**REPORT ON PROCEEDINGS BEFORE**

# LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON REMOTE, RURAL AND REGIONAL HEALTH

## THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

**At Coral Sea Room , Orange Ex-Services Club, Orange on Tuesday 28 May 2024**

**The Committee met at 10:00 am**

**PRESENT**

Dr Joe McGirr (Chair)

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

**The CHAIR:** Welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health inquiry. Today's hearing is part of our inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional New South Wales. I'm Dr Joe McGirr, member for Wagga Wagga and Chair of the Select Committee on Remote, Rural and Regional Health. With me today are my fellow Committee members, Ms Janelle Saffin, Deputy Chair and member for Lismore; Mr Clayton Barr, member for Cessnock; Ms Liza Butler, member for South Coast; Ms Trish Doyle, member for Blue Mountains; Mrs Tanya Thompson, member for Myall Lakes; and Mrs Leslie Williams, member for Port Macquarie.

We are holding today's hearing at the Orange Ex-Services' Club. It's great to be in regional New South Wales where we can meet with stakeholders in the regional health system. We're grateful to have so many of you participating in today's hearing as we hear evidence from a range of witnesses from across the community sector, health service providers, local government and health research. The hearing is being broadcast via the Parliament's website, and people from our engagement team will be taking photos today. Before we commence, I acknowledge the Wiradjuri people who are the traditional custodians of the lands on which we meet in Orange. I also pay my respects to Elders past and present 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.

**Mrs JESSICA BROWN**, General Manager, Strategic Policy, Marathon Health Service, sworn and examined

**Ms ALYSSA FITZGERALD**, Group Manager, Business Development, Marathon Health Service, sworn and examined

**The CHAIR:** Can you 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?

**JESSICA BROWN:** I can.

**ALYSSA FITZGERALD:** I can.

**The CHAIR:** I understand you would like to make a brief opening statement. That will be restricted to about four minutes and then the Committee will take turns to ask questions. I'd ask you to try to keep responses to the questions to a couple of minutes so that we can get through a fair bit of material. Would you like to commence with an opening statement?

**JESSICA BROWN:** Thank you for the opportunity to come here to share some of our perspectives today. A bit about us: Marathon Health is a not-for-profit allied health provider serving regional New South Wales. We have more than 120 clinicians and a further 100 VET-trained healthcare workers supporting people across 50 LGAs and regional communities throughout western New South Wales, down through the Riverina and into the Murray. We're funded to provide health and wellbeing services through the New South Wales Government, primary health networks, the NDIS and through corporate and philanthropic partnerships. We focus heavily on developing the rural allied health workforce of the future through student placements, new graduate and early career support and VET health traineeships.

Our workforce delivers a range of services in the community to support people's health goals and keep them well and out of hospital. Half of our services are designed to support people's mental health, including young people through six headspace centres in regional New South Wales; a further quarter of our services support people with chronic complex conditions, such as diabetes or chronic pain; and the final quarter is providing therapy and other supports to people with disability under the NDIS.

We responded to the inquiry, initially, to draw attention to the importance of allied health and also the not-for-profit sector in the discussions about healthcare access in regional New South Wales. We wanted to highlight some of the place-based solutions we were working on at the time to keep people well, out of our hospitals and continuing to live in the community. Equity of access to health and wellbeing service continues to be an issue in many of the places that we live and work. We've reviewed the Committee's terms of reference and would like to offer some concrete examples of what's working well to address healthcare access and equity issues for people in remote, rural and regional New South Wales.

Specifically, recommendation 5 is around working with charities and communities to address service gaps. Marathon Health is working with Variety – the Children's Charity to implement a place-based, community-led model of care to meet the gap of holistic paediatric assessments for children and young people in rural and remote communities. We can talk more about the Variety Flying Start clinic. We are calling for the New South Wales Government to bring together key stakeholders to discuss integrated, collaborative solutions to paediatric and early childhood services in the regions before significant investment is made without considering the total service landscape.

Recommendation 11 is around the mental health workforce development. Marathon Health has worked with two private psychology practices and the Western NSW LHD to develop a program to support provisional psychologists to come and start their career in regional New South Wales. The program has supported 18 people so far and there is potential to support another 36 over the next three years, so we can talk more about the Core Connect program.

Recommendation 31 is around cultural barriers for the use of telepractice for First Nations people. We can share our data around First Nations service delivery modes for headspace and our strong minds mental health program, and the learnings there. Recommendation 33 is around First Nations healthcare workforce development. We can talk more about our Aboriginal wellness worker traineeship program that will see more than 30 First Nations people in 10 communities across western New South Wales achieve their qualification in mental health, Aboriginal primary health care or community services while being employed in sustainable jobs in their communities, providing vital health coordination, navigation and health literacy support. We are looking to expand this model through a proposal being considered by the New South Wales Government currently.

Finally, recommendation 43 is in relation to place-based health needs assessments. Marathon Health has come together with the Western NSW LHD, Aboriginal Medical Services and other not-for-profit healthcare

providers, like the Royal Flying Doctor Service, to progress discussions around the needs of our communities, new models of care and workforce development initiatives. It's called the Western NSW Health and Care Employment Collaboration Group. We can provide more information about that. That is a brief outline of some of the things that we're working on in relation to the recommendations you're looking at. We look forward to your questions.

**The CHAIR:** My question is related to your first point around the partnership with Variety, which I think is in relation to assessment of paediatric and child needs. You talked about that partnership—the work that's being done—and you emphasised the need for people to be aware of the work already being done before going to introduce new services.

**JESSICA BROWN:** Yes.

**The CHAIR:** Could you describe in a little bit more detail what work is being done, particularly what you mean by people being aware of the work being done already?

**JESSICA BROWN:** Yes. As you know, the healthcare funding and service landscape is quite complex. The Australian Government fund a range of primary care services and the New South Wales Government fund services also. Often there's the potential to look at the funding streams, and the services that are offered under those funding streams, in isolation of each other. We talk about paediatric services and early childhood services having four main components: One is around assessment and diagnostics; one is around short-term intervention and then ongoing therapy for those children; the third part is the building of capability and capacity of families and their schools and preschools and mainstream services; and the fourth part is the workforce development that needs to support the workforce that's going to do those three services.

When we discuss putting significant investment into one part of that—around, for example, assessment and diagnostics—without considering service providers who are providing therapy and capacity-building, and the workforce solutions that will support that, it creates additional demand in one part of the system and the supply is not there in the other part. So you're just overloading one section. That's the part about the integration, the different funding streams and the complexity of the landscape. Alyssa will talk to the specifics of the outcomes that we're seeing with the Flying Start clinic.

**ALYSSA FITZGERALD:** The Flying Start clinic was started from a roundtable discussion of service providers and Variety, the children's charity, who really saw a need for paediatric assessments and access to those for children in rural communities. Marathon Health was funded by Variety because we were in place and delivering services. Each of those clinics looks different in every community. It builds on the strengths of what is in community and then we fill the gaps—so providing a paediatrician, a senior OT and speechie. The outcomes we're seeing—we've held our first clinic in Walgett and we have another scheduled in Lightning Ridge shortly. The first clinic saw six children, and all of those will now have access to ongoing supports through the NDIS, as well as support at school. Those children were not even on a waitlist for a paediatrician because the waitlist was too long. That work will continue with the support. We've got another three clinics scheduled at this stage, looking to expand to other communities beyond.

**Ms JANELLE SAFFIN:** The question that I had planned to ask was around recommendation 43. You talked about that collaboration. You called it "west" or "western" something with LHDs.

**JESSICA BROWN:** Yes.

**ALYSSA FITZGERALD:** Yes.

**Ms JANELLE SAFFIN:** How did that come about?

**JESSICA BROWN:** A recognition by service providers of health services, focused on western New South Wales in this particular instance, that no one service provider can solve the healthcare access issues, and that the changing face of our communities and our community migration to larger centres means that the current way that we deliver services will not be the way we can continue to deliver them in the future. We all have workforce shortage issues. When we go out into the market to recruit, at the moment we're not doing our workforce development collectively. We're just poaching from each other. It's just shifting deckchairs; it's not actually creating new workforce.

It was workforce-driven largely to start—how we can work together and looking at things like single-employer models. There might be in a community a 0.4 of a role with an LHD and we might have a 0.6, but someone is not going to be able to join those two together themselves and paying two lots of tax isn't particularly attractive. So how can we work together so that one or other of the organisations employs the person and they can provide services across the public and not-for-profit sectors? That's one example. How can we be working together to provide new graduate experiences that are potentially multi-organisational experiences? How can we be

working together to provide traineeship opportunities for vocationally trained healthcare workers across multiple organisations?

**Ms JANELLE SAFFIN:** Thank you, Mrs Brown. How did it come about? Was it from the LHD? Or did you—

**JESSICA BROWN:** It really is a meeting of the minds. We were the first group to hold it in the room and put the sandwiches on, but it was calling the right organisations around the table and asking who is willing to come with us on this journey.

**Mrs LESLIE WILLIAMS:** I have a quick question first, before my other question. You said in your introductions that you're funded largely by the New South Wales Government. I'm assuming that's through NSW Health.

**JESSICA BROWN:** We're funded largely through the Australian Government, through primary health networks, with a small portion of our funding coming from the New South Wales Government, predominantly through child protection.

**ALYSSA FITZGERALD:** DCJ.

**Mrs LESLIE WILLIAMS:** So it's not program funding. You've got long-term funding?

**JESSICA BROWN:** No, we are largely grant funded through primary health networks. We respond to commission services.

**Mrs LESLIE WILLIAMS:** I was going to ask you about your Indigenous health workforce, because obviously that's one of the issues in relation to recommendations. Do you think there is more work that we can do to support the employment of more Indigenous people into the workforce, particularly out here in rural and remote areas?

**JESSICA BROWN:** Yes. The health and social service sector is obviously Australia's largest growing sector and we need more people in the workforce. We have developed a program that's delivering completion rates in VET traineeships around health care of double the national average, upwards of 85 per cent. That is really strong wraparound support for the trainees, not just around the academic part of their qualification but also the pastoral care and the wraparound support to help them overcome any barrier that they're experiencing while they're on that traineeship journey. The second vital part of that is a living wage while people are doing their traineeships. People can't commit to moving out of their current role and into a new industry if they're being paid at a wage that's not able to support them or their family or in their community. A living wage in a sustainable role, in a host organisation in their community, has been a critical part of that.

**Ms TRISH DOYLE:** Thank you both for your work and for being here today and speaking in such an articulate way about what you do. Our Committee is obviously looking to see where recommendations have been implemented, where there is progress and where we need to do a lot more. If you were to choose one of each—where we need to do a hell of a lot more and where there has been some progress that we can celebrate—what would they be? Just one of each.

**JESSICA BROWN:** The critical risk to healthcare services in regional areas is workforce and so more collaborative workforce development is where we can do more. There are some really great green shoots started at the grassroots level around workforce development initiatives across psychology and across First Nations healthcare workforce. Peer workforce is another opportunity, particularly around mental health services. Coming together to support the workforce development initiatives that we're doing, and expanding those on a collaborative basis, would be key as a place to develop further.

**ALYSSA FITZGERALD:** From my perspective, it would be a shift to more community-based early-intervention services embedded in community, place-based working with community and bringing together federal and state funding to more closely align to making best outcomes for communities.

**Mrs TANYA THOMPSON:** My question is in relation to recommendation 11, focusing on mental health, drug and alcohol services. Do you feel that the communities you work with have adequate access to mental health services? In particular, do you feel that the Indigenous workforce is large enough to provide access to culturally appropriate mental health services?

**JESSICA BROWN:** Following on from my previous comment, the answer would have to be no—not enough currently. Have we got some evaluated opportunities to expand to be able to do that? Yes, we have. The Aboriginal wellness worker program that the New South Wales Government invested a million dollars in from Aboriginal partnerships to see employment outcomes and healthcare skill sets embedded in those regional communities—I guess the blueprint is there. We would hope that is a platform that can be built upon because

I think from both seeing the first group graduate, who were the cert IV mental health workers, come through that program with their own lived experience to bring to those roles and the connections already in community, that has already reaped benefits for those communities, with those people working for the PCYC within schools, within Aboriginal medical services and providing those connections. It's not necessarily the six-year clinical degree that's needed in the first instance. It's the support in the community to create the trust to reach out and access services.

**Mr CLAYTON BARR:** In particular, we're chasing up some recommendations that were made two years ago by the then upper House inquiry. In terms of the work that you do—and thank you for doing the work you do—have you noticed a significant change and a few markers of change just in the last two years since that inquiry? Are things getting better? Are things getting worse? Are things getting easier? Are things getting harder?

**ALYSSA FITZGERALD:** I think the LHD, there's a willingness to collaborate, which is probably a change in a positive way. I'm not sure, though, that it's making its way to NSW Health, so maybe there's still a barrier between place- and state-based services.

**JESSICA BROWN:** I think the rural health strategy talks about the landscape more broadly than just the New South Wales public health system. I think that's what we've seen—understanding that there are other players in the health system that are funded through different streams that are equally there with their shoulder to the wheel and opportunities to share and collaborate about what's working well. I think we can still extend the collaborative work around, for example, more collaborative commissioning frameworks where you've got state and federal government funding streams coming together for specific purposes and more outcomes-based funding. But I think those conversations are starting to happen.

**Ms LIZA BUTLER:** You spoke about your training and recruiting of First Nations people around recommendation 33. Thirty-one is having First Nations communities better access face to face. Are you seeing a real outcome by training First Nations people? How do you collaborate with the Aboriginal community-controlled health organisations in those communities?

**JESSICA BROWN:** The work that we're doing is to provide that enabling health service base, so you've got the trained people in place to provide the community connection and trust that then allows services to be able to come in on a less frequent basis—either face to face, fly-in fly-out, drive-in drive-out or telepractice—but there's a supporting framework for those communities in place in their community. It would be great if we could have senior allied health and clinical people in every regional community. That's, obviously with workforce shortages, not necessarily possible. But having people in place in communities that can hold communities and people, provide a really trusted first point of contact, health navigation to support them to be able to start their patient journey, to connect with services and to build confidence and to be supported while they're doing that—that's the strategy we're taking.

**Ms LIZA BUTLER:** Have you seen telehealth reliance decrease or remain the same?

**JESSICA BROWN:** The statistics that we see, particularly around our mental health services, is that—for example, with headspace, for First Nations young people, 50 per cent of people are seeing people face to face in headspace. Interestingly, for First Nations people compared to non-First Nations people, we're seeing much higher numbers of people outside headspace centres in other places—medical services in other community places—so they're not coming into clinics as such, but we're going out now, reaching them in places that are relevant to them. In relation to teleservices, telephone is the preferred mode, not video. We are seeing a lot of First Nations people via telephone.

**The CHAIR:** Can I just follow up on the comments you made that relate to recommendation 43 and your relationship with the LHD? I think you answered Ms Butler's question by—what I picked up was that you were initiating the contact. You had set up the meetings. You did point to the fact that you felt that the local health districts were responding to that, but you were initiating it. You also made the comment that you weren't sure whether NSW Health was into that space yet, or quite across that need for collaboration. Could you just expand on that a bit?

**JESSICA BROWN:** I think probably our strongest understanding of the relationship is with our local health districts, both the Western NSW LHD and Murrumbidgee LHD, to a lesser extent. The relationship is strongest in western New South Wales. I think the willingness is absolutely there to come together, particularly around workforce. Service delivery is a more difficult conversation because it is around funding streams and where money goes. That's funding where it's not being funded within the health service and coming out into community—that's a harder conversation than how we can share the resources and skill and capability around supporting collaborative workforce development initiatives. But I think the intent is absolutely clear—that they are willing to do that. The second part of that is around the health needs assessment and the LHD understanding

that service providers like ours in community have really strong intelligence about what communities' needs are and what they are saying in their own words, and using that intelligence to come together around joint planning.

**ALYSSA FITZGERALD:** I was just going to say, in terms of it not getting to NSW Health, we are primarily funded by primary health networks, which is federally funded. I think that's just a result of our funding sources and not necessarily the right hand knowing what the left hand—we work very closely with local GPs in community to get people well at home.

**Mr CLAYTON BARR:** That's interesting.

**The CHAIR:** It is, absolutely. To summarise, conversations have begun, there has been a change in attitude, but perhaps the formal structures are not yet in place to build on that.

**JESSICA BROWN:** Yes.

**ALYSSA FITZGERALD:** Yes.

**The CHAIR:** Thank you very much for your evidence. We will move to the next witnesses.

**JESSICA BROWN:** Thank you for the opportunity.

**(The witnesses withdrew.)**

**Mrs JENNY HAZELTON**, President, Orange Push for Palliative, sworn and examined

**Ms JANICE HARRIS**, Vice President, Orange Push for Palliative, sworn and examined

**The CHAIR:** Good morning. I welcome our witnesses from Orange Push for Palliative. 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?

**JENNY HAZELTON:** Yes.

**JANICE HARRIS:** Yes, I can confirm.

**The CHAIR:** Would you like to make a brief opening statement, Mrs Hazelton?

**JENNY HAZELTON:** Thank you for extending the invitation to Orange Push for Palliative to participate in this hearing. I'm Jenny Hazelton and this is Janice Harris, both in the executive of Orange Push for Palliative. Orange Push for Palliative is a small but mighty advocacy group in Orange that was formed in 2015 in response to community concerns about the provision of palliative care services in Orange Health Service. We are all volunteers who have come to our group with varied careers and solid skill sets. We are armed with a determined, united passion of making a difference in people's experiences of palliative and end-of-life care. We all have our own personal stories—some good, some bad—that drive our involvement.

We have welcomed this report and its recommendations for improvement and change in palliative care services across rural, regional and remote New South Wales. We believe that this report has been instrumental in highlighting the inequalities of access and equity in health outcomes for our rural communities. It has been a springboard for many initiatives and improvements in our area in palliative care in Orange and district. In short, the report and recommendations have already had an impact, and we believe that the Government is listening and is receptive to feedback, as is the LHD.

In 2023 I was invited to be on the Orange Hospital steering committee to develop the palliative care service statement. For the past 12 months I have been a member of the World Class End of Life Care project development committee for Orange re: the three additional beds that have been allocated. As the only community member, I feel that my contributions have been valued and respected.

When our group formed in 2015 there were no palliative care beds at the new hospital. There were two beds at the old hospital, and a lounge and garden and privacy, built by the community in the 1980s. For years we were told that 45 single rooms spread across the hospital were sufficient for end-of-life care. The community thought otherwise and told us their stories of single-room unavailability and their loved ones dying in four-bed wards, with just a curtain between them and visitors limited to two. They told of the pace, the hustle and bustle of acute care wards where priority had to go to the acute care needs of the living. They told of having no privacy and confidentiality, and of nowhere for big families.

In 2017, 10,000 signatures were collected and delivered by our local member Mr Phil Donato to the Minister for Health, the Hon. Brad Hazzard. Upon his election Mr Donato established the palliative care strategic task force, with all government, non-government and community stakeholders as members. This is ongoing to this day. What followed was a successful 18-month trial of four end-of-life care beds at Uniting Parkwood. That trial finished and there was the creation of two designated beds in the HOPS ward at Orange Hospital. The general manager of Orange Hospital was passionate about this and enabled this change. We then became involved in the World Class End of Life Care project from the Ministry of Health. We welcome this opportunity to provide some more insight into our progress and comment on the implementation of the report's recommendations. Thank you.

**The CHAIR:** Thank you, Mrs Hazelton. You indicated in that statement a number of improvements that you have driven. I'm particularly interested in improvements that you may have seen in palliative care, locally or elsewhere, in the last two to three years since the publishing of the report and, of course, the last Government's announcement about palliative care funding. Perhaps you could just build on what you see as being some improvements in palliative care?

**JENNY HAZELTON:** I honestly think that the injection of funding from the previous Government made a huge difference to starting a process that needed to happen. We were behind the eight ball. Orange has been playing catch-up in a non-level playing field for a long period of time. The improvements have been in funding and staffing. We got the dedicated beds at the hospital, but they had to be created from the establishment position of beds at Orange Hospital. But they were tremendously successful. Two beds weren't enough, clearly. We've got a large community—a referral centre for five districts—so we certainly saw that that was one part of the picture.

There has certainly been an injection of funding for additional staff, but there are things that need to happen and continue to need to happen to even just bring us up to par. What we've found is that having a large regional hospital like Orange Hospital, which is rapidly growing, has meant that there is incredible pressure for beds across the board. Frequently the hospital is in what they call "code black", which means that there are no beds available. So what happens? What we have found—and we are really only able to talk about Orange and the district extending out to Parkes, Forbes and Cowra. But Cowra, Blayney, Canowindra and Molong are small hospitals and they've all received funding to fund palliative care units—usually just one bed. But it's easier in small communities to get that increase and to have local people cared for in their communities.

Really, smaller communities are able to do it better than the larger hospitals because, in Orange, we outgrew our footprint for the hospital as it opened. There has been extra, exponential growth in the number of services and the referral sites. We are often a referral site for five local health districts. There is not enough room. What concerns us is that we got the two palliative care beds, but that was never going to be enough, and we made it very clear to the government of the time and the LHD that it wasn't enough. So there will be a question about data collection, and I will contribute to that at that time. But what happened was that it is much harder to keep and maintain beds, even though they are designated beds, at an acute care hospital where there is competition for beds at all times.

**Ms JANELLE SAFFIN:** Thank you for what you do and for appearing today. I have a question about recommendation 24, which is that the local health district expand the Far West NSW Palliative and End of Life Model of Care to other rural and remote settings. I know you said you couldn't comment out of that, but is there anything you have heard, and is that operating in Orange itself?

**JENNY HAZELTON:** I don't think so. I really can't comment on the Far West because we don't get the data or the information about how it operates. But there are a variety of models of care that run across not only the Central West and the Western NSW Local Health District but across rural communities in New South Wales. That has been the hard thing. There have been no standardised models. We say, well, let's create it for the community and model it on that, but that has been hard. The models of care have not been easily accessed, and the local health districts have often kept their information very tight to each local health district about funding, about numbers, about models.

**Ms JANELLE SAFFIN:** Thank you. You've answered it.

**Mrs LESLIE WILLIAMS:** Firstly, Jenny and Janice, congratulations on the work that you've done. I met with Push for Palliative a long time ago.

**JENNY HAZELTON:** Yes, I remember.

**Mrs LESLIE WILLIAMS:** Congratulations on your advocacy because clearly it's made a difference. We were up at the hospital yesterday and could see where there's going to be further expansion of palliative care beds. That must be extremely satisfying for you on behalf of the community. Well done. I want to go to recommendation 23. You did briefly touch on data collection. A part of that was the establishment of an agreed uniform statewide platform for the collection of data in relation to palliative care services. Have you seen that develop in any way? Is there any intention, do you think, since the report of that uniform collection of data?

**JENNY HAZELTON:** That has been one of the most frustrating things. To get the numbers has been extraordinarily difficult. To get the numbers to compare them with other health districts and what would be acceptable, say, in Wagga or in Tamworth—what is happening there—has been very frustrating. A lot of the figures seem to us, previously, to be anecdotal because there was no central collection of data that could talk about usage of palliative care beds. What changed—and it was quite remarkable—was that there was a review of allocations to palliative care from the previous Government. In 2023, when the new Minns Government came in, he created a review of the projects that were committed to. Part of that was justifying the three designated beds that were additional to us and we welcomed that. It was a serious job that was done by Western NSW Local Health District and I was fortunate enough and privileged enough to participate in that. The data collection was astounding because we had been told for years that there was only a need for two designated beds at the hospital and that the need wasn't there.

**Mrs LESLIE WILLIAMS:** Without any data?

**JENNY HAZELTON:** Without any data—or with rubbery data. Finally, the service statement that was developed for palliative care for the Orange Health Service as part of this was solid. It said that we needed five to six designated beds right now and that we had been playing catch up to get three additional beds. We knew this; the community told us this. The two designated beds that were there were overflowing. We calculated that it was 128 per cent occupation at one stage. We had surge beds which were often used but never counted properly. We

have welcomed a much more systematic and structured way to look at where the beds are being used and what the needs are so that has improved, but there's a long way to go.

**Ms TRISH DOYLE:** I'm going to quickly make a comment. Thank you both and thank you to Push For Palliative for all the work you've done for many years. I met you back in 2015. I supported the petition and stood and spoke to that petition in 2017, and I acknowledge that there's been some steps towards improving the situation. For your persistence, dedication and commitment to offering opportunities to people in the Orange district, I thank you.

**Mrs TANYA THOMPSON:** I would like to confirm that recommendation 18 of the report was that NSW Health employ a geriatric nurse in all peer group B and C hospitals such as Orange Base, and where a geriatric nurse is not available, that hospital staff should be given annual training in geriatric care. Do you know if this has occurred in Orange?

**JENNY HAZELTON:** It's outside of my scope. We are totally focused on palliative care. But we do know that there have been, certainly, increase in staffing and targeted staffing in the community, but I don't know.

**Mr CLAYTON BARR:** Can you describe to me what services are available for in-home palliative care?

**JENNY HAZELTON:** There's a mix of non-government organisation support and district nursing and community nursing, and the specialist palliative care team that operates across the district. So there are a number of services. LiveBetter is the primary non-government organisation that is involved in end-of-life care packages. The 24-hour or the 48-hour care packages that exist are administered—the LHD has the money, but it's administered through LiveBetter. So there are some partnerships that are developed. We do have a variety of support for people in the community. There are still some issues about support after hours and on weekends. There's a telephone support service staffed by a clinical nurse consultant, but it is more difficult to get face-to-face care on weekends. And I think that's a common thing, but it's not good.

**Ms LIZA BUTLER:** Thank you. Just following on from that, are you aware of any innovative models of palliative care services that might be able to fill those gaps that you just spoke of?

**JENNY HAZELTON:** There are a range. We need more staff and infrastructure because what we're finding—the Government also did a wind-back of $150 million in palliative care, and that's pretty tough. A lot of the impacts, from what I understand, will be from staffing and recruiting, and that's what we need. We need more people to be able to support and we need people trained, because it's different training, and it's different nursing, and it's a different style of medicine, with palliative care and end-of-life patients.

**The CHAIR:** If I can just follow up on a couple of points you made. You spoke earlier about small hospitals?

**JENNY HAZELTON:** Yes.

**The CHAIR:** You made the comment that small hospitals often have a greater capacity because there's not as much pressure for use of the beds. Are you aware of additional training or staffing numbers or resources in smaller hospitals to provide this, that's taken place recently?

**JENNY HAZELTON:** I'm certainly aware that that occurs and that there is money for training. That is a really important part of supporting people in local communities. At some stage I would like to talk about First Nations people. So if someone could—

**The CHAIR:** Yes. That was my next question.

**JENNY HAZELTON:** That's very good.

**The CHAIR:** Culturally appropriate care. By all means.

**JENNY HAZELTON:** One of our passions is also the support of end of life for First Nations people. I know that the recommendation was to ensure culturally appropriate palliative care services are available to First Nations people. This continues to be a gap. We have worked and have developed a partnership with Orange Aboriginal Medical Service, and we are working on some projects now that hopefully are going to allow Aboriginal and Torres Strait Islander people to access more palliative care services. What we've found is that the LHD has 13 per cent of First Nations population, compared to the 3 per cent in New South Wales and, in Orange, 6.3 per cent; Cabonne, which is the surrounding community, 3.7 per cent. But there is a very low access to these palliative care beds at the hospital.

Historically, traditionally and currently, there is a reluctance by Aboriginal people to access these services. They historically have a distrust of hospitals, so creating more beds in a busy, bustling hospital is not the answer for First Nations people. Jamie Newman, who is the CEO of Orange Aboriginal Medical Service, has highlighted

this over and over again to us. This is why our ultimate goal is to have a hospice, which he is 150 per cent behind. We assumed that First Nations people would want to, one, be cared for at home and, two, return to country. That is true, but what Jamie has told us is that First Nations people get quickly overwhelmed with the responsibility of caring for someone at home. What he said was that it results in ongoing trauma following the person's death. That really turned the tables for us. We're a small advocacy group, but we're passionate about First Nations people and people getting a fair go, and they were missing out. It has become a frightening experience for Aboriginal people.

What we have done, and this has been independent of the LHD, is put in a joint submission with Orange Aboriginal Medical Service, Orange Push for Palliative and LiveBetter—which is really exciting—to provide death doula training. Doulas are often associated with midwifery and the start of life, but there's also a certificate for end-of-life-care doula training. We have put in a submission to the World Class End of Life Care to support that, and they are very keen. First Nations people need to be supported by someone who can walk them through the process, someone who can stand beside them—which is what doulas do—explain the process and go with them to hospital if they need or stay with them at home and tell them what to expect. We have an application in right now to do this, because we are so concerned and we want First Nations people to have access—which we think is a right—to quality palliative and end-of-life care.

**Mrs LESLIE WILLIAMS:** Can I clarify is that an application for funding a program?

**JENNY HAZELTON:** Yes.

**Mrs LESLIE WILLIAMS:** For how long? Or are you planning on doing it—

**JENNY HAZELTON:** Four years.

**Mrs LESLIE WILLIAMS:** Good luck.

**JENNY HAZELTON:** And LiveBetter is already doing doula training. They've got 13 staff members who are already trained. They are going to walk beside us to provide that sort of help. That's exciting. This is where we want to be. We want to build the body of skills and expertise in a variety of sectors and support that. We still don't have a specialist palliative care physician in Orange. Only 16 per cent, as your report notes, of palliative care physicians are in rural districts. That is a huge gap. When you have a leader in palliative care, what comes with that are registrars. We do have some GPs in training at the moment. It brings on a whole body of work.

**The CHAIR:** I understand that the health district is trying to recruit a specialist in palliative care. Is that correct?

**JENNY HAZELTON:** I understand that's correct, but we haven't got them yet.

**The CHAIR:** But they've recognised the need.

**JENNY HAZELTON:** Absolutely.

**The CHAIR:** Thank you for that description and that discussion around First Nations people and palliative care. You raised an issue around data and data collection. You said that there had finally been some transparency around data in the district. That clearly identified a need at Orange. Did it reveal other needs in the district that you are aware of?

**JENNY HAZELTON:** This was the service statement for palliative care only. It highlighted exactly what your inquiry highlighted—the high levels of mortality and morbidity for our general population. There were three or four points about that. I don't think that the service statement has been published yet on the website, so I can't really speak to that.

**The CHAIR:** Thank you for appearing before the Committee. Ms Harris, would you like to make a statement before we finish?

**JENNY HAZELTON:** I think you should.

**JANICE HARRIS:** Just a very brief statement that we're very appreciative of what's happening with the additional three beds. It's not an ideal situation. The unit will be split with two beds on the ground floor and three on the first floor, but we do understand that the hospital has already outgrown its footprint because it is a specialty hospital and a major referral centre. But one of our ongoing concerns is recurrent funding of these beds and the preservation—our volunteers—of those beds. Our volunteers go out each day. We provide food for families, because there is often access after hours to food at our hospital. We provide that. We visit every day, and one of our concerns is seeing—everyone needs treatment in hospital. But, on a regular basis, those—which we were told—designated beds are being used by other patients who have been allocated that space. That is an ongoing

concern for us—the recurrent funding and the preservation of what will be, by this time next year, those five designated beds.

**The CHAIR:** The dedicated beds and the funding to support that.

**JANICE HARRIS:** Just one other thing, very quickly. The latest member of our advocacy group joined because of an incredibly negative experience of the hospital. It was classified as a failed admission. This person was already terminal. They were sent home without palliative support at home. Without appropriate care, they deteriorated and were transferred by ambulance and passed away a couple of days later. That person—their family told me they had to actually beg for a private space for their husband and father to pass away. They were in a four-bed ward because all the other beds were occupied. We are concerned that this is still happening right now despite the efforts of staff. It's a bed pressure issue at Orange hospital, which is why a hospice, to us, would be seen as a—

**JENNY HAZELTON:** To get it away from that competition for beds. The pressure of beds will always be there because the specialties have grown so much. We are very proud of our hospital, but it's becoming not the place—everyone is working really hard to make it work, but the reality is that the need is bigger than what the hospital can deliver.

**The CHAIR:** Thank you for sharing that with us. It is distressing and it does highlight, as you highlighted, the importance of dedicating space and time to palliative care. Thank you very much for appearing before the Committee today. We may also send you some further questions in writing, and your replies would form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

**JENNY HAZELTON:** Absolutely.

**The CHAIR:** Thank you very much for today.

**(The witnesses withdrew.)**

**Ms JUDY BLACKMAN**, Secretary, Mudgee Health Council, sworn and examined

**Mr JOE SULLIVAN**, Chairperson, Mudgee Health Council, sworn and examined

**Dr ROSS WILSON**, Member, Bathurst Community Health Committee, sworn and examined

**The CHAIR:** I welcome our witnesses from Mudgee Health Council and Bathurst Community Health Committee. Will 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?

**JUDY BLACKMAN:** Yes.

**JOE SULLIVAN:** Yes.

**ROSS WILSON:** Yes.

**The CHAIR:** Would you like to make a very brief opening statement, perhaps of a couple of minutes, from Mudgee and then from Bathurst?

**JOE SULLIVAN:** Thank you for the opportunity to voice the concerns of Mudgee Health Council to the excellent and well-researched report and the 44 recommendations that were made. Information from the Health Intelligence Unit report for the Western NSW Local Health District from February 2022 into the mid-western local government area provides worrying statistics that potentially avoidable deaths are 22 per cent higher than the state average. A major cause of this statistic is a lack of regular access to primary healthcare services. The rate of non-urgent presentations to our emergency department is 14,174 per 100,000, compared with the New South Wales average of 3,955 per 100,000. This is more than 300 per cent higher, resulting in a huge waste of resources and long wait times in the emergency department. These potentially avoidable presentations lead to increased hospital staffing, often involving locums recruited at great expense.

Mudgee struggles to attract new doctors, and the number of registrars applying for short-term placements has dropped since the report. Added to this is that a number of GPs are approaching retirement. There appears to be no strategic plan, as recommended in Greg Donnelly's foreword to the report, as successive state and federal governments focus on the short term. Recommendation 8 is:

> That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

It is extremely disappointing to us that a rural and remote commissioner, as recommended, was not appointed, with current and emerging challenges such as insufficient full-time health positions and lower salaries compared with other states; population growth accelerated due to renewable energy projects; and changes to aged-care regulations resulting in a reduction of over 50 nursing home beds locally, putting strain on hospital beds. We hold grave concerns for the future of health care in rural, remote and regional New South Wales unless changes are made.

**The CHAIR:** Thank you, Mr Sullivan. Can I just say how pleased I am to see Dr Wilson. Dr Wilson and I have been colleagues over many years in different forums, so it's very nice to have you here today, Dr Wilson. Would you like to make a brief opening statement?

**ROSS WILSON:** Yes, thanks. I come wearing several hats today, as a member of the Bathurst Community Health Committee; secondly as a rural director for Western Sydney University with a clinical school in both Bathurst and Lismore; as a board member of the rural faculty of the Royal Australian College of GPs; as a board member of the Remote Vocational Training Scheme; and as a board member and director of the Bathurst Walu Aboriginal health service, yet to commence activity.

With those multiple hats, there are several of the recommendations that interest and concern me. They centre around the communications issues. They centre around credentialing. They centre around training and expectations as far as delivery of workforce in primary care and specialist services. They also interest me as far as the development of community-controlled health facilities and finally, and not least, the development of maternity services.

I would point out that at this very moment I'm the consultant obstetrician for Bathurst Base Hospital, and fortunately I have an exceptional registrar on service who has allowed me a couple of hours to get up to this meeting. We are desperately short of obstetricians in Bathurst to the extent that they've converted an old GP into a consultant obstetrician in the last couple of months, and that I think is symptomatic of the shortage of workforce that Mr Sullivan alluded to. We are desperate.

**The CHAIR:** Thanks, Dr Wilson. Actually, maternity and obstetric services is a particular focus of this inquiry, so I am going to take the liberty of following on from the points you've just made. Perhaps you could provide the Committee with some further information about obstetric services in Bathurst and what are the plans to sustain that service going forward. Thank you for the work that you're doing in that area.

**ROSS WILSON:** The Bathurst obstetric service teeters on a brink. Currently we have one full-time obstetrician gynaecologist. We have two GP obstetricians, and my role as a GP obstetrician has been elevated to that to cover two days of consultant obstetric practice. We depend on locums from Friday to Monday on a revolving locum system. We have no dedicated other gynaecological services other than the one consultant. We depend on a locum registrar and one non-accredited registrar. We do about 700 deliveries a year. We have a local Indigenous population of about 7 per cent, and we have about a 16 per cent Indigenous female delivery rate and a 22 per cent male Indigenous delivery rate—that is, the fathers are Indigenous to other women. It moves from, if you like, one disaster to the next.

**The CHAIR:** What are the plans in place at a health district or NSW Health level to address this ongoing workforce shortage?

**ROSS WILSON:** That is a mystery to me, and I believe it might be a mystery to the health service as a whole. I know I probably shouldn't be speaking about things about the local health district without their permission but I'm that close to retirement that if they sack me, it doesn't worry me. Basically we're I think rudderless in a lot of areas, and obstetrics is one that frightens me, having done obstetrics now for 50 years. I've never been in a situation where there has been little support. We are forced to discharge women before they are fully competent at breastfeeding, haven't had chances to debrief. We've pushed for midwives, and I have first-rate knowledge of that as my wife was the director of the maternity unit for about 15 years until she decided that child and family health nursing was a smarter way to go to relieve stress. Women in the bush get a poor service as far as obstetrics is concerned.

**Ms JANELLE SAFFIN:** I want to focus on one of the recommendations from the inquiry. It's the one where local health districts review and promote the role of local health advisory committees to ensure genuine community consultation on local health and hospital issues. I noted, Dr Wilson, that you mentioned communications just in passing but would any committee or council members here now like to comment on that? Is there any engagement or liaison?

**JUDY BLACKMAN:** To be honest, I'd say we've seen very little. However, there was a meeting of the local health district members at Mudgee Hospital probably a month ago, and our committee asked if we could be invited to meet with them because they were in Mudgee. I was unavailable but a couple of members did go. It was just informally, over lunch. We had the mayor and the general manager of council on our committee. They went along and felt it was very useful.

I think in the past there have been much greater opportunities to talk openly with members of the local health district, and that has been a bit of a failure. It probably is happening with staff more regularly but, as far as we've been concerned, there's been a gap in that area, I'd have to say. We actually had to advocate and ask could we have some input. And particularly in light of the fact that there is this great increase that we know is coming and is already starting to happen with the workforce for the renewable energy zones and all of that, we were trying to find out what planning is in place—

**Ms JANELLE SAFFIN:** For the added population

**JUDY BLACKMAN:** —towards that because it's going to be massive. The feedback that we got back from that meeting was that they were aware of the issues but there was virtually no funding available to address any of them. That seems to be the biggest barrier to a lot of things. We know that our local health district has just come in at $48 million over budget, and everything seems to get back to the budget and the difficulties around that. So financial resourcing as well as staffing issues seem to be huge in our area.

**Mrs LESLIE WILLIAMS:** I want to continue on that line of questioning from my colleague. One of the recommendations from the report was about local health districts better communicating with community, providing more data so that community better understands what the services are, where there are gaps and so on. My question is: Have you seen any change in that communication and the information sharing with community since the report came out two years ago?

**JUDY BLACKMAN:** No.

**Ms TRISH DOYLE:** Thank you all. You provided so much information in just your opening statements and, whilst it's somewhat depressing, we need to speak to the truth of the matter in order to capture the reality on the ground in our report. I ask about the recommendations that were made and where there has not been progress—

which is what the substance of the work of this Committee is about—and the recommendations from a couple of years ago that may have been implemented or not. You've spoken to the fact that some of them have not. With the recent injection of funding into Bathurst hospital and the redevelopment there—we're talking a significant amount of money—following on from my colleagues, what sorts of communications have you had with the local member, the local health district and local community groups about sharing in some of that? If it's not particular to Mudgee, there are certainly services, I'm sure, and groups that should be sharing in that money.

**ROSS WILSON:** I'll answer for Bathurst. Yes, we've got $200 million. No, we don't know where it's going to go, particularly. There have been community consultations, which, from my aspect, have been rather one-sided. We are dictated as to what is going to happen. Our local member is actually active at the advisory committee level at the local council, but he is not in power at present. He was the former police Minister. He is now the shadow police Minister. He is active and he asks the questions, but a great number of them are stonewalled. Although I have a good working relationship with the planning team, who occupy an office not 20 metres from me, I can get very little out of them that is concrete about what is going to happen with the 200 million. We've seen some attractive drawings and such, and some redevelopment plans and so on like that, but the whole redevelopment is two or three years away—at least. With escalating building costs and so on, I doubt whether we'll actually see $200 million worth of improvement.

A big issue has been whether we can afford parking around the area. There have been various solutions suggested but none have been accepted. Our mayor, Councillor Jennings, is going to speak to you this afternoon. He's probably more across that than I am. I'm more concerned with the delivery of the services and the availability of education within the developed facility. I can say that education will be better afforded. We've got dedicated teaching areas, but I can't say that the service will improve because until we have a body of specialist and general practitioners attending the hospital, the service isn't particularly going to improve. It'll just be rearranging deckchairs on the *Titanic*.

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

**JOE SULLIVAN:** On the recommendations, we as a health council have the list of recommendations here. Going through them, we can't see much in recommendation 2, which is the IPTAAS; recommendation five, which was engage with local community groups and charities; recommendations 7, 8 and 9—I can go through them, but we're not seeing what we should be seeing, and it goes right through. One point I did miss in my opening statement I would like to come back to is it was extremely disappointing that a rural and remote commissioner, as recommended, was not appointed. It gives everyone a point of focus where they can go to this person, and it's missing. Unless we get everyone on the same page, we're not going to get too far, I don't think. This commissioner, the way we understood it, was going to relate to both sides—the health, the service— and the whole lot, and it didn't happen. It was his recommendation, and his recommendations were very, very thorough.

**Mrs TANYA THOMPSON:** I will reference the example in your submission of the gentleman who needed to find his own way back to Mudgee after suffering a stroke. It's a shocking story, but thank you for sharing that and for your honesty. Are you able to elaborate and give us your perspective on what patient transport is actually like in this area? Have you seen any improvements at all since the report came out?

**JUDY BLACKMAN:** It's a huge difficulty. That person had to be operated on in Sydney and was then released after a couple of days and told to get the train back home. I think there's a lack of understanding, and it may not go directly to this. The city hospitals don't understand the difficulty in that travel zone. I can give an example of a family that I've been supporting for a long time. The dad has muscular dystrophy. They have four little children. Mum came from a background of abuse and neglect, so it is a very difficult situation. But she has risen above that magnificently and, despite his physical disabilities, which are huge, they are doing a marvellous job in raising four little children and have beaten the statistics in every way. I've often said to this mum, "Statistically, you probably should be a drug addict prostitute in jail."

Here she is doing a wonderful job, volunteering at the school and raising four little children, one of whom has a form of muscular dystrophy that affects children. The dad developed it as an adult; this little girl has it at a young age. Again, they have to travel to Bathurst to see a paediatrician. Here, there and everywhere—they've always got to go somewhere, which is very disruptive. The little girl had been booked into a Sydney hospital last week to have a stoma—or whatever the medical term is—to be tube fed through the stomach. She is currently tube fed through the nose, which creates all sorts of barriers and difficulties at school. She was quite worked up about this. The mum was looking forward to this happening but fearful because there are some medical risks. Lots of planning went into this trip to Sydney for this to happen. The NDIS were paying for some support to help dad care for the other children at home while mum and the little girl went to Sydney.

All of that was in place. At five o'clock on the afternoon they were to head to Sydney for the operation the next day, they got a phone call from the Sydney hospital to say the surgery was cancelled. You can imagine the

difficulties that that presents for a family. Yes, they were driving to Sydney but it is that ripple effect, if you like, of the transport and the lack of understanding in city hospitals. We hear of it regularly. Something has been cancelled, changed or whatever. It's like they think you're coming from Penrith rather than four hours away in the middle of winter in a fog or whatever it is.

**Ms LIZA BUTLER:** Dr Wilson, in regard to maternity services, in your opinion, why do you think we are not attracting gynaecologists, obstetricians, GPs and VMOs to regional areas, and what do you see is a way that we could address that?

**ROSS WILSON:** I think there are two factors. One is rural reluctance amongst medical graduates—that is, they have been told for the last 30 or 40 years that it's very busy in the bush. You've got 30 per cent of the Australian population rurally; you've got 20 per cent of the medical practitioners. That means I have to work harder. The other thing is we are not educating our high school students, who become our university students, in the facts of life about work-life balance. It has now become a life-work balance, and they don't want to work the hours. You commit yourself to almost 24/7 as a GP obstetrician or specialist obstetrician in rural areas, and people don't want that lifestyle. You heard from Jenny Hazelton earlier about palliative care services. The fact that you can't have palliative care physicians in a town like Orange—I believed they still had one. We have a part-time one in Bathurst who was lucky to get his contract. We had to fight extremely hard for the hospital to sign the contract for him because there was going to be a budgetary issue.

**Ms LIZA BUTLER:** How do you think we can overcome these issues?

**ROSS WILSON:** I don't have any clear solutions. I have thought about things such as rural conscription—you send people there for two years. Even the specialist colleges are now starting to pull back on commitment to training the specialists in rural areas. I sit on the board of the Remote Vocational Training Scheme, which places GPs in difficult-to-work-in situations. We do it by rapidly increasing the amount of money they can earn and using overseas medical graduates to fill those spots—people who generally have a moratorium on their ability to move urban.

We find that although they're given an exceptionally good training program, they'll only last about one or two years after they've got their fellowship before they move to an urban area, anyhow. I don't have any clever solutions. Some people in the Government think that longitudinal study as high school students fits you for longitudinal study as a medical practitioner. It doesn't seem to be translating into numbers and that sort of scheme has been going on for 20 or 30 years now and hasn't produced the numbers that we want.

**The CHAIR:** Can I come back to you, Mr Sullivan, and Ms Blackman and Dr Wilson, you might want to comment on this. You mentioned primary care being a significant issue in Mudgee currently. Dr Wilson, I think you also commented on the shortage of primary care doctors. Are you aware of anyone who is taking action to address that in Mudgee? Is there anyone whose job it is to recruit and find primary care practitioners for Mudgee?

**JUDY BLACKMAN:** Both the medical centres have been working on this and we have a doctor on our health council, Dr Peter Roberts. He recently said, "For 20 years we have been trying to attract more GPs." I think there's something like five going to retire within the next—he's certainly retiring in a month, and there a number of them retiring not long after that. He said they've been working for 20 years and supporting students from Wollongong university and other places. He said it takes a lot of time. It's somewhat inconvenient for patients coming to the medical centres because you've got to go through two—you go through the student and whatever—and then we have to write reports. He said that in all those years there's only been two that have stayed and come out of that. They're finding it really frustrating and we don't know what the answer is.

**JOE SULLIVAN:** Also, there was a fund that all the doctors in Mudgee put in to recruit and they had the mines that also contributed, but it didn't produce any. They had people scouting overseas at that stage and nothing transpired there. I don't know the full details, but there was a lot of effort that went into it a few years ago.

**The CHAIR:** Is the local health district involved in recruiting to primary care positions?

**JOE SULLIVAN:** No. I think they've got their own worries. Really, I haven't heard of them wanting to recruit or advertising to recruit for Mudgee. Is that what you mean?

**The CHAIR:** You made the point that there are 14,000 admissions, attendances, at the ED, which is three times the level you'd expect. Presumably that's because of the deficit related to primary care services. I would have thought it was in the interests of the local health district to try and address that rather than just deal with it through the emergency department. But that's a comment, not a question.

**JOE SULLIVAN:** Yes. I wouldn't have the answer to that, I'm sorry.

**The CHAIR:** Dr Wilson?

**ROSS WILSON:** I can say that there is only one body in New South Wales that's dedicated, if you like, to try to recruit for rural and that's the Rural Doctors Network. The Rural Doctors Network sits in Sydney, so I think that's probably not the right scene, if you like, to set for people they're recruiting for rural areas. It has a vacancies page which goes for about 10 or 15 screens on the computer. They have been highly unsuccessful. Primary Health Network, I believe, was meant to have helped. There's no evidence of that happening. Certainly the district doesn't want to show too much interest because they're too busy trying to find nurses, specialists et cetera like that, to staff the hospitals.

Once a month I go for three days to give anaesthetics in Coonabarabran because they're unable to get an anaesthetist to travel there, even from Dubbo, to provide services. I know for a fact that the GPs in Coonabarabran, who are colleagues, are both about to throw their arms up and walk out, such is the incredible load and the inability to recruit to the position. It's the same—most of western New South Wales, anyhow, is filled by locum doctors on a two-week fly-in fly-out basis. Whilst that occurs and they've got a bum on a seat, I don't think people are looking too hard at filling a requirement long term.

**The CHAIR:** Thanks, Dr Wilson. That will bring us to a conclusion. I thank the witnesses for appearing before the Committee today. We may send you some further questions in writing. Your replies will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

**JOE SULLIVAN:** Yes.

**ROSS WILSON:** Yes.

**The CHAIR:** Thank you very much. We are going to have a five-minute pause to the broadcast.

**(The witnesses withdrew.)**

**(Short adjournment)**

**Ms HELEN GOODACRE**, President and Welfare Officer, Can Assist Orange, sworn and examined

**Ms LITA MATHEWS**, Member, Can Assist Orange, sworn and examined

**Ms MAUREEN FIELD**, Treasurer, Can Assist Forbes, affirmed and examined

**Ms SARAH MacINESS**, Paediatric Occupational Therapist, SEED Paediatric Services, sworn and examined

**Ms MICHELLE MAUNDER**, Co-Director, SEED Paediatric Services, sworn and examined

**The CHAIR:** I would like to welcome, first of all, our witnesses from Can Assist. Can you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders related to the examination of witnesses?

**HELEN GOODACRE:** Yes.

**LITA MATHEWS:** Yes.

**MAUREEN FIELD:** Yes.

**The CHAIR:** I now welcome our witnesses from SEED Paediatric Services. Each organisation has the opportunity to make a very brief opening statement. We will try to keep it to two minutes. We might start with you, Ms Goodacre, on behalf of Can Assist.

**HELEN GOODACRE:** Thank you very much for the opportunity to speak today. Can Assist Orange branch has been operating since 1956 and, since that time, has been dedicated to providing financial assistance to anyone in the community and surrounding towns impacted by cancer. I have served as president since 2019 and for seven years prior as treasurer. Since 2017 we have delivered assistance to some 290 people. This financial year we have received 32 new patient referrals and we continue to support 44 patients from previous years—a total of 76 people. Of the 76 people, eight have passed away during the past year, 33 are aged over 67, and 35 people are under 65, with the youngest being a four-year-old child. We are still currently supporting these people.

The expenditure to April was $43,000 and was split as follows: travel, 10 per cent; utilities, groceries and other, 29 per cent; out-of-pocket medical, only 1 per cent; pharmacy, 44 per cent; and wig library, 15 per cent. We are flexible in our approach and help our clients in whichever area they are experiencing the need. In Orange, with proximity to our local health services, we spend very little on out-of-pocket medication, which accounts for only 1 per cent of our overall expenditure. The biggest stress area we see are in medication costs, particularly for palliative patients, and supplement foods, accounting for a high 44 per cent of our annual expenditure. I would like the Committee to raise this with me today.

**SARAH MacINNES:** Thank you so much for having us here today. SEED is a private paediatric occupational therapy service providing specialised therapeutic services to neurodiverse children aged zero to 12 years. We have seven occupational therapists in our team and one occupational therapy assistant. We have clinics in Orange, Dubbo and Bowral. We were established 13 years ago. The problem, as we see it, is that the demand for our services, particularly with increased accessibility through the NDIS, outstrips our capacity to service the demand.

For us, it remains a workforce issue. We're consistently losing the bid for recruitment to metropolitan areas such as Sydney, Melbourne and Newcastle. We have worked tirelessly over the years internally on strategies, for example, of a really strong induction program, really strong weekly clinical support, sustainable case loads, variety of work, and career pathways. We're now looking at a solution that is a unified approach, working across sectors—for example, not-for-profit, government and private practices—and within local government areas to improve communication and coordination of care for the child and family.

We are looking to improve collaboration between organisations, leaning on each other's strengths in the diagnostic, intervention and community capacity-building areas. We're looking to increase efficiency through knowledge development by specialising in, for example, particular diagnostic areas rather than generalising. I guess we consider it a workforce strategy that acknowledges the unique needs of our candidates. For example, we're a really female-dominated industry. We have new graduates and working mothers who need flexibility and part-time roles. For us, it's about having the right people in the right roles. I'd like to pass on to our co-director Michelle for further comment.

**MICHELLE MAUNDER:** We are really trying to come up with some initiatives. After working for 13 years to recruit occupational therapists, we are now aware that lots of small businesses such as ours are investing lots of our time as clinicians on a workforce issue. We're really interested in having a coordinated

regional and rural workforce strategy, similar to that of Tourism Australia, which has "Come and Say G'day". It has a selection of videos that can be testimonials to people like us who come from metro areas, who have had really great career advancement and specialisation, as well as the lifestyle rewards that a town like Orange and those further can provide, as well as having a financial comparative to metro areas. I guess everybody who has spoken today has acknowledged the workforce issue. We would love to see it as a really united regional response—a strategy that goes across all of our areas so that we're all not just doing it individually and unsuccessfully.

**The CHAIR:** Thanks, Ms Maunder. I'll start off the questioning. I come back to Can Assist. I start by acknowledging the work that Can Assist does throughout rural New South Wales, particularly in my area. It's absolutely outstanding.

**HELEN GOODACRE:** Thank you.

**The CHAIR:** I know so many people have benefited from it. You've made an excellent submission. You've highlighted issues around community transport, which I hope we'll get to later. But you did flag, in your opening statement, the challenges of palliative care and you did reference that a lot of your funding support now is provided to people with palliative care. Palliative care was a feature of recommendations from the first inquiry. We're interested if you could expand on what improvements you've seen in that area and what still needs to improve in that area in rural and remote regions.

**HELEN GOODACRE:** In our area, what we're finding, basically, is prior to being diagnosed as palliative and coming into the stages of palliative care, the medication costs are horrendous. I'd just like to say that the figure we looked at is a 12-month figure provided to me. Medications for end-of-life patients—there was a total of 10 we looked at—was $10,000. That is a high percentage of our budget. What happens is that a palliative patient is not immediately treated at the hospital. They are sent away with morphine or drug relieving products leading into their care.

We had one situation where a patient was palliative and we had to do a bedside will, which cost us $880. But that patient turned out to have other medications supplied, such as morphine or whatever, and was later moved into a nursing home. To my knowledge, she is still existing or continuing in the nursing home. The situation is a bit grey, actually, in that area leading up to when people are suffering from severe pain and it can be said, "Well, you're in your palliative stages of the last two weeks, three weeks or a month." We actually start it before they are actually on their deathbed at that time—I guess that's not a very good way to describe it.

But these costs of the medication are very expensive. We don't get any help. Often the patients are under the age of 65—or 67, I should say—and so they've got no subsidies for it. They have to pay the full amount. That has been a big area of stress by the families, so they seek our support in that area—and along with other areas they will request support in, of course. The supplement foods are also very expensive. We have 13 patients—$3,500. That is increasing immensely at the moment, not only for patients that have throat cancer or oesophageal cancer. They rely on these foods to survive. The last one we organised, just in the last few weeks—the Sustagen food cost $440, and that is about a month's supply. Obviously, we've started with that, but we won't be able to continue with it.

**Ms JANELLE SAFFIN:** My question is about the out-of-pocket costs. You have detailed that well in your submission. Recommendation 21 was that NSW Health work with the Commonwealth and service providers to find strategies to reduce the out-of-pocket costs. Have you been approached, as a service provider, on this matter?

**HELEN GOODACRE:** Not locally. Perhaps our head office has been, but we haven't been approached locally. No, I don't have any knowledge of that at all.

**Ms JANELLE SAFFIN:** I have noticed that the costs are big.

**HELEN GOODACRE:** They are, exactly. With that cost, the 44 per cent includes pharmacy accounts. We pay 20 to 30 pharmacy accounts a month.

**Ms JANELLE SAFFIN:** I know. I have read it. Your bills—they're big.

**HELEN GOODACRE:** And that is ongoing. It is a high cost—the highest cost.

**Mrs LESLIE WILLIAMS:** Thank you to all of you who do the work for Can Assist. I think the Chair and most of us as local members really appreciate the work that you do on the ground. We understand the incredible difference it makes to families who are being impacted by cancer. I will go specifically to the report and to recommendation 24. One of the things that the recommendation suggested was to expand the Far West NSW Palliative and End of Life Model of Care to other regional communities. Have you seen any indication or

are there any conversations happening about how that type of model of care that has been used in the Far West might come over to your local health district?

**HELEN GOODACRE:** Not to my knowledge, no. Sorry, I don't have any knowledge on that either.

**Ms TRISH DOYLE:** Welcome to you all. It was particularly lovely to have a bit of a catch up with the Can Assist ladies before we began today—a great way to start the day. Thank you for your work and I echo the sentiments expressed by my colleague. Recommendation 30 was about New South Wales committing to a number of workforce improvements, particularly investigating telehealth cancer care models, so improving access to cancer treatment and care, and boosting clinical trial participation in regional areas. We heard from someone yesterday who felt very strongly against cancer patients in conjunction with telehealth as a model to treat and care for cancer patients. Have you seen any cases in this telehealth trial model? Have you seen any cases or heard about any cases about that in regional areas and whether it's to be recommended?

**JENNY HAZELTON:** No

**Ms TRISH DOYLE:** Are there any comments around that?

**LITA MATHEWS:** I have worked for seven years as a palliative care and oncology social worker at the Orange Health Service and I have joined Can Assist after I retired so I know a little bit about what you are asking. I think our population, and especially people in the rural and remote areas, are not terribly skilled in working with technology so people are reluctant to engage in that kind of service model. Another thing that I like to harp on about always is the fact that we have limited connectivity in terms of internet. I live in Molong and there are certain blackspots—and that's only 30 kilometres from Orange. If I have to make a phone call with my mobile in my house, I have to stand and look at Mount Canobolas or people can't hear me, so so much worse would it be for people in greater rural areas! I don't think, despite it being on paper, it is a really positive and clever solution to engage with patients. I don't think it's always that practical.

**Mrs TANYA THOMPSON:** What has been one positive change that you have seen in relation to cancer treatment since the inquiry and the report has come out? Then again I would ask the same to SEED in relation to paediatric services. So just one positive change.

**HELEN GOODACRE:** Basically the area that we look after is providing—once we, the social workers, receive a referral from the hospital, we provide support for all kinds of areas. One area I would say is the support we're now receiving from our local community because all the money we raise local stays local. Each branch operates independently so we look very much to our local community for support. The range of support we give I'm very passionate about because we support people in an area higher than a lot of the other charities. We don't focus on just medical; we look after—and we treat this as critical. I always feel it's critical. We don't need to use IPTAAS because we have such wonderful services at Orange hospital.

What we do is we provide at least a $200 fuel voucher to a patient when they apply to us. That gives them the money to fuel their vehicles—or a friend's or carer's—to take them to the hospital for treatment. That is the area that we look to. We will also pay full vehicle maintenance—the registration, insurance and green slip, and whatever they need to keep the vehicle on the road—because that is critical. Another area that has come to notice very recently is the request for grocery and food vouchers. It's usually a double whammy, and we always give at least $200 because we feel that they need that amount. The transport situation in Orange, my brief knowledge is—through the local ambulance service, is absolutely excellent—from the patients that we've had transported to hospital.

Another item I need to mention is you might note on my report that 15 per cent of our costs go to the wig library. That is not just wigs. We have that sponsored by a local pharmacist, and she provides funding for the lymphoedema bras, which include leg and arm sleeves. They are all very expensive. Some of them can be up to $1,800. So our support to the community is very broad, and we rely totally on our social workers to provide the information. I would like to say at this point, in relation to the social workers, when a patient is diagnosed with cancer, the anxiety that person suffers is horrendous, and the social workers refer these people to us. We need more social workers. I can go back to 2014, when we had four social workers, and we were receiving up to 40 or 50 recommendations a year. Now we're receiving about 30 to 40 or even less. It's because they're not there to work.

**Mrs LESLIE WILLIAMS:** How many social workers now?

**HELEN GOODACRE:** They don't all work full time. That's the issue, I think. They travel the district. We cover a radius around Orange, approximately 50 kilometres, which encompasses the small villages or towns, like Canowindra, Cargo, Manildra, Cumnock, Yeoval—if you draw a circle around. The district social workers

have to cover that area, so they can't always be in Orange. That is a critical situation, I think, but it was covered in one of the sessions as well.

**Ms LIZA BUTLER:** Thank you for all the work you do. I just want to understand about the IPTAAS. In your submission you say that, if they're accessing community transport, they can't put a claim in.

**MAUREEN FIELD:** That's right.

**Ms LIZA BUTLER:** We've heard on some of our other visits to Broken Hill that they actually do but the money goes to the community transport. Can you just explain what barriers you're finding with IPTAAS?

**MAUREEN FIELD:** We rely on IPTAAS quite a lot. Because I'm from Forbes, we have to travel to Orange. Our patients have to travel quite regularly to Orange. We do give money for fuel. But when there is accommodation involved and what not, then they apply for IPTAAS, if we can get them to. The forms are very involved. They just sometimes take one look at them and say, "It's too much trouble. Can't do that," so then we also miss out on the rebate from IPTAAS if our patients don't do it, or we take on doing it ourselves. This involves time. Patients need to have a referral from their GP before they can visit a specialist, so we're thinking maybe that could be done away with, that first referral. We have found, as I said, they take one look at the forms and decide they don't want to do it. What else was the question?

**Ms LIZA BUTLER:** I think you've answered. Just the barriers that you're finding when IPTAAS can't be claimed when they're getting community transport. I think you've just addressed those reasons.

**The CHAIR:** There were a couple of other members who wanted to ask SEED Paediatric Services questions. I might come back to you, Mr Barr.

**Mr CLAYTON BARR:** Recommendation 5 asks that NSW Health and local health districts have a better understanding of what services might be in the fabric of the community. What awareness or understanding would NSW Health or the local health district have of the services that you offer? How would that work? Would you report back to them or share that information? I don't see the line of connection.

**MICHELLE MAUNDER:** To our knowledge, there isn't one. When we started, and when we have new staff join us, there is a paediatric network that is run through Health. We're not invited necessarily. We might go to it, but it really doesn't relate to anything outside of Health. It's very internally focused, so there are no pathways at all. Because we're a small community of occupational therapists in the region, we know of each other, but we certainly don't know the role of OT in community health or at the hospital. Roles change rapidly and there is really not a lot of communication out of Health about who they see, when, why and what the diagnostic criteria are.

**SARAH MacINNES:** I think, too, I would say that 98 per cent of our children access the NDIS and, currently, NSW Health doesn't see children through the NDIS, so we work very separately in that way. There are not a lot of cross-referrals or understanding of each other's strengths.

**Mr CLAYTON BARR:** Disappointingly, I thought you might say something like that. That's a real shame.

**Ms TRISH DOYLE:** Following on from my colleague's question, I was thinking about when a private set-up can step into a space to support a community need. You refer to the fact that you can't service the demand. You went on to say that workforce issues require a strategy. I'd like to ask whether you've reached out to that network you talk about to devise such a strategy and come up with a solution? If there isn't that pathway between the private-public service network directly to Health, have you talked in your network about coming up with a solution and sharing a strategy?

**MICHELLE MAUNDER:** Not in a coordinated way. Certainly, there's a disconnect, in our experience, between public health and private and not-for-profits. I think you've heard it mentioned today that they're pretty internally focused on their own recruiting issues. Theirs are not as great as ours, to be honest. I think everyone has just got their eyes down. We're not aware of a coordinated structure. We have certainly talked in our private, not-for-profit areas about having coordinated placements for students to come out. As you'd know, having a student is really difficult in a small practice. We have our duty to support the new profession, but if it doesn't convert into a placement, then it's just hard work. We have talked about that. Nothing has really ever come of our discussions, no.

**SARAH MacINNES:** It's our intention to, though. We were just chatting to Jessica Brown outside. That's where we're at.

**Ms TRISH DOYLE:** Excellent. We look forward to seeing it.

**The CHAIR:** Can I just follow up with SEED Paediatric Services? We have heard that organisations that provide services through the NDIS often pay well above rates for allied health personnel compared to the NSW Health system and other non-NDIS providers. That has created some difficulties for other organisations in terms of recruitment. That's what we've heard. Ms MacInnes, I think you mentioned this concept of an integrated approach to recruitment. I wonder if you could expand on that description a bit. First of all, what is your response to the issue around payment and, secondly, what do you mean by an integrated recruitment strategy?

**SARAH MacINNES:** In response to your question around payment for allied health professionals, it really depends on the business model. Privately, you will find varying salaries, which I assume is based on their business models. We actually have a specialised clinic that's purpose-built and that has equipment, so our overhead costs are high and our salaries are more matched to NSW Health. Whereas if you had a mobile clinic and you didn't have the overhead, you could then afford to pay higher salaries, and that definitely could be the case. So I do think it depends.

**The CHAIR:** That is very helpful, actually. Thank you for that.

**MICHELLE MAUNDER:** Can I just interrupt? Sorry. Particularly if you are having a workforce that sits at home and provides telehealth, which has even lower overheads than having a mobile service sitting in Orange that drives to a school, that drives to a preschool or that drives to a parent's home. Telehealth is probably the most cost-effective for a business. Our experience is it is not what consumers want. It does not meet that need for relationship building—

**SARAH MacINNES:** Outcomes.

**MICHELLE MAUNDER:** —and meeting those complex child's health needs. Many have got multiple diagnoses and are non-verbal, so they can't even—

**The CHAIR:** Particularly in relation to people with complex needs.

**MICHELLE MAUNDER:** All needs but, certainly, the children we see with complex neurodiverse needs.

**The CHAIR:** Thank you, Ms Maunder. You were just going to expand on that description.

**SARAH MacINNES:** Integrated approach.

**The CHAIR:** How do you see that working?

**SARAH MacINNES:** As I see it, we build partnerships with non-government and government organisations where we can offer a role across those different areas. For example, we might utilise our strength, knowledge and understanding of autism and they might work two days within SEED Paediatrics, and then they might work three days in Marathon Health in a role within the context of a team. That's where I think that would be attractive for an occupational therapist or a candidate because it offers a variety of work. It offers that balance of working within a team, as in working one-on-one with direct clients. I do think there's opportunity and scope to do that. How that would logistically work, we'd have to figure out.

**The CHAIR:** That is two non-government organisations. Do you think you could do a similar thing with NSW Health and job-share like you have just said?

**SARAH MacINNES:** I don't know if there would be bureaucracy on the NSW Health side that would make that challenging, but I would definitely be open to the conversation. I don't know whether that would be possible, but I would hope so. I definitely think there's opportunity for an integrated approach where you'd have a role across organisations. I think, too, it's about organisations leaning on their specialties—really specialising rather than becoming a generalist. We see occupational therapy private businesses in communities working across paediatrics and aged care, whether it's pain management or return to work, and I think a lot more efficiency can be gained by specialising and having a knowledge bank—so organisations working together in that way where they might specialise rather than generalise.

**Mrs TANYA THOMPSON:** What do you think would be the biggest barrier with that moving forward, particularly with the Government and NSW Health?

**SARAH MacINNES:** I guess I don't know what I don't know. I haven't actually had a discussion with anyone from NSW Health around whether they would be open or whether there are actually barriers there that I'm not aware of that would prevent that. I don't know.

**The CHAIR:** I do not think there are any more questions from the Committee. Thank you for appearing before the Committee today. I very much appreciate that it can be a nerve-racking experience. We may send you

some further questions in writing. Your replies will form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

**MICHELLE MAUNDER:** Yes.

**SARAH MacINNES:** Yes.

**HELEN GOODACRE:** Yes.

**LITA MATHEWS:** Yes.

**MAUREEN FIELD:** Yes.

**(The witnesses withdrew.)**

**Ms JULIE DIGNAN**, Director Data and Quality, Lives Lived Well, affirmed and examined

**Ms MELANIE MEEHAN**, Team Leader, Residential Services Wyla, Lives Lived Well, affirmed and examined

**Ms ANNE WORRAD**, Mental Health Occupational Therapist, Ramsay Clinic Orange, sworn and examined

**Ms JESS SILVA**, Program Manager Western New South Wales, Mission Australia, affirmed and examined

**The CHAIR:** I welcome our witnesses from Ramsay Clinic Orange, Lives Lived Well and Mission Australia Orange. Can you each please confirm that you've been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses?

**JULIE DIGNAN:** Yes.

**MELANIE MEEHAN:** Yes.

**ANNE WORRAD:** Yes.

**JESS SILVA:** Yes.

**The CHAIR:** Would any of the witnesses like to make a brief opening statement of about two minutes on behalf of your organisation?

**JULIE DIGNAN:** Lives Lived Well delivers drug and alcohol treatment services across Queensland and New South Wales. In Orange we have two residential programs and an out client program, just as background to what we deliver here, for context, and have done for many years. One of the services is newer—in the last five years—funded by NSW Health for women and children. But the other residential rehab dates back as many years as I can remember—maybe 40 years or something.

**ANNE WORRAD:** Ramsay Clinic is part of the Ramsay group of hospitals. We are the only private hospital in the Central West—probably out to Adelaide, in actual fact. We have a 14-bed mental health inpatient unit. With psychiatrists and our allied health team, we run a group program and do individual therapy with people, and we can't keep up with the demand.

**JESS SILVA:** For the context of today's meeting, I'll be speaking on behalf of the Community Living Supports program, which is a NSW Health funded initiative, and also the alcohol and other drugs Continuing Coordinated Care Program, equally funded by the Ministry of Health.

**The CHAIR:** One of the key concerns of the inquiry and the Committee has been access to mental health services. Ms Worrad or Ms Silva, have you noticed improvements in access to mental health services since 2022, since the inquiry in the region?

**ANNE WORRAD:** No, I would have to say I have not noticed any improvement in mental health services. I think there are huge gaps in service provision in the mental health, drug and alcohol space. I have not noticed or become aware of any real initiatives to address that. I think it's becoming harder for people to access a mental health service within the public space. I think a lot of the burden for moderate to severe mental illness is now sitting in the primary healthcare space, with GPs and private service providers trying to provide an adequate service to people who, 15 years ago, when I worked in the public space, would have received a service from a community mental health team but are now not deemed severe enough or unwell enough to receive a service. So I think there are some big issues right across the region.

**The CHAIR:** Just to clarify, you're saying people with moderate to severe mental health issues are now being looked after in the primary care setting because they're not being deemed unwell enough to access what traditionally would have been community mental health services.

**ANNE WORRAD:** That's right.

**The CHAIR:** Ms Silva?

**JESS SILVA:** Just echoing what Anne is saying as well. Sitting in the public space where we work very closely with the community mental health hubs across the region, what we see is a lot of filtration happening—that really rapid triage and assessment and looking at alternative referral pathways external to community mental health hubs that can pick up the load and support that. Certainly here in Orange we see a lot of that filtering out to services such as LikeMind and then through other NGO-managed programs like Strong Minds, back to GP case management—those sorts of things.

**The CHAIR:** There has been some growth in those services, Commonwealth-funded services—as part of the national mental health plan, for example—funded often through PHNs. It wouldn't be entirely inappropriate

for some referral to those services if they've expanded. So I'm not necessarily concerned that there would be referral to those services, but are you saying that you think the capacity of community mental health services themselves has been reduced?

**JESS SILVA:** Yes, absolutely, especially where there is continual pressure in staff retention in some of these community mental health settings and also the drug and alcohol settings, and a lot of movement of people across different regions. We're seeing people move a lot into virtual teams at the moment as well, so coming out of that face-to-face clinical assessment and triage and moving into a virtual setting, but they're not physically being replaced on the ground.

**The CHAIR:** With the Committee's indulgence, I will go to Lives Lived Well for your reflection on my question.

**JULIE DIGNAN:** Can you repeat the question, please?

**The CHAIR:** It's around changes to access to services—in your case I guess drug and alcohol but obviously there's a big overlap—since 2022, since the last inquiry, and the challenges currently being faced, and perhaps a reflection on the evidence from Ms Silva or Ms Worrad about increasing referrals out of the public health system.

**MELANIE MEEHAN:** I can speak to that. With our clients, a lot of them aren't from this area, and so local services for mental health counselling won't accept their referrals. We actually do a lot of referrals to telehealth, so PSYCH2U and telehealth referrals like that, to see psychologists because we just can't access them locally.

**JULIE DIGNAN:** In terms of have we seen any change, there has been no change to the basic funding model or level of funding that we've had since 2022. As I understand, NSW Health did the funding round—I think it was last year—for service expansion across New South Wales, and we were successful with a couple of small programs out of that in Nowra and Lithgow but there was nothing funded in Orange or the Orange region. Also, to my knowledge, the PHNs and the AOD services they fund in this region, it's western New South Wales and many of them are in Dubbo and regions like that and out further. But the PHNs don't fund any AOD in Orange itself. We have one small Orange outreach program funded by NSW Health, but there is such demand on that program from the other regions that they outreach to—Bathurst and Parkes and places like that—so there is very little to go round there. But there has been no change to the basic funding model of the residential programs and the number of clients that they can take for many years. They're very old contracts.

**Ms JANELLE SAFFIN:** I want to draw your attention to recommendation 43 of the inquiry, which is that LHDs work with local communities and local health providers, in particular, to develop place-based health needs assessments and local health plans. My question to your organisations: Has that happened here? Have you seen that? Is there anything going on in that space?

**ANNE WORRAD:** I haven't become aware of anything like that, no.

**JESS SILVA:** I can, maybe—yes, to the contrary to that. I guess that's because we work along side the community hubs for drug and alcohol and mental health. There's actually some effective working relationships, but it's also because they form part of the quorum of those programs and it's in the terms of reference and things, how we deliver and govern those. For us, I think, yes, there certainly has been some improvement to relationships. We're seeing a reduction of that sort of siloing because there's a lot more pullback to depend on some of the community-based programs to support the clinical intervention.

**Ms JANELLE SAFFIN:** Is that developing those local health-based plans and working with the LHDs?

**JESS SILVA:** Yes, we actually have really good working relationships with the LHDs, unlike some of our metro counterparts, because we attend a lot of community of practice meetings and things and hear consistently how hard it is to get in the door. We're actually very fortunate, I think.

**JULIE DIGNAN:** Not to my knowledge. We have had quite a lot of management instability in Orange over periods of time so some of that knowledge could have been lost along the way—but not to my knowledge in a formal place-based health planning model. We're certainly working with the local public health—with the hospital and those sorts of things but not in a strategic planning sort of way.

**Mrs LESLIE WILLIAMS:** I have a general question to all of you. Other than this inquiry and the one in 2022, do you see this kind of communication channel, where you can provide feedback about the demand on services in your local area and so on, to raise your concerns about the delivery and access to services when it comes to mental health?

**JULIE DIGNAN:** We certainly try to have those conversations with our funding contract managers. Usually they don't go far in terms of the contract managers feel somewhat powerless and say, "They're just the buckets of money that we have available." We certainly take an advocating position to demonstrate the gaps and seek additional funding when contracts are renewed, but we don't have much luck in that respect.

**Mrs LESLIE WILLIAMS:** Does anyone else want to make a comment?

**JESS SILVA:** I'm happy to jump in again. I would add, sort of mirroring what I just answered then—again, arguably, it may be because of the governance structure that's applicable to the programs that I work in that are supportive to that relationship. Certainly there are nominated coordinators in the programs for the LHD that are looking after the community living portfolios or drug and alcohol that if there are those issues at a local level, we can be channelling those communications through. They're generally responded to, to us. How that impacts the bigger picture of the NSW Health model in its entirely—different story. But, locally, it works well.

**Mrs LESLIE WILLIAMS:** That's good to hear.

**Ms TRISH DOYLE:** Thank you all for the work that you do and for being here today. I'm going to play the devil's advocate a bit here. If we're going to make any inroads—we've seen recommendations from a couple of years ago implemented—we need to acknowledge that across the public and private system, you're all competing for the same staff and the same resources. Going back to a previous session we had, if there was some sort of regional strategy around—particularly speaking to drug and alcohol, rehab, mental health services, what sorts of conversations have you been having with one another, with networking across the region with your expertise, with your skill and knowing acutely what you need so that we can implement those recommendations? I'm interested in your take on the competition that exists for staff, for resources, for a piece of the pie.

**ANNE WORRAD:** It's an ongoing issue across just about every health profession there is. I know at Dudley we're very short-staffed at the moment. We're struggling to find nursing staff. We currently have a full allied health complement but that could change like that. If one or two of us left, then we could be really struggling, again, to find some more allied health staff. Being in a private hospital, we don't actually have a lot to do with the local health district. We don't have those conversations around staffing. Because we have colleagues across different systems, we know that they're also struggling, and they know that we're having a lot of difficulty as well. I'm aware of some of the Health initiatives and incentives to try to get people to some of these positions. Within Dudley, there's an incentive where if you can find another staff member, you'll get some sum of money—I don't think it's terribly much. Everybody is competing for the same staff. I don't know that anybody has come up with a really easy—

**Ms TRISH DOYLE:** Solution.

**ANNE WORRAD:** —way to address that, because there is a limited workforce. I don't know. It's a real issue.

**Ms TRISH DOYLE:** It is. Does anyone have any other—

**JESS SILVA:** I was going to jump in and offer to Lives Lived Well about what I'm saying here. That competitive tendering process and everyone fighting for their piece of the crumbs is what adds to the problem. When we're talking about staff retention, especially in regional areas, that lack of job security past contract terming is problematic. I'm certainly in the middle of that now, where I've only just got the green light six weeks before my contract is due to end for one of my programs. So we're trying to retain staff and make sure we're delivering that effective service, and all the things we need to do, but you can't give security to people when there are external factors happening, like the cost-of-living crisis and pressure against housing and all the other bits that add too.

**Ms TRISH DOYLE:** Thank you. I was looking for someone to identify the fact that once the system moved to competitive tendering, it was broken. Lives Lived Well, did you want to jump in on that one? What sort of strategy and communication do we need? Why are we competing?

**JULIE DIGNAN:** We're reasonably lucky in some ways that we're not as impacted by competitive tendering because we have a residential facility. It's assumed we have the infrastructure to run the residential programs and they're not going to take it and give it away to someone else—not so far, anyway. We can rely on it and it's reasonably stable, but we're still definitely competing for staff, particularly nurses and particularly because we run a residential withdrawal service. I don't have any solutions. I certainly don't think public health delivery, who need the staff, are interested in resolving that with us because they are competing against us. They're probably more interested in filling their own staffing than helping us out to do ours.

We manage the staff turnover as best we can. We're lucky at the moment that we have a reasonably full complement of staffing, but it's easy to lose a few casual nursing shifts and you have a few people sick, like you do now, and you drop into the overtime category and those sorts of challenges. So, yes, staff turnover is higher

here than just about any other region in our organisations New South Wales and Queensland wide, and it's a constant issue. The challenges are also in clinical risk and quality of care and health outcomes—not just can you get enough staff but can you keep the staff long enough for stability to make sure that the care that you're providing is always of the highest quality possible?

**Mrs TANYA THOMPSON:** I wanted to focus on the Indigenous health workforce, recognising how important it is for the Indigenous community to return to country with treatment and to be supported throughout their journeys as well. Is the Indigenous health workforce large enough in the spaces where you work to provide culturally appropriate mental health services in your communities?

**JULIE DIGNAN:** We have very few numbers of Indigenous workforce. We're committed to it as a principle. We have a reconciliation action plan, and work really actively on it, but we're not funded specifically for any identified positions or cultural support or cultural expertise. We just happen to have an Indigenous worker in one of our roles. We have very high numbers of Indigenous clients. We do our best in terms of culturally appropriate and culturally secure care. We have some Indigenous components as part of our residential treatment modules and the program content. We do a lot of internal training of our staff, trying to expand their expertise in offering appropriate care to Indigenous clients, but we don't have a specific Indigenous workforce. We just do the best that we can with what we've got, which is what we're always trying to do.

**The CHAIR:** Mission Australia or Ramsay, do you have any comment on that question?

**ANNE WORRAD:** We don't have any identified positions at the moment. When I've worked in other positions with the primary health network and the local health district, of course there are. I know that that has been a priority for those organisations, but we're a small outfit at Ramsay. It would be amazing for us to have an identified position, but we don't at the moment that I'm aware of.

**JESS SILVA:** It is the same for us as well. The way that our programs are contracted is they're identified positions specifically in those roles. Currently across the region we have three staff in my programs that are identified delivering casework. I introduce to the conversation that potentially one of the barriers, again, to retention is people having to move off country to work in some of these positions that we're working specifically with the structure of. It's that lack of place-based care. It's not in communities where it needs to be, so people are having to travel and outreach, and there is the commitment and burden that ensues with that as well.

**Mr CLAYTON BARR:** This is a question that all three of you could take. How much line of sight, awareness and understanding would NSW Health have about the programs and services that you offer? I don't see a direct line of connection or communication.

**JESS SILVA:** My answer is probably going to defer to everyone else's in that NSW Health govern my program. So I hope they're pretty switched on to what's happening. We have really close working relationships with the Ministry of Health who we report back to through our funding channels. That goes above me. But they are very communicative with us and very much listening to what we need.

**ANNE WORRAD:** The channels aren't great between the private hospital and NSW Health. There is informal stuff that goes on because many of us have worked for NSW Health and vice versa, so we have a bit of an idea. But I feel almost embarrassed to say that when I did work for NSW Health and community mental health, I had no idea what Ramsay offered or that they even had an inpatient mental health unit, which is not great because, for people who have private health insurance, it is an option. It's more informal liaison rather than—perhaps the management having some meetings together. I don't really know about that.

**JULIE DIGNAN:** For the contracts that NSW Health funds us for, we certainly have a reporting line of sight and a contract management line of sight to the Ministry. Almost unfortunately, some of our programs are funded through multiple buckets of money and NSW Health maybe doesn't have a good picture over the whole lot and the service offering, only its narrow piece of the jigsaw. Certainly the contract managers at the Ministry are very involved and knowledgeable about their contracts with us and what we do and deliver for them.

**Ms LIZA BUTLER:** Recommendation 44 is a recommendation that the New South Wales Government adopts a Health in All Policies framework to ensure that not just the community's physical health but also their mental health are central to any government decision-making. Have you seen any evidence that mental health wellbeing is considered in governments when they're making a decision? Anybody?

**Ms JANELLE SAFFIN:** They're not trick questions. They go to the nature of our inquiries.

**Ms LIZA BUTLER:** Are they putting out for a tender, for example, that you are identifying mental health outcomes?

**JESS SILVA:** For my programs, talking explicitly to consumers—like the people we're supporting? For my programs, yes. There would be mental health outcomes measured and recorded within those.

**Ms LIZA BUTLER:** Anybody else?

**JULIE DIGNAN:** We have mental health outcome measures reporting as well in ours.

**Ms LIZA BUTLER:** Do you see improvements in those outcomes?

**JULIE DIGNAN:** Absolutely.

**Ms LIZA BUTLER:** That's one positive for today.

**The CHAIR:** Can I come back to a couple of points that have been raised. Ms Silva, you've just alluded to the fact that you've had a contract renewed with six weeks to go. Is that with NSW Health?

**JESS SILVA:** No. That sits with an external funder.

**The CHAIR:** It sounded like that was not unusual.

**JESS SILVA:** Yes, no.

**The CHAIR:** The person who is employed under that contract doesn't get issued with their own contract until you've got confirmation of funding. Correct?

**JESS SILVA:** Correct, yes. They're still sitting in their pre-existing contract that had an end term of 30 June, and then we're awaiting that notification to be able to extend the contract past that.

**The CHAIR:** Has that been an issue with NSW Health—what I would call late decisions around issuing contracts—or have they been reasonable in terms of time frames?

**JESS SILVA:** No. They're definitely pretty good—probably setting the bar around that. We got notification. CLS, for example, has just been extended until 2026. That's another 12 months on that.

**The CHAIR:** CLS?

**JESS SILVA:** Community Living Supports. Sorry, I talk in acronyms. We got the notification of extension 18 months prior to the contract coming to an end.

**Ms LIZA BUTLER:** Well, that was good.

**The CHAIR:** The contract would be for—you said until 2026, so that's another—

**JESS SILVA:** There's a 12-month extension on that.

**The CHAIR:** Lives Lived Well, you've referred to the turnover being worst here of all your regions. Have you identified the reasons for that?

**JULIE DIGNAN:** Not specifically. It's a bit hard to track, but just lack of a recruitment pool and all of the factors that surround that: the competition, not enough people in the pool, not quality staff that you may sometimes choose to move on due to lack of performance or safety issues or behaviour issues. Just all of the problems that come with having a limited recruitment pool.

**MELANIE MEEHAN:** I think, too, that a lot of our staff also have two jobs. They might work with the LHD as well as us because we can't offer the hours they need and so they supplement with another role within NSW Health. That makes it hard as well to replace staff. They might be working a night shift. We might need a night shift but they're already working elsewhere. That contributes to it as well.

**The CHAIR:** There was reference to dealings with contract managers in the ministry. I think, Mission Australia, Jess Silva, you mentioned that. Those contract managers—when you say they're in the ministry, are they in the LHD or in the ministry?

**JULIE DIGNAN:** Both, for us. I think we have some contracts that are managed out of the LHD budget and we have some contracts that are out of the ministry budget. Depending on what it is, we would be dealing with one or the other at various times.

**The CHAIR:** Is there communication between the ministry and the LHD?

**JULIE DIGNAN:** No. It's usually one or the other. It's not communicating with one through to the other.

**JESS SILVA:** Specifically, to the mental health and drug and alcohol programs that I have, we have a care coordination lead for western New South Wales for the Community Living Supports program. That's a direct channel to local, LHD, that report up to the ministry as well. For the AOD CCC program that I manage outside

of, it's funded by the ministry and we can communicate to them but we report into NADA, who is tasked with governing all the CCCPs across the state.

**The CHAIR:** That's local services here, but contracted centrally?

**JESS SILVA:** Yes.

**The CHAIR:** Reported centrally?

**JESS SILVA:** Yes. Again, two different programs and that's where I kind of sit on the fence with it. The mental health program—great in its structure and how that works. Drug and alcohol—we have a really good relationship with the funders that we're reporting to, who go straight back to the ministry. The ministry channels down information to us, but we have to go through the third person, that middleman, to have those conversations. The two are working very differently.

**The CHAIR:** It sounds as though the mental health relationship, which is brokered through the LHD, means that you're more confident about shared information. It sounded like, in the mental health space, you've got some good relationships networking going on locally.

**JESS SILVA:** Yes, very much.

**The CHAIR:** You've been at pains to point out that you have a good relationship with your drug and alcohol funder, so we're not interested in being critical of that. But I guess the issue is the value of having a centrally run service when services are local. I anticipate there would be quite a lot of overlap between drug and alcohol and mental health services. How is the information on, say, drug and alcohol services shared locally when your contract manager is in the ministry, I presume, in Sydney?

**JESS SILVA:** That's dependent on the local relationships that we do the work to maintain with agencies like Lives Lived Well and LHDs and how we bring those together. That burden sits with managers and the people on the ground, versus a governance structure that says, "This is how it has to work."

**The CHAIR:** That's interesting. I've got one more item I want to raise, and this is in relation to drugs and alcohol. The Government has flagged a summit at some point coming up. I'm just interested in what issues from a rural perspective are important in relation to illicit drugs and so on?

**JULIE DIGNAN:** I think they're the same challenges that NADA has put on the table for all AOD services. Regional and rural may struggle even a bit more with the barriers in terms of distance and access to service and workforce retention and recruitment, but otherwise the challenges and goals are all the same. Just access to adequate treatment services for drug and alcohol—the demand that we face, the waiting lists, enough services to go round to meet the demand, and the funding model. Given the challenges, I think that's fairly consistent across the board. We just face more of it in regional areas.

**Ms TRISH DOYLE:** We heard yesterday from informal conversations—they weren't public hearings—with workers across the health sector in Orange, two conflicting comments. Someone said, "The issue really isn't around alcohol. It's definitely methamphetamines. There's a huge problem in Orange. It's out of control." Then someone else didn't really believe that that was the truth of the matter. I'm interested, because you work on the ground, in hearing—further to what might be raised at the summit—what is happening, in your view, in Orange?

**JULIE DIGNAN:** I have some stats and then Mel might be able to speak to it more anecdotally on the ground. In Wyla, which is our residential withdrawal and rehab, alcohol is the primary drug of concern at 54 per cent of clients in the past year, and methamphetamine was 27 per cent of clients in the past year. That's just indicative of the percentages of clients who access treatment; it's not necessarily indicative of the size of the problem. But at Elouera, which is our women's and children's program—not all women have children, but some do—many of the referrals are DCJ referrals and are case managed. Methamphetamine is 64 per cent as the primary drug of concern.

**Ms TRISH DOYLE:** Wow.

**JULIE DIGNAN:** That's an increase of 80 per cent on the previous year.

**Ms JANELLE SAFFIN:** How many per cent?

**JULIE DIGNAN:** It was 56 per cent in the previous year and 64 per cent in the year just gone. That's identifying that drug of concern as their primary drug of concern. Methamphetamines was 64 per cent and alcohol was 16 per cent. Smaller numbers through Elouera than there is through Wyla, but there is also a very high number of Aboriginal clients at the women's program as well. But given that Mel manages the detox and sees the actual impact of the drug of concern coming in, she might be able to speak more anecdotally.

**MELANIE MEEHAN:** It depends on the demographic of the client as well. We get a lot more males through our service, obviously because we are a co-ed rehab, and we do get a lot of older people, so 40-plus. The main concern is alcohol. I think for the younger generation it's ice, but what we are seeing is a lot more alcohol, as it says in the stats here. I think the demographic for Elouera is younger people, younger women, which is probably why you're seeing the ice more so at Elouera.

**JULIE DIGNAN:** I'm speaking a little bit out of my scope of practice, but as I understand it the more alcohol detoxes we're facing—alcohol detox is one of the most clinically risky detoxes in terms of the treatment required than it is for other drugs of concern.

**Ms TRISH DOYLE:** Did the other services wish to comment?

**JESS SILVA:** Yes, I was going to suggest to these guys—we actually see ice, methamphetamine, as the highest presentation out of the demographic of consumers we're working with, 18-plus. Arguably, we're also seeing more male participants in that program across the region. We have case loads that cover Bathurst, Orange, Cowra, Dubbo and Parkes at the moment. Certainly we see alcohol coming in at second. Again, it is the access to treatment and intervention, where people are just filtered back out to GPs. I know the drug and alcohol hub in Bathurst has a waitlist of up to 40 days to access support at the moment because they're so understaffed. That's putting a lot of pressure on outreach services, Lives Lived Well and other providers. The triple-C program is not a clinical intervention; it's a psychosocial intervention. That definitely burdens back to us, where we can't offer counselling or any sort of therapeutic support in that space. We're just picking out the psychosocial factoring.

But I do want to double back and have my extra 10 seconds on the mic to answer your first proposition. When we're talking about what we need in this space, it is early intervention models. We are seeing the rate of occurrence of addiction happening for younger people a lot sooner and these programs are still capped at 18-plus. We moved the mental health space back to 16; we need to recognise that for drug and alcohol for young people as well, to start treating them as adults at 16 because they're recognised in any other setting that way. That's certainly a barrier for a lot of drug and alcohol services around the region—unless you're 18, not much to happen. Mission also has the residential rehab in Dubbo for 10- to 17-year-olds and the turnover of children coming through—because outside of the 12 weeks of aftercare that we can provide to that, there isn't any other direct support.

The other recommendation I'd throw on the table is that mental health and drug and alcohol community-based teams work more alongside each other and less as a resisting force, because very much we see in our line of work that you either have mental health or you have drug and alcohol—never the two shall cross. That creates such barriers for people, especially those who are then tasked out to drug and alcohol because they're someone with schizophrenia who's using methamphetamine—that's drug and alcohol. So they sit there, but then they're limited to access to a public psychiatrist because that is, for lack of a better term, gatekept by the mental health setting. We're seeing these barriers sort of feed against themselves, where if there was more push and a focus to unite, we'd maybe remove some of that.

**Ms TRISH DOYLE:** Good point. Interesting.

**The CHAIR:** Just to be clear there, you've made a point around lowering the age for drug and alcohol services. You've pointed to the prevalence of methamphetamines as an issue. You've also highlighted this issue of relationships between mental health services and drug and alcohol. There was a commission of inquiry into ice. There were a number of recommendations. There was a delay before they were implemented but a plan has been developed. Can you comment on any changes in the last year or two in relation to ice treatment, early intervention services or any of the strategies? Or are they not here yet? Do you see something coming? Is there any comment you could make?

**JESS SILVA:** I think, at a local level, especially here in Orange, we know that funding is available—drug and alcohol hubs across regions. I think they're still in a process of trying to work out what's happening with some of that funding. I did hear it thrown around the other day that there was going to be some staff training for vicarious trauma. I know that they're employing a couple of OTP positions within the drug and alcohol hubs because I sat as an independent for those interviews, so that will come out of that funding. Outside of that, not much.

**The CHAIR:** Opioid treatment program positions?

**JESS SILVA:** Yes.

**The CHAIR:** Any comment on that from Lives Lived Well?

**JULIE DIGNAN:** No knowledge of any outcome of that.

**The CHAIR:** I thank you very much for appearing before the Committee 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?

**JULIE DIGNAN:** Yes.

**MELANIE MEEHAN:** Yes.

**ANNE WORRAD:** Yes.

**JESS SILVA:** Yes.

**The CHAIR:** Once again, I thank you for coming today. It's been very helpful for the Committee. We really appreciate you making your time available. At this point we will take a short break. The hearing will recommence at 1.30 p.m.

**(The witnesses withdrew.)**

**(Luncheon adjournment)**

**Professor MEGAN SMITH**, Executive Dean, Faculty of Science and Health, Charles Sturt University, sworn and examined

**Dr CATHERINE KENIRY**, Senior Lecturer in Medicine and Head of Research Unit, Charles Sturt University, School of Rural Medicine, Orange, sworn and examined

**Associate Professor FRANCIS GERONIMO**, Course Director, Director of Assessment and Associate Professor in Medicine, Charles Sturt University, School of Rural Medicine, Orange, sworn and examined

**Ms JUSTINE BRINDLE**, School Manager, Charles Sturt University, School of Rural Medicine, Orange, sworn and examined

**Associate Professor RANDALL GREENBERG**, Associate Professor, Deputy Head of Rural Clinical School, School of Rural Health, Orange, the University of Sydney, affirmed and examined

**Dr ANNA NOONAN**, Associate Lecturer, the University of Sydney, School of Rural Health, Orange, affirmed and examined

**The CHAIR:** Good afternoon. Welcome to the afternoon session of this hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health. I welcome our witnesses from Charles Sturt University, and the University of Sydney, School of Rural Health, Orange. 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?

**CATHERINE KENIRY:** Yes.

**JUSTINE BRINDLE:** Yes.

**FRANCIS GERONIMO:** Yes.

**MEGAN SMITH:** Yes.

**RANDALL GREENBERG:** Yes.

**ANNA NOONAN:** Yes.

**The CHAIR:** Thank you very much. Would any of the witnesses like to make a brief opening statement on behalf of their organisation, limited to two minutes for each university?

**RANDALL GREENBERG:** Yes, if that's all right, I'll make a statement. Thanks very much for getting here to hear this evidence. Things I'd like to touch on, if we have time, would be funding incentives to transition from a rural student in New South Wales to a rural clinician in New South Wales. I'd like to talk about a submission I gave at the inquiry two years ago which was to do with access to beds for, particularly, rural sites. I'd like to talk about air transport funding and, basically, the lack of pilots. That's causing a real strain on the New South Wales air ambulance. I'd like to talk about recommendation 22, shared medical records; that still hasn't happened yet. I note when I worked as a state retrieval consultant, looking after sick people in the whole state, I did not have access to medical records for the whole state.

I'd like to talk about recommendation 41, which says to establish an independent office of the Health Administration Ombudsman. I note the previous Government made a decision not to do that. I think that's a mistake. There are still issues with culture and I think that would be very helpful. The last thing I'll talk about is certainty of funding. With my work with the Royal Flying Doctor Service in primary health, a lot of the funding for programs in western New South Wales particularly is on a grant, and that gives a lack of certainty to people when they're working in rural sites. I'd also like to point out that a lot of the rural academics are on fixed contracts. That is to do with funding. I know that it's a Federal issue and not to do with New South Wales, but it's a real disparity in that people like Dr Noonan are on a fixed contract, whereas her colleagues in Sydney have just got a permanent job. Thank you.

**MEGAN SMITH:** Charles Sturt University has made a submission which the Committee already has, so we're happy to have that as our tabled piece and are happy to answer any questions you have.

**The CHAIR:** Thank you very much. Professor Greenberg, you've raised some issues in relation to medical records, the health ombudsman and transport and access to beds. To start with, we want to focus on workforce—particularly the primary care workforce, the rural generalist workforce and the maternity, nursing and midwifery workforce. The Committee has so far found that the situation with the primary care workforce in rural areas is probably worse than it has been for 10, perhaps even 20 years. The rural clinical schools have been a strategy

designed to improve the rural workforce and have been operating for some time now. I note the recent establishment of end-to-end rural medical schools based in rural locations.

What are your reflections on the situation with the rural general practice workforce? What are your observations about what needs to be changed in terms of training, attraction and pathways, and the same for the nursing and midwifery workforce? I appreciate you coming from the perspective of being educational institutions, but I guess I am taking a bit of a broader view. Not just about education—because you're educating students—but also what happens afterwards and what needs to change in the system to ensure that we have an adequate nursing and midwifery workforce and an adequate rural generalist workforce. Perhaps I could start with Professor Smith and then whoever would like to make a statement.

**MEGAN SMITH:** I was going to ask a question. I think, as well as the medical workforce and the nursing and midwifery workforce, it's important to raise the allied health workforce in that as well if we're going to talk about primary care, particularly in relation to the scope of practice. If we're having everyone at work then the full scope of practice and the value that brings in terms of primary care.

**The CHAIR:** Thank you for raising that. I was going to raise that later, but you are absolutely right that it is very pertinent.

**MEGAN SMITH:** I might hand over to my colleagues to talk about general practice, but I am happy to come back and talk to the allied health one when that question comes up.

**JUSTINE BRINDLE:** One of the issues we find is with the GP placements. Our students are based in Orange for the first two years and then we have nine rural clinical schools around the state. There's something—and Joe knows about this—called the RUSC program. Some of the metro medical schools still send their students for four weeks and it's generally in general practice. That's tying up some of the GPs, so students on long-term placements can't actually go there. The big thing that our students talk about—yes, they want to do general practice, but there are students who also want to have other careers—is how hard it's going to be for them to get into college. No one controls the colleges; we all know this. We call them the biggest union in Australia and they determine the numbers of doctors who get into their program.

We have done one thing that I think is helping. We are working with local ophthalmologists and we take unaccredited registrars—so they're not in the program—as PBL tutors in Orange. We've worked up a relationship with them, and for the past two years those four unaccredited registrars have actually got into the ophthalmology program. If the hospital wants more GPs, there has to be GP rotations in an internship so they're exposed to it. We can do so much during medical school, but if they then get sucked into the hospital system they're not exposed to general practice. There is no relationship, often, between general practices and the hospitals. I've got friends who are GPs in Orange and I'll mention the new staff specialist and they'll have no idea. So there has to be an improvement in communication to the general practitioners from the hospitals.

They're generally the bigger hospitals because the GPs are running the smaller hospitals. I've had a fantastic female student say she wants to be a surgeon, but she said it's going to be too hard. We can set things up for them but, once they're out there in hospital land, it's very hard. And, as we know, there's bureaucracy. There are politics. There are doctors who, in particular, won't teach certain medical school students because they're affiliated with another medical school. That is something that we find hard to control.

**RANDALL GREENBERG:** I was a rural generalist in Bourke in the mid-1990s. I did obstetrics and anaesthetics. They didn't call it that in those days; we were just rural GPs. The three of us, we all did obstetrics and anaesthetics in Bourke. Now, no-one does it in Bourke; it's mainly FIFO in Bourke. It's mainly fly-in fly-out in a lot of western New South Wales towns. My take on it is a few things, but one is it's just generational and that a lot of people my children's age don't want to do what we did. I think, probably, that we need to accept that and support that.

I note that there was some criticism of telehealth in the previous report, but my take on it is that it's something that the local health districts have to do, and it supports some of these smaller towns with, particularly, emergency care—and lower acuity care as well. My take on it is that we have to accept that things have changed. We can tune out rural generalists as much as we want, but there are going to be few that are going to go to places like Bourke and Walgett and those smaller towns. I'd also like to pass over to Anna who has actually done research in maternity services, so she might have some expertise in that.

**ANNA NOONAN:** Thank you, Randall. Thank you, Chair. Yes, one of my areas of research expertise is sexual and reproductive health, in rural access to comprehensive reproductive healthcare including abortion care. I note and thank you for having this inquiry. We're still waiting on the recommendations from the Government on the universal reproductive access healthcare inquiry that happened last year. We're still waiting to find out what

those recommendations are, so it's great to see that progress is being monitored closely at the New South Wales level.

One of the comments that we often get from our postgraduate medicine students in relation to sexual and reproductive health is they have very little exposure, clinical or educational or otherwise, to comprehensive sexual and reproductive healthcare. What I mean by that is all stages of pregnancy, and all care that needs to be delivered to pregnant people, regardless of the outcome of that pregnancy. I'm talking here about both antenatal, postnatal as well as abortion care.

One of the two things that we see often is that there, as Justine has mentioned, are very unclear pathways from primary into tertiary care for all of those people, as well as lack of comprehensivity. We're seeing that people are going to their local GP to ask for particular care if they don't want to continue pregnancy, and they're unable to access that service in primary care, nor are they able to access that service in the public hospital system. That also means that our students don't have an opportunity to experience clinically what that is like because the service just simply doesn't exist.

**CATHERINE KENIRY:** I just wanted to share an example of one of the research projects I'm involved with at the moment because I think it's a very good demonstration of a very significant issue. We have a rural generalist who is from Scone who does FIFO into Parkes and runs a surgical clinic. As I understand it, you might be able to share with me more facts, Randall, but there is no AST pathway for rural generalists for surgery. The only option is to do anaesthetics and obstetrics and gynie, so he has done that training and he operates a surgical clinical in Parkes.

He does things like vasectomies, carpal tunnel and skin cancer removal. He told me an example of an elderly patient who's a pensioner who has lots of melanomas. He wasn't able to go to Parkes for a period of a few months for family reasons. That pensioner had to have a melanoma removed, so she had to travel to Orange—that was the only option she had from Parkes—pay to see a dermatologist and paid for the pathology. That cost her $700, which was her pension for the fortnight. I think we need a real focus on surgical skills in rural generalists, and the ability for people to have minor surgeries in rural areas without having the need and expense to travel for what people in metropolitan areas just take for granted.

**Mrs LESLIE WILLIAMS:** You will notice that one of our terms of reference is in relation to patient transport. Associate Professor Greenberg, I am pleased that you raised the issue about air transport. Could you expand on that issue? There are a couple of parts to my question. Firstly, what are the specific issues, and are there some solutions? Secondly, do you have an opportunity to raise those issues? Do you think that NSW Health is aware of the issue as something it needs to address? If anyone else wants to comment on that, they can.

**RANDALL GREENBERG:** I can expand on that. The issue is that the provider that has the contract to provide Air Ambulance with pilots, planes and engineers is unable to provide all of the pilots. Today, for example, there are 10 shifts that Air Ambulance is supposed to have—like, two at six o'clock. They stagger it. Out of those 10, only five of them will be running. There will be a nurse assigned to that as well, so NSW Health is paying a nurse to sit there and do nothing. But this is frequent. This is every day. It is not always five, but it is three to five, I'd say, every day.

I don't know the ins and outs of the aviation reasons. I worked for the Royal Flying Doctors service, so I am biased—I will put it out there. We are generally able to have pilots in almost all of our shifts in the regional centres, and they are having to use the Royal Flying Doctors service to back up the provider. On weekends, and there's one shift per day that we do out of—after yesterday, it was out of Bankstown. That's the issue. I think part of it was COVID, and they weren't able to get pilots back. There is a worldwide shortage. I don't have the solution to it.

And are they aware? Absolutely. Everyone is aware. I think the administration of Ambulance is aware. It is devastating for us. I work as a state retrieval consultant for Ambulance. I go into the call centre in Eveleigh near Redfern. When I see that board where there are five shifts, it means that—like today, there was one shift at six o'clock and then nothing until midday. That would have been tasked from the night before. And so there is nothing. They have to then use the Royal Flying Doctors service out of Dubbo to fly to Port Macquarie—leave the west unmanned. It is quite dire at the moment. It's the worst that I have seen. I have been in the game for quite a long time.

**JUSTINE BRINDLE:** If I could give a personal experience, my mother was playing tennis here in Orange and her ascending aorta split. Fortunately, she got to Orange Hospital and was flown to RPA. Long story short, if the helicopter, sorry, wasn't here—which some nurses told her when she came back—she would have died. They actually said there were patients the next day who died because the helicopter wasn't available. She was in RPA for a long time. So much money was spent on my mum from the public purse. They were amazing at RPA intensive

care—I will just tell you that. Then we had to fly back to Orange. Because our plane was late, the patient transport, sorry, was in Dubbo. "Could you catch a taxi?" I said no, because I was on the plane with my mum.

She had monitors going on. The pilot had to help her down the stairs. She'd had her lungs drained. She'd had major, major surgery, and here she was at Orange airport going down the stairs. And we sat in the airport—the pilot shed—until the patient transport came from Dubbo. Why is this? Why can you not have patient transport that's actually based at a regional centre? It is so shortsighted. I did write to the health Minister after that because there were lots of things that also happened during that process. I got a very—how would you describe the letter I got? It was quite patronising that I didn't know what I was talking about. They saved her life but there were so many things that did go wrong that were small things that could be fixed.

**Mrs LESLIE WILLIAMS:** I want to clarify then. There's basically a contract for this air service, but we're paying for a contract that's not actually being fulfilled most of the time.

**RANDALL GREENBERG:** Correct.

**Ms TRISH DOYLE:** We did hear from the Royal Flying Doctor Service and others about those issues when we visited Broken Hill and Wilcannia, so please know that they'll be part of our report. My question is around the CSU submission, which talks about various specialist areas. We haven't heard much in our last lot of public hearings about radiation and podiatry, for example, where there are declining student enrolment numbers. I am wondering whether there are any specialties—and we can ask the School of Rural Health this as well—where enrolments have improved since 2022?

**MEGAN SMITH:** Have improved—that's a really interesting question actually. The reason I hesitate on that is because one of the things we want to do is—the question is how are we going to grow our health workforce. Some of the factors that have influenced our numbers of students over the period—it's clearly COVID that's been a real factor. We saw a real volatility in student behaviour over that period of time. Particularly what's influencing now is the cost of living. When you look at the numbers enrolling in universities, the cost of living impacts on that. At Charles Sturt University, for example, we have a larger proportion of students who come to study having done something else in their lives, so they're non-recent school leavers. What you find under conditions when the economy is poorer, where it is at the moment, and the demands on people, is that group is more likely not to go to university. School leavers are fairly stable; they exit school and they enter in to do what they're doing. But if you're a mother or a family, you're going to be privileging the mortgage over and above your further education. It's counter cyclical in that way.

So we've got some contextual factors that are in there. I think the other thing with our numbers is, as universities, the numbers of students that we will enrol will be constrained by a lot of the things we're talking about, and that's what the capacity of the system to grow is. I might have a demand for an extra—paramedicine is a really good example where we might take in, say, 250 students per year. We could take more than that based on the demand from students to study it. So you'd say, "That's great. Let's grow it", but I can't take anymore because we've absolutely got the maximum number of students who've got the opportunity for a placement through NSW Ambulance. You're in this situation where demand doesn't lead to future supply, where you've actually got students who are keen to undertake that work. In fact, we haven't been able to grow paramedicine in the way that—certainly the intent was, within New South Wales, to grow the number of paramedics but we've actually been constrained in our ability to do that.

**Ms TRISH DOYLE:** They're going to Western Sydney—wink.

**MEGAN SMITH:** They could well be. Interestingly, I think NSW Ambulance shares—and NSW Ambulance are very good in that respect. They will look at the total capacity and they will distribute that evenly amongst university providers. That's a really fair way to do it but, like what we've seen, the capacity for us to educate is limited by the size of the workforce as it exists at that point in time. Growing it is a scaling process. You need to grow and you need the supervisors there, then you can take more students and then you can grow. It's a cyclical process of improvement.

To answer your question as to where we have seen demand increase—perhaps that's the question you are asking. I think paramedicine has good demand. Nursing has had stable and fluctuating, but generally strong, demand. Allied health in physiotherapy, occupational therapy and speech pathology have good demand. Podiatry has poor demand. Medical radiation is probably fairly stable demand, I would say, across the board. Medicine has exceptional demand. It has more exceptional demand—off the scale—than anything else we do. Dentistry and oral health are still strong. Are there any others that you're particularly interested in?

**Ms TRISH DOYLE:** No, I'm just interested whether there was any kind of incline.

**MEGAN SMITH:** Yes, that's why it's not an easy question to answer. But that gives you some perspective.

**The CHAIR:** Any comment from Sydney?

**RANDALL GREENBERG:** You're talking about enrolments in the medical school?

**Ms TRISH DOYLE:** Yes.

**RANDALL GREENBERG:** There is always strong demand. What we've found is that we have a lot of interstate students and, because we only want to take rural students, sometimes we struggle to get New South Wales rural students in. So I was wondering whether some sort of incentive for New South Wales students, which then, hopefully, will stay in New South Wales, might be of use to the New South Wales Government.

**JUSTINE BRINDLE:** We're very similar, as well. The rural New South Wales—our lowest percentage is with school leavers. We are doing a big push to encourage high school leavers. We're also—Catherine's part of it, and Francis—looking at our selection process because we have students who have very, very low ATARs, who did nursing before, but they went to the wrong school, or it wasn't the right time to study, and so we have to work out—and I did talk to these students the other day. I said, "How can we measure?" It's like, "We're resilient, and we're diligent." But how do we ask that in an interview question? How do we make sure that you will succeed? But you don't need the ATARs that we demand.

**RANDALL GREENBERG:** It's also hard for us because it's a postgraduate degree. We do go to all the local schools in various towns, but they've got to get a degree before they come to us. That makes it a bit harder for us.

**Mrs TANYA THOMPSON:** Just keeping on that same theme, further to that, you made reference on page 7 of CSU's submission to the announcement by the New South Wales Government for new scholarships to attract staff and return talent to the New South Wales public health system. What, if any, impact do you think those scholarships are having or have had? Pros and cons of the scholarship. Just wanting to hear your thoughts verbally about this.

**MEGAN SMITH:** I think it's a really interesting question. I don't think we've fully evaluated what sort of lever is it for student choice. The health profession has a reasonably strong demand. There's a question about which health profession do they choose. I think what we have seen—most of my time, I'm on the Albury-Wodonga border. Victoria had some real incentives, so you could see students who'd make a choice of which way they would go. The students will follow where the piece is. Financial security and finance while you're studying is a major driver of student choice. I think what we saw in that case was, yes, where they have that opportunity to follow the funding, that's what they will do. I think we're relatively early on. But, certainly, there's been a large uptake of scholarships.

We did some interesting work. We offer placement scholarships, plus the ones that NSW Health provide, for our students. When we asked a group of our students what percentage had access to a scholarship to support them to do their placements, it was about 10 per cent of the total number of students, who actually secured financial support for a placement. I think we're talking about a relatively low—in terms of students who are actually benefiting from that at this point in time. We've seen that's been the incentive. But do we continue to do that? We have to have reasons that students will choose health careers. We need to support them to do those careers and to complete them, and to complete them in a timely way. I have to say that a financial incentive seems to be a reason to—

**JUSTINE BRINDLE:** We just have to make sure, though, because students don't find out they get into university until January, February. A lot of the scholarships—they don't find out until they're actually in the course, and so the ones that you're really trying to focus on might not actually apply because of the expense.

**Mr CLAYTON BARR:** Thank you very much. If tomorrow you were going to be the Premier and the health Minister for a day and whatever you put in place would be locked in place for the next 10 years at least, what would you change and do straightaway to fix all of this—dare I say—complexness? I'm just going to work from left to right.

**RANDALL GREENBERG:** We've got one, have we?

**Mr CLAYTON BARR:** Twenty seconds—you've got an elevator answer.

**CATHERINE KENIRY:** I think education, more access for students from rural and disadvantaged areas to come to university. We did some focus groups with a lot of our students, and they come from disadvantaged backgrounds. They are often the first in their family to go to university. They have a passion about rural health.

**Mr CLAYTON BARR:** Ding. That's your time.

**JUSTINE BRINDLE:** More money needs to go into the hospital systems. Everything's about money. They don't have enough money.

**FRANCIS GERONIMO:** In a similar vein, on funding for students, especially when they go on to clinical placements, there are a number of students who need financial support to be able to rent a place, to travel from place to place and to be able to sustain themselves while they're on that clinical placement.

**MEGAN SMITH:** I'd require the places that take our students to have designated staff, that education is a requirement and that they're suitably funded to employ people for education.

**RANDALL GREENBERG:** It's so complex, but I think I'd have to agree with my colleagues about funding for students, as in scholarships, to help them to get through their medical school.

**ANNA NOONAN:** We're funded federally. Rural clinical schools are funded by the federal government, not by the state government.

**Mr CLAYTON BARR:** You can be Prime Minister as well.

**ANNA NOONAN:** What would it look like if NSW Health and the Federal Government were working together to patch those gaps together with your double purse?

**Mr CLAYTON BARR:** That's actually going to be our next inquiry. We're going to concentrate our attention on that Federal funding thing. We're not quite ready for that yet.

**The CHAIR:** But it's a point well made.

**Mr CLAYTON BARR:** It's an excellent point. Thank you all so much.

**Ms LIZA BUTLER:** Ms Noonan, just to follow up on abortion care, you talked about women who require a termination for whatever reason, but it's not available here through primary care or a public hospital. Where do they have to go?

**ANNA NOONAN:** That's a really good question. It depends on what kind of abortion. There are two types of abortion. Medication abortion, or abortion pills, is available until nine weeks gestation. GPs are allowed to prescribe the medication and the TGA has approved nurse practitioners as well, but under New South Wales law, nurse practitioners still cannot prescribe. GPs can prescribe, but it's whether they do that is the question. There are very few GPs in Orange, the town where I live, that do prescribe. Surgical abortion care is provided routinely in two regional hospitals in New South Wales that I know of, and nowhere else. It's private providers.

**Ms LIZA BUTLER:** Where are those two?

**ANNA NOONAN:** John Hunter and Wagga. That means that if you want an abortion and you're under 14 weeks gestation, you'd be travelling to Sydney at a cost to you and going through a private provider.

**Ms LIZA BUTLER:** Yesterday we met with some wonderful med students. They'd had a career beforehand, and they all want to go into specialties. They've put roots down, they have families here and they don't want to leave here, but to go into a specialty, they have to. How can we fix that?

**RANDALL GREENBERG:** Can I talk to that? That is actually a lot better. Certainly, a lot of the specialty training can be done in regional centres. I know that in my town of Dubbo, when I first went there nearly 20 years ago, you had to leave as soon as you'd finished your intern and postgraduate two year. Now, in some of the specialties, you can do most of your training in the regional centres. That has been a big push from some of the colleges, the federal government and the state government to help that happen. It's also facilitated by our rural health hub, which is a federally funded hub. The one that we've got is based out of Dubbo and Orange. They help with postgraduate training for doctors as well. That is happening. That just needs to improve a lot.

**JUSTINE BRINDLE:** For Orange, you could only do psychiatry training here and general practice. You'd still have to go to a smaller site. I don't think you can do 12 months in emergency in Orange anymore. I'm not sure if they've got their accreditation. The problem is that they have to be accredited by the college. For example, emergency medicine would accredit the emergency department here in Orange. If there's not enough staff, there's supervisors or they're not exposed to enough, then they won't get accreditation. It's a bit of a vicious cycle sometimes, because you want more places so that they can do their time here, but if there's not enough doctors or they're not accredited, they're not able to. I used to work at the hub at Sydney uni, and I learnt so much about pathways. You can do a bit of obstetrics in Dubbo and Orange.

**RANDALL GREENBERG:** Dubbo is the first one in the country where you can do your obstetric training in Dubbo. Yes, you have to go away to do some tertiary stuff, but you can do most of your training in Dubbo.

Physicians—they call it dual training where you can do two years. You do your first year in Dubbo doing general medicine, then you go away and do your specialty for two years and then you come back to Dubbo. But you're actually employed by Dubbo, rotating out as opposed to the other way around.

**JUSTINE BRINDLE:** The problem is that you want them to come back. They get settled if they go away.

**RANDALL GREENBERG:** No, we've had a lot of success with people doing a lot of their training and coming back to Dubbo.

**JUSTINE BRINDLE:** That's good.

**Mr CLAYTON BARR:** Employed by Dubbo?

**RANDALL GREENBERG:** Yes.

**The CHAIR:** I am aware, Professor Greenberg, that we have to come back to a couple of issues not related to training queues. I am aware of that, but I just want to pursue this issue of training. The gap we see is in primary care or general practice. Professor Greenberg, you have spoken about the need to rethink models of primary care, and we need to move away perhaps from a pretty old-fashioned model around a few doctors in a hospital, on-call around the clock, to expand scopes of practice for other practitioners.

Ms Brindle, you spoke about the importance of exposure to general practice in the intern year and making sure that recent graduates do not get sucked into the hospital system. At the moment, we understand that less than 15 per cent of graduates intend to enter general practice. We know that rural general practice training programs are completely under-subscribed. NSW Health has started a single employer model to try and address this. I think that is an important initiative, but what else do we need to do to encourage our medical graduates to take up rural generalist practice?

**RANDALL GREENBERG:** I will kick it off by agreeing with my colleagues about the colleges. When I was with the Royal Flying Doctor Service, they just dictate—I had people who wanted to go to Broken Hill to do a year out there and they said, "No, you can't. You have to go somewhere else." It's just ridiculous. The colleges need to get their act together a little bit. In those days, it was the health providers rather than the GP Synergy. So there is that. General practice has fallen behind. It's the lowest paid specialty. I still am a qualified GP. It is the hardest job. It is really hard, and it's just under-remunerated. All of the students—most of them aren't in it for the money, but they look at their colleagues going to other specialties and earning a lot more. It's been absolutely underfunded for many years.

Just briefly, the new John Flynn program—I think that's an excellent idea. They had the old PGPPP where, by PGY2, doctors could go and work in a general practice. I thought it was wonderful. They'd go away. They'd spend three months in a general practice—it was subsidised by the Federal Government—and they'd come back to the hospital, and you could see them writing letters to the GP going, "They'll want to know that. They can't do this. They can't do that." There is this new John Flynn program which—

**The CHAIR:** That is trying to do a similar thing.

**RANDALL GREENBERG:** Yes. I think that's a good thing.

**JUSTINE BRINDLE:** I think having GPs working in medical schools—we have a lot of GPs who are PBL tutors. We have something called PPD—personal and professional development—which is PD for GPs. You need role models in there. I'm just trying to think. This sounds terrible, but I do know that some of our students, because of their having to move away—and we haven't got our graduates yet, so we don't know what they're going to do, but I predict that they will go into general practice because of their commitment to rural communities. Hopefully, I think they will be rural generalists, meaning that they will have the general physician, or they'll be GPs with added skills in obstetrics. They'll do that because they want to stay here. They don't want to move to metro.

**The CHAIR:** Professor Greenberg, you spoke about shared medical records and an independent health ombudsman. Can you give us one minute on each?

**RANDALL GREENBERG:** Shared medical records—New South Wales has got an electronic medical record. It's called—it's Cerner models—PowerChart and FirstNet. When I work as a state retrieval consultant, I'll sit there in Redfern and if a patient comes in that's really sick that's at Walgett or Bourke or Dubbo I can access their notes because I work in the local health district. But if they're in Deniliquin or Port Macquarie, I can't do it. It's just absolutely ridiculous that we don't have access. They actually tried to get us all read-only access to every LHD, and it was clunky, no-one could figure out how to do it and half the time it didn't work. This is something that you guys could help with; it just needs the will. It just needs someone to say, "Just do it", and the IT people need to fix it.

**Mrs LESLIE WILLIAMS:** Can I just ask a supplementary on that?

**The CHAIR:** Yes.

**Mrs LESLIE WILLIAMS:** Are there other jurisdictions that do it—where you have access?

**RANDALL GREENBERG:** My understanding is Queensland, I think, has statewide access.

**Mrs LESLIE WILLIAMS:** It's always good to have somewhere else to listen for.

**RANDALL GREENBERG:** It's not hard; it's just them figuring out how to do it.

**Mrs LESLIE WILLIAMS:** Yes, I'm sure it's not. That was my point.

**RANDALL GREENBERG:** But when they set up the system, they decided that each LHD should be slightly different, so that made it hard.

**Mrs LESLIE WILLIAMS:** Just to make life easy.

**The CHAIR:** You made a comment about independent health ombudsmen.

**RANDALL GREENBERG:** Yes, last year I had reason—there were some cultural issues where I work. I escalated it right up to the top and nothing seemed to happen about it. I'm not intimidated; I'm not scared of being bullied. I'm old and grizzly, and I'm actually a fairly experienced health manager, and I still didn't know what to do when I got nothing back. I just wanted someone independent to come in and say, "All right, let's have a look at this. Randall, you're wrong." But that hasn't happened.

**The CHAIR:** There is a portal.

**RANDALL GREENBERG:** A portal? Well, no-one told me about the portal.

**The CHAIR:** So you didn't go to the portal?

**RANDALL GREENBERG:** No.

**The CHAIR:** Okay, I just wanted to check you didn't use the portal. Maybe the portal is not active yet.

**JUSTINE BRINDLE:** Can I just say how much I would support that. We have an ombudsman in our university which is independent. If NSW Health employees could have someone independently look at a case, instead of it being hushed up or it doesn't go anywhere, that would be—

**RANDALL GREENBERG:** I don't think mine was malignant; it just didn't happen. Anna, you had some experience with your research in maternity as well, I believe.

**ANNA NOONAN:** I mean, one of the things—this was a recommendation from the original inquiry, so why has it not happened? In my research, the outcomes of talking to primary care providers about their experiences providing or choosing not to provide abortion care were largely around professional obstruction, bullying, stigma and secrecy. There was no-one to whom they could report because often these people were in the highest levels of management in the hospitals, and so how do they negotiate that for abortion care? We've had some really tragic circumstances happen across our region in maternity care services as well. That becomes really complicated in small towns, where you know everyone, so how do you actually make those complaints?

**The CHAIR:** I fully acknowledge that. Just to close off, it was a recommendation not supported by the previous Government.

**ANNA NOONAN:** Correct.

**The CHAIR:** It has been supported by this Government, and we have taken evidence on it in the first inquiry and will continue to pursue that. Thank you for that.

**RANDALL GREENBERG:** Good.

**The CHAIR:** Professor Greenberg, you mentioned access to beds on rural sites as another issue.

**RANDALL GREENBERG:** Yes, this is something that I'm sure you had experience with when you were in Wagga as a clinician. You'll ring your tertiary hospital—we ring Prince Alfred; you would have rung St Vincent's—and they say, "Oh, yes, this patient needs to come. They've got X condition; they need to come." If it's not actually life-threatening and they're not about to die straightaway, they say, "We'll just wait for a bed to come up." The number of times when I was a medical director of a hospital where they'd just loll about every day—"Oh, there's no bed; there's no bed; there's no bed."

Now, Dubbo, Orange, Wagga—they don't have neurosurgeons and they don't have cardiothoracic surgeons. They never will; they haven't got the numbers. Everyone understands that, but please do not deny us access to those services. A person who happened to live in Newtown or Darlinghurst would actually be in their ED in that exact same situation. My submission—which didn't seem to get anywhere—was that if two clinicians agree they need to go, they just go. If they go to the ED in that hospital, they go, because that's what would happen if the patient was in Newtown.

**The CHAIR:** That brings us to the end of that session. Thank you for appearing. We may send you some further questions in writing, and 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?

**ANNA NOONAN:** Sure.

**CATHERINE KENIRY:** Yes.

**JUSTINE BRINDLE:** Yes.

**FRANCIS GERONIMO:** Yes.

**MEGAN SMITH:** Yes.

**RANDALL GREENBERG:** Yes.

**The CHAIR:** You may also have information that you wanted to let us know that you may want to forward, which we can accept. A lot of material was touched on about clinical placements, for example, and we barely scratched the surface of the nursing midwifery workforce, so we would appreciate any further information. At this stage, though, I thank you and excuse you as witnesses. We very much appreciate you making the time to appear.

**(The witnesses withdrew.)**

**Cr FRANCES KINGHORNE**, Councillor, Orange City Council, affirmed and examined

**Mr SCOTT MAUNDER**, Director Community and Cultural Services, Orange City Council, affirmed and examined

**Cr NEIL WESTCOTT**, Mayor, Parkes Shire Council, sworn and examined

**Cr KEN KEITH**, Councillor, Parkes Shire Council, sworn and examined

**Dr JESS JENNINGS**, Mayor, Bathurst Regional Council, sworn and examined

**The CHAIR:** I would like to welcome our witnesses from Orange City Council, Parkes Shire Council and Bathurst Regional Council. Can you each please confirm that you've been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses.

**SCOTT MAUNDER:** Yes.

**FRANCES KINGHORNE:** Yes.

**NEIL WESTCOTT:** Yes.

**KEN KEITH:** Yes.

**JESS JENNINGS:** Yes.

**The CHAIR:** Would you like to make, on behalf of each organisation, a brief two-minute statement as a way of opening? Then we'll proceed to questions.

**FRANCES KINGHORNE:** I'm a first-term councillor on the Orange City Council. I'm also a community pharmacist with a postgraduate certificate in diabetes education, so I'm here with my Orange City Council hat on but my perspective on health is shaped by my decades of working in community pharmacy in Orange. I can see from the submissions I've read that everybody wants more money, which would be nice, but it's not an isolated solution. Terms of reference (1) (d), (e), (f) and (g) are the ones in which I have knowledge and experience and I'm happy to answer questions about these.

I think there are some areas of health that are done well here in Orange. The opioid treatment program changes—the Federal one—last year have been life-changing for the people in this marginalised group. I think our cancer services are great, and I speak here as a patient as well. CSU Medical School—masterstroke. Their history with training dentists who subsequently choose to practise in rural areas is indicative that this program will help address the shortage of doctors in rural areas. The recent introduction by the Primary Health Network of an Urgent Care Clinic is great and was desperately needed. It could be better promoted. Our Aboriginal Medical Service is a brilliant resource, with a CEO who focuses not just on people's health but addresses social problems as well.

The Orange City Council Health Liaison Committee is really useful. There's a wide range of members, and they deal with a variety of health issues. Orange City Council has a health role in promoting physical activity as a way of providing health benefits. We have upped our game in recent years, providing lots of new footpaths, covering play areas, lighting existing walking paths to extend hours of use and building facilities to enhance participation in sport. There are problem areas here too. The ones that come to mind are vapes, mental health treatment, long COVID, stock and medicine shortages, workforce issues, palliative care, diabetes incidence and treatment, lack of focus on preventative health care, and, possibly, a lack of coordination between levels of government.

**NEIL WESTCOTT:** Thank you for this opportunity to present here today. I was here only last week for the Cabinet meeting. I met with Ryan Park. I also met with the staff down in Macquarie Street this year as well. I come here as mayor of Parkes to say that in the two years since this report was made, our health outcomes are diabolical. They continue to fail the constituents of Parkes shire in the most dramatic of ways. The loss of GPs in the current two years—it originally started with the loss of birthing service in our brand-new Parkes Hospital back in 2019. That was the canary in the coalmine. The loss of that single facility has meant the loss of anaesthetists, the loss of midwives, the downgrading of surgery—albeit, we have the most modern of facilities, the most modern of hardware and the lack of people to procedure in those.

As I said to the Minister, we don't come to just complain about the situation. We come as residents of Parkes to say that we have ideas, especially around section 10 of this report that wishes to have a project. We have a medical precinct plan, a master plan, that could bring together the services that we require. What is happening in Parkes today is our emergency department is being smashed. We have no GPs—or very few GPs. I'm going to the doctor on Friday; I got that booking six weeks ago. This is in a town of 12,000 and a shire of 15,000. There

are 50 people a week coming by our community transport service from Parkes to Orange, and many of them for GP services. Add Lachlan, in which that same service is bringing 20 from, that's 70 a week coming from Lachlan and Parkes—that's a further hour west of us. It means that there's probably 300 patients a week coming from Parkes shire and Lachlan into Orange. It's nonsensical if this continues.

What is happening is that the first presentation of residents of Parkes shire to, quite often, the emergency department, is—on the scale of their illness—too high. It's not being intervened early enough. Whereas when we used to have enough doctors, where you could get into a doctor within a fortnight, that particular ailment would be diagnosed at an earlier stage. So we're presenting at a later stage. We're finding our ambulance service is being used as transport services, so they're not there when they need to be there. And yet there are ways around this.

I heard it mentioned in the earlier council just then that, whilst primary care and hospital care can live quite happily alone east of the mountains, in regional areas health is health. It seems to be lost on the people who have power over these things that we need to have a one-stop shop. We have a master plan for health, where we could have our GPs, we could have our specialists, we could have our nurse practitioners and we could have the virtual care coming in as well. It could all work and we could get it up and going quite quickly. We have a wonderful relationship with CSU, where there is training of doctors coming through Parkes at the moment. As I said, our facility is magnificent. An $80 million hospital was built back in 2015. It would probably cost a quarter of a billion dollars to build now. It's state of the art and we haven't had a baby born in the two beautiful maternity units for five years. It's tragic.

**The CHAIR:** Thanks, Mayor Westcott. I'm keen to come back to you but I would like to hear from Bathurst Regional Council.

**JESS JENNINGS:** I would point out that I'm not a medical doctor. I am in agriculture, so it's not my background in terms of medicine and the medical sector. In preparation for this I've canvassed several local surgeons, specialists, staff and stakeholders of Bathurst Base Hospital and the private health sector. In short, the answer to the primary question of what has changed since the last inquiry was emphatically not much, and possibly the situation is worse now than what it was then. That was essentially the message that I have got to convey to this group today. Some of the issues that they touched on were around administrative burdens, staffing processes, staff numbers and levels for doctors, GP shortages et cetera, and budget constraints—all the things you've heard about this morning. I endorse everything Dr Ross Wilson said this morning as well, particularly relating to the maternity issues. There is still no emergency orthopaedic service at Bathurst. That's a notable absence for our community. There's also an interest in the idea of the independent Ombudsman and why that didn't happen, and a lot of interest coming to fruition in the future.

I would like to touch on not just what's happened in the last two years, but I believe Bathurst is in a really critical scenario for the next two to five years, shall we say. We know we have a $200 million upgrade to the public hospital. We also have a private hospital that covers, we believe, approximately 20 per cent of patient demand. That is talked about as declining and closing imminently. It hasn't happened yet, but there is a lot of talk around how it hasn't got very long to go. There are also discussions going on with another entity to build a private hospital in Bathurst, but they have not yet submitted a development application. It is entirely a private market decision as to whether or not that proceeds. What concerns me greatly is that if the new private hospital was not to proceed, and we also have the closing of the existing Gorman's Hill private hospital at Bathurst, all of that extra demand of 20 per cent or more will be loaded onto the public system at the same time as the trade is going ahead, whereby the access to the existing services is likely to be compromised. It really does concern me that we're looking at a potential crunch point here. Even if the new private hospital does go ahead, it's still two to three years away before any services become available.

I would also put into context that I'm not just here to complain about that. I do think there are solutions here, but they also extend beyond the medical and Health ministries into the planning ministries. I will give one quick example. Bathurst Regional Council several years ago identified a health precinct around Bathurst Base Hospital. It's a perfect area, just outside the CBD as it starts to go into parkland and residential areas. In that same parcel of precinct land is Bathurst Regional Council's works depot. It was fine in the 1950s and '60s for it to be based in that area. It is now right on the fringe of the CBD and totally mislocated. It has outgrown its usefulness and we're having to spend money just to keep it alive, to get rid of asbestos et cetera. It would cost our council over $20 million—more like $30 million-plus—to relocate that works depot out of the health precinct so that we could free up the land for health activity. It could be services, it could be clinics, it could be rooms, it could be another private hospital space or it could be key worker accommodation. It could be a range of those things. But until we can unlock that, then we're constrained in other ways.

I do think there are ways forward, but it's probably a more multifaceted approach in the short term to realise some of those solutions. I would also point out that Bathurst has over 5,000 dwellings, half of which can be built

almost immediately in the face of a housing crisis in the state and nationally, which just underscores how quickly a town like Bathurst is growing. Most of these regional towns are growing, but being the first large centre over the range, that growth of pressure is really notable, and obviously that's going to have a huge bearing on the way health services cope.

**The CHAIR:** Thanks, Dr Jennings. We have a number of questions the Committee wants to ask. I'm going to start. I will mainly direct my comments to you, Mayor Wescott of Parkes. The Committee has heard, and is extremely concerned, about the crisis in primary care. I've made comments before about how I'm not sure I've seen it as bad in 20 years. Your experience in Parkes seems to reflect that. Clearly, it was beginning to emerge as an issue in 2019 when there was a loss of maternity services. What action is being taken by either the Commonwealth or the NSW Government to address this issue of primary care provision in Parkes?

**KEN KEITH:** I'm happy to—

**NEIL WESTCOTT:** Ken has been sitting on these committees for a long time.

**The CHAIR:** Yes, by all means. Councillor Keith?

**KEN KEITH:** I am happy to support it. I've had a history with Health. I was part of the regional health advisory committee set up by former Minister Bronwyn—Ryan Park, the Minister, asked me to stand down from that committee when I stepped down as mayor—to try to implement the recommendations here. It was, to me, a very important committee that was working on practical ways of solving some of the issues. In Parkes, to go back to your question, we've been trying to provide additional support to make things happen in our community. We work very hard on trying to keep maternity going and providing attractive incentives for doctors to come. We had one come in, but you needed two or three at least to implement maternity again in Parkes. We recommended to Health that we get more doctors lists to utilise the two wonderful operating theatres that we have. There has been some work done there.

We've also worked with Charles Sturt University in getting some more training happening in our community. I'll refer back to the Rural Health Commissioner, Adjunct Professor Ruth Stewart, and studies that she has done in Queensland which showed that if doctors trained in a metropolitan area such as Brisbane, 5 per cent of those doctors would move to a regional area. If doctors did half their training or most of their training in a regional area but went to Brisbane for their final year, then about 50 per cent would go back into a regional area. If they did all their training in a rural area, then 90 per cent of them would go back to a rural area to practise. We've been encouraging and working with Charles Sturt to have trainee doctors train at the Parkes and Forbes hospitals to try to get that training. It's a long-term solution, but unless we start training people in rural areas, and not just focus on the metropolitan areas, then we're not going to solve the problem. We need people, from lifestyle and family connections, to train out in rural areas and continue to do so.

**The CHAIR:** There have been schemes to train medical students in rural areas for two decades. I've been intimately familiar with them. To this point, their output has been pretty disappointing in New South Wales. But I agree: I think that, particularly, Charles Sturt University's model of a full set of medical training here will have some considerable potential. I congratulate the council on working with them on that. But to you and the Charles Sturt University, I'm just interested in the Commonwealth Government or the New South Wales Government or NSW Health and their approach to your primary healthcare crisis.

**KEN KEITH:** When we built our new hospital—and Councillor Westcott's talked about that—we built it on a greenfield site so that we could have ancillary services based around that hospital for care. We wanted to have a medical centre. We wanted to have aged care facilities. We've just had a nurse in an aged care facility in Parkes announce only last week that they're going to close their doors. The other two nursing homes in our community are full to capacity. The nursing home that's closing has 48 residents. They have to find somewhere else to go. There's no room in our community to put them at this particular point in time and they've been given, basically, three months to vacate the Rosedurnate nursing home.

It's a Salvation Army home that basically has decided to divest itself of any nursing homes west of the Blue Mountains—a huge impact on our community, no consultation with anyone until the announcement was made. We spoke to them five years ago about the possible relocation over near the hospital and they decided they'd persevere with their existing facilities. But they've made a decision to go. We have land around that hospital where we're about to build some additional facilities for trainee doctors or visiting medical professionals to be able to come and stay there—nurses as well, to come and board right beside the hospital so they can just walk across, if they were doing maternity, or whatever it might be. We've tried to support them. We've had registrars using accommodation that council has provided.

The long term is to try to build facilities that doctors are happy to come and work in our community because they've got the support of both the federal and state governments. It's difficult because, basically, the federal

government looks after the doctors and the state Government looks after the health facilities—the hospitals—but the two don't seem to work together. We've had some success in a collaborative care model, particularly in Trundle and Tullamore in the northern part of our shire with Tottenham and Trangie. They've worked out a model there where everyone's working together to deliver the services. I think we put in a proposal there that is directly recommendation 10—to set up a rural area community health organisation pilot example—to try to make sure that we could make that work with the state and federal governments working together to deliver health services for a community.

**The CHAIR:** Okay. I'm going to leave it there and pass to Ms Williams. I might come back at the end.

**Mrs LESLIE WILLIAMS:** I want to continue with that particular issue. Bathurst, you talked about the health precinct that was potentially possible once you move your worksite.

**JESS JENNINGS:** Yes.

**Mrs LESLIE WILLIAMS:** Obviously, you've done a lot of work in that space in Parkes as a part of a solution, let's say, in terms of the healthcare issues. What's stopping you from progressing it? A health precinct—you obviously have said you have a master plan.

**NEIL WESTCOTT:** We have a master plan.

**KEN KEITH:** One of the issues that we have is the site that it was built on. The new hospital had to pay a significant amount of money to sort out an Aboriginal land claim on that area and the rest of the area is Crown land around it. Council isn't able to build anything on it that's profit-generating for council because that's against the state law that we can't use Crown land for that—onsell it for financial gain—and you've still got to solve that Aboriginal land claim on the rest of that land. That's why we would like the state Government's involvement in that to streamline access to that land that's available around the precinct.

**NEIL WESTCOTT:** I think, as you were indicating there, if Commonwealth and state could come together on this, it could be fixed very quickly. Obviously local councils do not have the financial capacity to build these facilities. As it is, Parkes Shire Council has spent over $1 million providing doctors' residences, doctors' surgeries, ongoing maintenance and accommodation. This is not local council remit and yet we're doing that. We are here today to once again lobby for this coming together of Commonwealth and state because we're broken. The health service in Parkes is broken.

The Minister already has it, but I'll offer it up for this group here—the solutions that we have. But basically it's coming out of that recommendation you have, recommendation 10—a pilot program—that we can prove and be an example to other regional areas of what can be done when you work together. It involves education but it involves upskilling and bringing all these services together under the one roof. This continual antagonism between primary care and the hospital system just doesn't work in a rural situation. Our two main GP clinics that we have in Parkes at the moment, we're now being told they're going to be put up for sale. This is a town of 12,000 people that, realistically, by the end of the year, may not hardly have a doctor.

**Mrs LESLIE WILLIAMS:** What you're suggesting then is that if you had a health precinct, potentially that's where you would accommodate those GPs?

**NEIL WESTCOTT:** That's where their service would come from, but we would also offer up temporary accommodation.

**Mrs LESLIE WILLIAMS:** Yes, as well as other services.

**NEIL WESTCOTT:** Part of the issue is that our local hospital is spending something like $13,000 to $15,000 a day bringing in these services and that's breaking their budget. It's a broken system.

**Mrs LESLIE WILLIAMS:** The next step is, as you're saying, using the Crown land and Aboriginal land councils. They're both state government jurisdiction. That's the next step.

**NEIL WESTCOTT:** They have the control to expediate this. That's what the Government does not have.

**Mrs LESLIE WILLIAMS:** That's right. Yes, absolutely.

**Ms TRISH DOYLE:** Thanks for speaking truth to power. I don't know how much power we're going to have with this, but it's important to speak your truth. I appreciate you outlining what some of the problems are and coming up with solutions. I'm going to turn to Councillor Kinghorne and Orange City Council. We haven't heard much from you yet. The report recommended that local health districts work with communities and councils about better informing communities about what services are available—not just in identifying gaps, but what services are available in their area—and publishing more data about wait times and also the facilities that they are

responsible for. Have you seen any improvement in that information coming from the local health district in the last couple of years?

**FRANCES KINGHORNE:** Most of the information that I get from the local health district is a weekly email, or I see it on social media. I think they probably could do better than that. For people who follow them on social media, they will get that update as well, but there is that demographic that doesn't engage in that realm and they just miss out.

**Ms TRISH DOYLE:** In terms of feeding back to the local health district about what you need, we've just heard the Mayor of Parkes outline a couple of projects and initiatives and ideas that they have that are ready to go. In terms of the gaps and the information that you have in Orange, do you have something ready to go? Do you have some solutions to address the need in your community?

**FRANCES KINGHORNE:** I think our needs aren't as great as these guys, which is lucky, but we've got a pretty strong history. One of the reasons that Orange does pretty well medically is because there's a strong history of medical specialists supporting new medical specialists and mentoring them. They've done that for a long time and they've done it really well, and it's paid off. I think one of the issues—I'm not sure if this is even relevant—is the different levels of government maybe not working well together. The best example I've got of this is—from a community pharmacy point of view—COVID vaccinations. When the first booster came out at the end of 2021, it was suddenly announced just before Christmas. It takes two weeks to get any stock of vaccine because you have to do it through the vaccine supporter incentive two weeks before. Everybody wanted their booster and nobody had any vaccine. But the hospital had some, and they were on code red so they weren't administering it.

I don't know if anybody knows, but the Pfizer vaccine's frozen and it's only good for a short time after it's thawed out. It was there at the hospital, thawed out, but wasn't going to be used. We heard that they had plenty at the hospital, so I rang the hospital to see if we could get some. We couldn't, because our supplies came from the Commonwealth Government and it was a state government supply at the hospital. They were happy to let it sit there and go out of date. To be fair, I rang Phil Donato and Andrew Gee and they fixed it within two hours. Somebody rang and said, "How many would you like?" But there shouldn't be those barriers in the first place. There is a bit of a blame game between state and federal governments about what can happen and what should happen. I don't know what the answer is. Just talk to each other and listen to each other.

**Ms TRISH DOYLE:** Mayor Westcott, have you noticed any improvements in that communication between the local health district and yourselves?

**NEIL WESTCOTT:** Following a visit to the Minister's office down in Macquarie Street, Mark Spittal did come and visit us. He has since been in contact with the general manager and we're trying to continue that relationship, but it has been a relationship that has been infrequent.

**JESS JENNINGS:** From Bathurst's perspective, I was someone who advocated to have a Bathurst Regional Council health committee for the last five years. It only got re-established a touch over a year ago, I guess. I think it's much better having that council-run committee as a communication distribution mechanism than not having one. At the moment for us the main game is the $200 million health upgrade. That's where a lot of the focus is. It's also become a forum, which I hadn't mentioned before, for debating the issue of car parking for the upgrade and as to how that plays out.

But that is also compounded, to some extent, by the fact that the $200 million, when it was originally announced pre the end of COVID and before the impacts of global supply chain squeezes and global inflation that have affected us nationally and locally—we're concerned that that $200 million is not going to buy us the original $200 million that it would've when it was announced, as you can well imagine. We've had other projects, construction capital projects, which have blown out between 20 and 40 per cent, not strictly in price terms but because of the implications of some of the increases here and there—having to change the design or the materials et cetera—having that kind of negative effect. That's definitely an issue that our community wants to hear an answer on or to get a sense of what we are going to get for the $200 million. As Dr Wilson said this morning, it's not really clear at this stage what we're getting. No doubt all good things take time, I would like to think, but it's hard to communicate to the broader community when there's not a clear message that's coming out at the moment.

**Mrs TANYA THOMPSON:** I'm interested to hear from all the councils what affordable options of transport are available for your community members in your regional areas? It's been a big issue over the last couple of days.

**FRANCES KINGHORNE:** For people who can't access treatment locally?

**Mrs TANYA THOMPSON:** Patient transport.

**FRANCES KINGHORNE:** I actually don't know a lot about that. Mr Maunder, do you know?

**SCOTT MAUNDER:** I know a bit. For Orange, most patients don't qualify for IPTAAS because they don't satisfy the minimum distance requirements. It falls to the patients individually if they have to travel to access health care in the city, when they do have to do that. That's the main barrier for us. It's also the community surrounding Orange. I think you have to be over 75 kilometres to access certain elements of IPTAAS, which creates a barrier for accessing health services for some people.

**KEN KEITH:** If I could just briefly talk about the Parkes situation, we have Neighbourhood Central, a community hub that provides volunteer transport drivers for people who can't drive. Basically, it's down to Orange Hospital for their health services or to GPs in Orange as well. There are probably over 50 drivers a week that come down to Orange and then there is at least that equivalent in private vehicles that would just drive down and visit. I argued many years ago that we should have more doctors coming to do some services, even if they're only minor services in the hospital. So a doctor would drive from Parkes to Orange and service 50 patients and then go home that night, rather than having 50 transport cars going backwards and forwards from Parkes every day. That is the sort of option that can be done if we think about the health system in a holistic manner.

**NEIL WESTCOTT:** I might just also add, Parkes shire has quite a high First Nations population and especially the situation around birthing on country is a very major one for us. The loss of birthing services within our shire, that is just one other pain that we feel.

**JESS JENNINGS:** I can't speak specifically to the costs per trip and eligibility issues, but we do have a strong Bathurst community transport service. It is a very common complaint across the entire Bathurst community that somebody "had to go to bloody Orange for a service". Not that we don't like the services being there, but we want them in Bathurst, to reflect our population's needs. I appreciate that there are historical reasons, possibly research and teaching type of reasons, that led to Orange being the hub that it's become. But Bathurst, I read recently, is growing at a rate faster than Orange and also faster than Dubbo. Those comparisons are relevant. All our regional towns are growing and so the infrastructure is under pressure, and the less travel you have to do when it's 50-odd minutes plus a heap of roadworks, which we're also grateful to be having, can really stifle a good medical experience. I won't delve into it now, but I do have an example of people having to go to Orange on a regular basis and the sort of rigmarole that it creates, particularly because they haven't got an adequate service in Bathurst, particularly over orthopaedic care.

**Mr CLAYTON BARR:** We heard quite a bit from Parkes with regard to the effort that local council is making to attract and retain some medical services and practitioners. Can I hear from Orange and Bathurst about whether your local council has been forced to step into that role of providing something to help attract the medical services?

**SCOTT MAUNDER:** Orange is fairly fortunate with its medical services. There are lots of reasons, as Councillor Kinghorne alluded to before. My role before working with council was working in the local health district in an executive role. I worked in Sydney and the region for about 10 years. Accreditation is probably the biggest barrier around attracting workforces and then support for the workforces once they're in place. So it's well and good to have a GP in a regional setting, but you well know that they're on call 24/7. People do weird things on weekends and require medical attention due to injury, and in those communities you can't go to a barbeque because you might have to go to hospital to attend to an emergency. They're real.

A lot of the issues today, and certainly in university, relates to workforce and how you increase the available workforce across all the disciplines, not just medical, nursing, allied health. How do you do that? Keep doing what we've been doing? It's not working. Keep throwing money at this and doing the same thing? That's not working either. So what do we do different? There are lots of people in Australia who are accredited overseas who are unable to work in the medical field because they aren't able to be accredited in Australia, they aren't able to be supported through their residency in Australia. You can build a $500 million hospital, but unless you've got staff to run it, both through all the disciplines and administratively—and we've heard the example in Parkes: fantastic facilities, no medical practitioners. It extends beyond what councils can do. They can do so much around building a house, paying someone and all the rest of it; but how do you increase the supply? That's the issue.

**Mr CLAYTON BARR:** Dr Jennings, is council out there doing anything to build houses or attract people? It's not really council's job, but I want to clarify that.

**JESS JENNINGS:** I would say yes. Strategically, probably about five or six years ago, Bathurst Regional Council teamed with Charles Sturt University and some others to commission a report on possible medical precinct areas around Bathurst city. It came up with a few options. None of those were taken forward except for the one that Bathurst Regional Council then went on its own with and said, "Where the Bathurst hospital is is what we are now calling our health precinct. That is our health precinct." That is deliberately designed to create an area that has critical mass and attracts both public and private services to it.

The reality is that it has worked to some extent. The ambulance station is within that precinct and recently constructed. Some allied services such as physiotherapy and the like have actually relocated from being in the CBD to that precinct, which is working in the right direction. The issue then is what's happening in the future. I would say that there are a lot of opportunities there along the lines of what I was saying before: that our council could be supporting key worker housing in and around that precinct. There could be other opportunities to open up for private sector investment so that, in future, we aren't all depending on the one Bathurst Base Hospital.

**The CHAIR:** Thank you. Ms Williams, would you like to—

**JESS JENNINGS:** Sorry, just one more thing if I could add to that? The Aboriginal medical service is long overdue and does not exist in Bathurst. Our council is working directly with the group that is organising that. We were hoping to have it further progressed than it is today, but there is a strong hope that it will be able to be based at the Kelso Community Hub, which is a council-owned asset which languishes a little bit financially from our books but offers brilliant services and great engagement with the community. That would be a massive step forward if that was to come to fruition in the near future. We are hoping to get some starting services happening in the next month or two but we're waiting to hear from the group that are organising it, of which Dr Wilson was on that board.

**Ms LIZA BUTLER:** I'm conscious of time, but we haven't heard this afternoon about cancer services or palliative care services. Just quickly, have you seen an improvement in both of those services over the past two years?

**FRANCES KINGHORNE:** Orange has changed its cancer services slightly so that they now service their machines on weekends instead of Mondays so that their radiation equipment is open five days a week instead of five days one week and four days the next. Although I believe that one of them is not working at the moment so they're doing lots of juggling to try to fit people in there. I think we've got extra trainee radiation oncologists and extra staff to try to deal with the increase in the numbers of people that require the services. We've probably got less people accessing our services now because there are now services in Dubbo for radiation oncology which weren't available before. That has eased the pressure on our system a little bit. I don't know that it's had to change too much because of the boost that we've got from people that live in Dubbo being able to have their treatment in Dubbo. I'm sorry, what was the other thing? Cancer care and—

**Ms LIZA BUTLER:** Palliative care.

**FRANCES KINGHORNE:** Palliative care is a big thing in Orange. I know people die everywhere and palliative care is more than just end-of-life care, but there's been a push to try to increase palliative care services in Orange for several years. It's changed in the last couple of years in that we've been given an extra two beds at the hospital for palliative care—dedicated palliative care beds which were needed as previous ones we had were used all the time. We were hoping to get a standalone hospice-type situation, and that was trialled at one of the local nursing homes for a while, but we went back to the hospital.

The compromise that was reached was to have extra beds at the hospital which they are in the process of organising. So that will give us a little bit more. The team itself, the palliative care team, are so good. We are really lucky with the ones that we have and I think we've got—that is one of the specialties that you can do in the bush. In Orange, anyway, they've got palliative care trainees working with the palliative care specialist there and that's really helpful. They do focus a lot on doing palliative care in the home as well. That's what many people want and that works really well. That's probably increased in the last couple of years as well.

**KEN KEITH:** Palliative care's probably one area that we've actually level pegged over the last couple of years rather than gone backwards. It was one of the things we argued to go into the new hospital, a bit like maternity in operating theatres. We have a wonderful breast care nurse that goes around, supported by the McGrath Foundation. We have regular fundraising for it.

We do have a couple of dedicated staff members that look after palliative care within the Parkes hospital with two rooms available that family are able to go and visit at any time. They are very sensitive people that are able to go out and meet with families and those recipients. In terms of the initial treatment, it often happens in Orange or further afield, but that end-of-life experience is being done now in the Parkes hospital and done with a lot of compassion and care.

**JESS JENNINGS:** I would say that the impression I've been given is that not much has really changed in the Bathurst circumstance. We do have Daffodil Cottage which does a lot of good work for the cancer issues. Ironically, I was not able to attend the Daffodil Cottage meeting today in order to attend this meeting, which would have been my first meeting with that group to have a more detailed response, but I'd be happy to seek further information for you from relevant people in Bathurst.

**Mrs LESLIE WILLIAMS:** I know that a couple of you are in the Country Mayors Association. If I'm correct, I don't think we've had a submission from Country Mayors and I just wondered two things. One is this issue around what our committees do. Has it been raised in the Country Mayors Association? Secondly, do you think there would be benefit in our Committee talking to a representative group from Country Mayors?

**NEIL WESTCOTT:** Ken is the former chair.

**Mrs LESLIE WILLIAMS:** I know that. That's why I'm asking.

**KEN KEITH:** As the former chair of Country Mayors, Country Mayors has a representative on that rural advisory committee in Councillor Rick Firman, OAM, from Temora, so he's a voice on that committee. Country Mayors' current chair, Jamie Chaffey the Mayor of Gunnedah, has been focusing on police and the lack of police resourcing in rural areas at the moment. But certainly we haven't lost interest in what's happening in the health space—although most of that advisory committee is very confidential so we don't get to see the feedback.

**Mrs LESLIE WILLIAMS:** I meant, as in, to make a submission to our particular select Committee.

**KEN KEITH:** I think it hasn't been done simply because we were waiting to see what the results are. I suppose my question for you, Dr McGirr, is the 44 recommendations two years ago that came before the Legislative Council. Part of it was this review that you're doing now, but we haven't seen—or I haven't seen, and it may exist—the report that actually says, "We've adopted 10 of those recommendations and implemented those in regional areas." What has actually happened out of this report?

**Mrs LESLIE WILLIAMS:** That's what we're trying to find out.

**KEN KEITH:** I'd love to know the answer because, when we see our health services declining in our regional areas, we get the impression that not much is happening. There's been a lot of talk but not a lot of action. We'd love to see that action come into place.

**The CHAIR:** Part of what we're trying to do is ground truth in the implementation of recommendations. It would be fair to say that the initial report we received from NSW Health, pretty much most of it had been done. Maybe at that higher level that's the case, but we're not picking that up on the ground. That's the point of doing this exercise over a couple of years: to try to monitor what's actually happening.

In the meantime, in regard to primary care and workforce more generally, there's been a deterioration so that the findings, frankly, two years ago, need updating in regard to primary care. Parkes is an example of a situation where there's to be some rethinking around how we approach primary care—which I think you flagged, actually. The Collaborative Care model that you've spoken about, and what I think is the 5Ts area—and I think you're flagging a similar model at Parkes. That's the sort of thinking we need to go forward with.

The issue from our point of view is who does it, because the Commonwealth isn't anywhere near it and NSW Health would argue that it's not in its remit. But, as you pointed out, NSW Health is currently forking out a lot of money to keep Parkes Hospital staffed—I presume with locum fly-in doctors—and a more constructive strategic approach would be of some benefit. That is just some commentary from me. We will need to wind things up there. I thank you all for taking the time to appear before the Committee. We may also send you some further questions in writing. Your replies would form part of the evidence and be made public. Would you be happy to provide a written reply to any further questions?

**SCOTT MAUNDER:** Yes.

**FRANCES KINGHORNE:** Yes.

**NEIL WESTCOTT:** Yes.

**KEN KEITH:** Yes.

**JESS JENNINGS:** Yes.

**The CHAIR:** Thank you very much. That concludes the hearing. I thank all the witnesses for appearing. I also thank the Committee members, the Committee staff and Hansard for their assistance in the conduct of today's hearing. I wish everybody a good afternoon.

**NEIL WESTCOTT:** The submissions we made, obviously we could only give an abbreviated report. Could we hand them in to you? Is that how it works?

**The CHAIR:** Have you got submissions there?

**NEIL WESTCOTT:** Yes. It's just a more lengthy report on what we were going to say.

**The CHAIR:** You can hand it to me or to the secretariat. Thank you.

**(The witnesses withdrew.)**

**The Committee adjourned at 15:05.**