areas. I think that's what is tangibly going to drive this effective change in culture, which we can measure through these devices and frameworks. That's what's going to make the difference.

Ms TRISH DOYLE: That's all well and good, Mr Sloane. I have seen myself a middle manager who relentlessly took issues on behalf of their staff to the Local Health District and the end for them was being booted out. I have seen myself occasions where the raising of complaints has resulted in the dismissal of a highly valued member of the community for being a whistleblower.

Mr CLAYTON BARR: I've seen that in several instances as well.

Ms LIZA BUTLER: I add to that that we have heard today, and at other places we've gone, that when you go through that complaints process and make a complaint, staff are subject to ongoing weaponisation. They're the notes I've actually taken. We've heard that firsthand. Mr Minns, you say that 43 per cent of bullying is undertaken by peers but that means that 57 per cent is from a leadership role.

PHIL MINNS: Not necessarily. I think there are more breakdowns than that, that I would provide you.

The CHAIR: I just want to make a couple of observations here. In relation to recommendation 40 in the Ernst and Young report that I'm looking at, the response is the development of the refreshed culture framework, which you've spoken about. What's been interesting from today's discussions has been clearly that's not just the response. Clearly, once that's refreshed, you've got a range of strategies that you intend to implement around empowering staff and educating staff and so on. To take on notice, I'd be interested to know what's going to be involved in that going forward with the framework, because simply having the framework on its own won't be sufficient.

I make the observation—you alluded to this, Mr Minns—that leadership is a critical component on the ground. The "culture is medicine" project that the Commonwealth is currently running through Jillann Farmer has some interesting information about the importance of leadership, particularly in clinical leaders. It's not just clinical competence. It's a different skill set. As you said, it's best to resolve issues on the ground, as close as possible and as soon as possible afterwards. But that does require managers with a certain set of soft skills and leadership skills. I'd like to see the plan that I think you've got in mind for developing that, because I think that will be transformative. Things like human factors training, for example, have been mentioned to us. Those programs that build that skill base up locally to implement the framework would give us a sense of assurance that there's a plan going forward.

I agree that it's going to take time. But the common thing is managers who are just out of their depth in terms of these soft skills. That is also, I think, probably an issue with peer to peer, because a good manager creates the right workplace with respect. A manager that doesn't have those skills can be a struggle, and then you go into a formal process. I just make that comment. The two other issues we're going to need to get a response to on notice that have come up for us are the locum issue, which has been consistently raised—the high use of locums, the expensive nature of locums and the fact that it's actually undermining efforts at recruitment and retention in rural areas. I understand NSW Health is tackling that at the Commonwealth level because there's a sense of it being a national issue, but it would be important to get some more detailed information on that response, please, about what the plan for that is.

PHIL MINNS: Chair, I'm happy to do so, but I might request that it is in camera because of the nature of some of the issues we have to consider that relate to national regulation et cetera.

The CHAIR: We'll facilitate that. The second issue that has come up has been the time taken to recruit staff. Partly connected to that has been the issue of credentialing across workforce and across areas for locum staff, who do move, but a big issue has been the delays on recruitment. I understand some Local Health Districts have been able to reduce delays, but they're the exception. We've consistently heard about delays of two to three months. I'm flagging that that's an issue. What strategies are being put in place to try and reduce that?

PHIL MINNS: We'll give you some data as well as the strategies. One of the recommendations of the people and culture review is to seek to streamline and reform the recruitment strategy that is in use everywhere, because there's a little bit too much local adaptation. Some of it is helpful and some is not. It's not my sense of the data that recruitment is taking three months because of process issues. It's often because recruitment fails, and fails multiple times, to attract someone. Our best districts are pulling off recruitment inside 30 days, but not all of them are. You're correct, and that's why we need to do some work system wide.

DEBORAH WILLCOX: Again, this is one of the issues that came out of the Time for Care work, so it will be attended to there as well.

The CHAIR: The other was that there was a commitment to review the credentialing process for GP VMOs.

PHIL MINNS: We have a specialist adviser on the medical workforce. I'm sure I can organise for her to provide a status paper for you.

The CHAIR: Thank you very much. It's now three o'clock. Thank you for appearing before the Committee. We may send you some further questions in writing. We've already flagged a set of questions that will come to you. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

PHIL MINNS: Yes.

DEBORAH WILLCOX: Certainly.

The CHAIR: Thank you. I sincerely thank you for coming and for your work.

(The witnesses withdrew.)

The Committee adjourned at 15:00.