Submission No 484

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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Date Received: 18 January 2021

I have been a Health advocate for the Deniliquin area for the past 6 years and together with a fellow advocate have had consultations with – The Hon Brad Hazzard NSW Minister for Health, Federal Member for Farrer The Hon Sussan Ley, Former State member for Murray Adrian Piccoli his successor Austin Evans & his successor the current sitting member Helen Dalton, The Hon Natasha MacClaren-Jones, Premier of NSW Gladys Berejiklian, The Deputy Premier NSW John Barilaro, The Member for Albury Justin Clancy and former state MP Daryl Maguire. The Federal Rural Health Commissioner Paul Wolsey, Federal Minister for Health Greg Hunt, President of the AMA along with numerous local government representatives, Edward River Mayor & Councillors and medical personnel working within MLHD including CEO Jill Ludford and many other senior Administrators of MLHD

My great grandfather was a founding member of the Board of the initial Deniliquin Hospital. I was a member of UHA for over 30 years serving as a fund raiser and held an executive position. I was awarded a Life Governorship of Deniliquin Hospital for my fundraising efforts and dedication to UHA of NSW. I moved to Deniliquin from Victoria in 1977 and subsequently had my 3 children at the Deniliquin Hospital needless to say along with other family members I have maintained an interest in Deniliquin Hospital longer than most current administrators of NSW Health and believe I have excellent insight into the function and administration of the Hospital. During my career I have worked for both the Victorian and NSW State governments as a Special Project Officer overseeing the separation and annexing of DoCS and DADHC departments including the relocation and redevelopment of both, so I have good insight into the protocol and procedures of Regional and Metropolitan Government departments.

TERMS OF REFERENCE

A)

Current statistics compared to 1980-90 indicated that people in Rural NSW now have a lower life expectancy than their metropolitan counterparts. We do not have the selection of aged care facilities that are available in cities and that can lead to quality control and significantly nurse or care ratios become lower due to lack of adequately trained staff. Staff also do not get the time off due to shortages and budgetary restrictions to further their career or by keeping up to date Continuing Professional Development (CPD) current certificates – this is an example of what led to and caused the death of in 2018 – the equipment was outdated and only 30% of medical and midwifery staffs CPD's were up to date and current.

Prior to Covid-19 border closures we were already compromised in areas of health that we had little or no services and we relied heavily on cross border access to Victorian Health, now we are further compromised as people find it challenging and confusing to cross the border as daily it seems the requisites change – this is particularly difficult for the elderly. Border closures or strict restrictions have caused many to withdraw from vital treatment and this year's figures on deaths will most likely support what I see actually occurring. Deaths in the aged are definitely up and considering there has been no major flu outbreaks we can assume there is some other reason. My own family has been impacted by Border closures and treatment to sustain life has been delayed.

Geriatric Health in rural areas is sorely lacking. Our council want to build a retirement village, yet we cannot service the elderly we already have. Residents in Nursing Homes have no way of accessing services out of town it falls to the family to achieve this as the Homes cannot afford the extra staff to accompany the resident. Usually, the resident just goes without like my mother who I discovered had not seen a podiatrist for 8 months and her toenails had grown over and then under her toes and

were causing her feet to bleed, the only Podiatrist was on maternity leave and there was no replacement. My mother later died as a result of a fall from her bed after pressing her buzzer for 40 minutes with no response she tried to get herself out of bed fell and died because of either the heart attack she was suffering or the massive blow to her head she suffered when she fell – we will never know because cause of death was never identified. She could have been murdered or sexually assaulted for all we know.

Generally, we do not have permanent access to basic services like women's health and breast screening clinics etc unless your issue arises when a clinic is in the vicinity you have to access it elsewhere if you wait until the next clinic schedule it may be too late to reverse a chronic condition. Early intervention in most illness is paramount to overall recovery rates. In Rural NSW we do not have the access so of course we will have a lower success and survival rate. Prior to 1995-2000 we had local access to all these abovementioned services but with the misguided centralising of services in rural areas e.g.: Wagga was obviously supposed to be the main hub for the entire MLHD, then the smaller areas that had no public transport available to Wagga suffered greatly which in turn created the major dependency on Victorian services – in retrospect the Deniliquin & Griffith facilities should have remained as they were Base/Regional institutions not downgraded to little or no services.

B)

It is not easy to differentiate between our rural services and NSW metropolitan services as due to our location we actually have little access to Sydney we can only compare to Melbourne which we know if you have private health has one of the best Health systems in the world. Public Health has some long waiting times however the Vic. Government have recently rebuilt all their major hospitals across the state and Victorians have excellent access -easy to do with such a small state. MLHD alone takes up almost half the state of NSW therefore its hard to make a comparison. Due to distance the Far West and our Far southern area has less dependency on NSW Coastal or metro but a massive dependency on Victorian towns of Shepparton Echuca Bendigo and Melbourne. At Deniliquin we had until 6 years ago a 10 bed Maternity ward now we have a 2 bed while we maintain the same population and its also growing. We were obviously meant to access Albury/Wodonga or Wagga however when this plan was adopted by metropolitan administrators, they obviously did not take into consideration the vast distances and the lack of public transport that would have made this a reasonable plan. We did not access Wagga or Albury instead we went into Victoria where we had some public transport access – so this left no footprint of numbers on the NSW system and the Health department made the incorrect conclusion – no one out there nothing to see here, so let us downgrade further. This has been the largest obstacle we have had as a Rural NSW community in that MLHD continue to give incorrect usage figures to budgetary committees, so we get nothing upgraded and services continue to be diminished causing us to suffer further. It is an infuriating position but obviously suits the financial figures for NSW Health.

Your committee needs to contact Echuca Hospital and ask them why they abuse our overflow of maternity clients saying to them "you girls from NSW are clogging up our system and we are never told you ae coming" Echuca was rebuilt to service its own area of Vic. not the massive excess flow of southern NSW that have nowhere else to go.

Deniliquin has been severely compromised due to lack of financial upgrading and the withdrawal of critical basic services compared to Wagga and its surrounding areas

. If the Deniliquin Hospital had been maintained properly and upgraded over the years as other MLHD facilities were, we would be servicing the community adequately. The lack of commitment by

MLHD and NSW Health to upgrade or rebuild Deniliquin Hospital while almost every other facility in MLHD has been upgraded rebuilt or rehashed as a Multi-Purpose Centre rankles me. I refer in particular to the Wagga by-election to save the Liberal seat of the disgraced Daryl Maguire we watched Tumut hospital in close proximity to the major Wagga Hospital receive funding of $54 million to upgrade when its population is less than half of Deniliquin and district and it was half an hour from Wagga, we are 2.5 hours from Albury 3.5 hours from Wagga, yet we missed out. If the NSW Government were honestly trying to improve rural health that money should have been for Deniliquin.

C)

Health Staff and service providers in MLHD are constantly badgered by MLHD administrators to cut costs. Considering most are taking on client portfolios due to lack of staff, of up to three times that of their city peers this is a ridiculous request, yet it continually forms a major part of any dialogue when ground staff ask for better services. MLHD moved the client intake phone contact from the Deniliquin local community health centre to a Wagga based intake centre which according to service users is never answered or it takes several days and calls to get a response. There have been major complaints regarding this, clients have gone into the Deniliquin Community health/Allied service centre to make an appointment, are then given a phone number to call in Wagga to make the appointment – so they go home and try the number that does not answer and there is no way to leave a call back number – one complaint was that it took a week to get onto the Wagga Call centre. A frustrated allied health worker who has been badgered by locals, while off duty says they feel it was a further premeditated move by administrators to prove their lying regarding access numbers in the Deniliquin area. If no one is accessing, then they do not have to provide a service. In the past our local receptionist was aware of local services and clients and could make a correct judgement having already dealt with these clients as to the urgency of the situation. The system in place now is another total fail in providing the best care in the best place at the right time.

Currently with border closures occurring in waves there are major barriers to access services, clients waiting up to 6 months for an initial consultation and more likely than not that will require travel to Albury or Wagga under their own steam – lots of clients at serious risk to their health have delayed service because of this. Prior to covid-19 a service could be accessed in Echuca usually within 2-4 weeks – even this can be a detrimental delay depending on the situation. Rural people have come to expect long delays as the normal, which again is totally unacceptable. Current access time for a speech pathologist is months as is an OT assessment on a child. If the standard and service, we had in 1995 had been maintained we would not have this issue today. The downgrading and eradication of some smaller Hospitals in this area like Barham now a Multi-Purpose Centre (MPC) means that those facilities that once provided a service are now just a holding yard for people to be moved on to a larger facility. My relation Edgar Pickles one of Australia's most decorated World War 2 pilots died in the Barham MPC last year in severe pain. His niece (a retired Nurse) visiting from Melbourne discovered him in agony – it took her 90 minutes to locate a nurse or staff member then another 2 hours for that staff member to call in an off-duty nurse so the 2 together could administer major pain relief. This goes on in these smaller centres all the time. Edgar Pickles based in London during the War was the youngest man ever to become a Squadron Leader and flew the highest number of sorties into Germany he was a legend in the UK and was presented twice to the Queen. He died In pain in the Barham MPC due to a lack of care and staff. His immediate family decided not to make an official complaint due to Edgars long time friendship with local staff at the facility – in a small town we rely on each other and to register a complaint would have greatly affected local staff who are not

to blame – the MLHD administrators are to blame and the NSW Health Minister is to blame as he has been told these facts yet refuses to believe the problems exist.

D)

I find the questions repetitive the comments in C) relate as well to this question

An example of waiting times for Women's Health. One local clinic has funding for a permanent women's health nurse we carried out an exercise and phoned and asked for an appointment for a pap smear – we were told 5 weeks wait, when we questioned the receptionist, we were told that the patient had to see the Doctor first. Most clinics have funding for this service and the presence of the Doctor was not required, the Nurse was available immediately, but the Doctor was rorting the system by wanting an appointment with the client, so the client had to wait the unnecessary 5 weeks – this is a deplorable practice of double-dipping yet quite common amongst the larger "chain store" type clinics and overseas trained Doctors. It is life- risking behaviour and needs to be stamped out.

Refer to attachment regarding waiting time experienced by when he had an accident with an angle grinder this letter also shows how inadequate the transportation system we currently have is, to get an injured man requiring microsurgery to the nearest centre capable of servicing his injury. We have witnessed people sent to Albury or Bendigo for urgent treatment then told the next day to make their own way home in their pyjamas – this is a frequent occurrence backed up by weekly urgent posts on social media asking for someone to drive them back to their own town. If the government insists on us seeking services out of town, they need to provide adequate access to that service, alternatively the service is provided here.

E)

Most planning and budgetary expenditure rely on usage data. The collectivisation of services by MLHD to create major hubs like Wagga should have also included Griffith and Deniliquin as similar hubs because of their location as satellite centres to surrounding smaller towns – this idiotic assumption that we would all travel to Wagga has now been tried and tested for 15 years and has proven to be a complete failure given the lack of public and community transport that should have been part of the original plan. Once again it was designed to suit a metropolitan scenario where if something is unavailable you can catch a train or a bus and access it in the next suburb.

Unfortunately, over the years MLHD administrators have become very efficient at skewing figures to suit their requirements and in order to downgrade services in the Deniliquin area. This process overtime has left them floundering and unable to address the actual shortfall they created. They have what was once a large regional hospital currently in a dilapidated and unsafe state the building itself has major issues regarding asbestos and structural instability. We have an extremely high incidence of cancer in our long-term Nursing staff that should also be investigated. Deniliquin Hospital is no longer capable of meeting the needs of the growing population in the area

F)

If there is no footprint then there is no funding. Due to our 20-year exodus into Victoria we have left virtually no footprint for a budgetary committee to follow.

A lack of adequate public transport from this area into central and larger NSW facilities created the avenue we currently have where most border residents access the Victorian health system and thus are not accounted for on the NSW system. A smaller degree of cases is accounted for whereby some cross border facilities charge the NSW health department for access defined by postcode from Medicare card addresses. This smaller degree totals over $50 million the same amount of money it would cost once only to upgrade & rebuild Deniliquin, yet this amount flows out annually just to access Victorian facilities. A huge amount of private health patients are swallowed by the Victorian system with no footprint. We became totally dependent on the Victorian system which then became inaccessible with the arrival of the current Covid-19 pandemic. Border residents had access cut from Victorian services and were unable to access the NSW system either due to transportation issues or Albury services unable to cope with the overload. Those cross border services later made accessible due to public backlash also included a stipulation whereby consumers then had to isolate 14 days on return. A trip to an ENT specialist normally taking 3-6 weeks in the Victorian system became a 5-month waiting list on the NSW side.

I have repeatedly asked MLHD for figures on usage in varied areas and services they are not forthcoming and when they are, they are not correct – this poor system of accountability has had a seriously detrimental affect on the provision of funding to our area.

Since 1970 less than $8 million dollars has been spent on the facility this includes the current band aid solution to A&E and oncology which was supposed to total 4.6 million however almost a million was spent on an overdue CT Scanner which should have come out of hospital maintenance not Government grants handed out by sitting members in attempts to retain their political seats. Both grants were obtained by pressure from my fellow advocate and myself. It is my opinion that the money has been spent unwisely with a band aid cover up that will require tearing down and a total rebuild in the near future. I object to this as it is a blatant waste of funds which are exceedingly hard to acquire.

Edward River Council has a figure of 40-60 million earmarked for a new Hospital in its current advocacy strategy -delivery 2030, we have urged the NSW Government to fast track the funds for this rebuild especially now after the Covid-19 issues where the current facility has been inundated and unable to cope with numbers presenting in A & E and in Maternity. We have had mothers from Hay and Moulamein needing to birth in Deniliquin during COVID-19 being sent on to Canberra almost 600kms away and with no family support The NSW & MLHD Health Plans towards 2021 and 2025 and the Rural Health plans etc do not refer to the area of Deniliquin and district in any point or form and this only confirms my belief that we are the forgotten corner of NSW. Recently Minister Hazzard made a major donation $1.5 million to the Echuca Victorian Peter Mac Cancer Clinic this also confirms local belief that he will not fund any further projects out here and wants to maintain the failed dependency on the Victorian system – he has listened to inaccurate figures produced by the MLHD Administrators that have been in their positions for way too long and who systematically downgraded our facility to a level that now they do not know how to reinstate. Why is Deniliquin the only facility not to receive major funding and what are the residents of this area of NSW supposed to do during future COVID-19 or similar pandemics.

G)

MLHD's strategy on staff recruitment is to complain loudly that they cannot get staff. One acting General Manager at Deniliquin commented that we do not need a new bigger facility because we can never get the staff to man it. Most staff will not work in a run-down asbestos filled building that

has no modern equipment that is why they cannot get staff. The other reasons being they have an extremely poor reputation regarding bullying and poor management.

NSW Health have thrown the towel in over recruitment – they maintain they are recruiting yet it can take over 12 months to recruit and place the new recruit in position – they obviously have no HR department capable of this process. Most successful applicants move on to a different job because of this delay and the process begins again. Between 2013-2016, 5 young energetic new midwives left the area because MLHD would not award them permanent placement – Midwifery has suffered ever since unable to maintain a decent reliable service over peak periods and engaging expensive agency nurses to cover the downfall. We have had women birthing on the side of the road and colliding with Kangaroos 5.5 hours after birthing. As far back as 2016 I met with Jill Ludford CEO MLHD regarding Maternity staffing issues, she promised me back then to sort it out its 4 years later she promised us again at the HAG meeting in December 2020 that Maternity would not go into COS Ops which means mothers have to birth away due to lack of staff, yet this is still happening. Maternity staff are abused and exhorted into working long and unsafe hours and the unit is not manned by a qualified midwife at night. My last grandchild born in October2019 under difficult and assisted delivery should have under NSW guidelines been monitored every 2 hours through the night he was not monitored at all. We advised Jill Ludford in 2016 that a baby would die in Deniliquin due to lack of adequate service and equipment and of course a baby did die for no good reason. Maternity and midwifery services in Deniliquin have still not been addressed correctly and because of this poor service women continue to swarm over the border into Echuca where they are often admonished by staff who tell them they are clogging up the Victorian system. When Deniliquin maternity goes into COS OPS the mother has a last-minute decision to work out where to attend, which facility can take her and how will she get back to Deniliquin and in doing so leaves the safety of her usual GP and midwife at the most vulnerable time in her pregnancy. Our new mothers that live on Rural properties often with no family support are supposed to birth one day leave the under equipped Maternity ward the next day and just fend for themselves. Any other woman in Australia would receive a visit from the domiciliary midwife and the child welfare nurse the next day and regularly over the next few weeks – not our women as MLHD have a 30km limit on rural driving so if a property is 35kms from Deniliquin they receive no visits. These women especially first-time mothers are most vulnerable, yet we provide no service to them and we toss them out of the hospital to make way for the next woman as the facility is too small since its downgrading 6 years ago from 10 beds to 2 yet in comparison our under-resourced MLHD staff and Nurses are often made to drive to Wagga and back in a day – over 500kms to attend a staff meeting on the whim of some administrator who should be making the trip here. During my time in NSW government, I argued against this dreadful waste of already under-resourced staff and the danger it put them in. NSW Health are now noticeably big on Telehealth it has become the new catch cry and according to MLHD will save us all and eradicate the need for any other resources -maybe their executives could use this miracle device and stop making our people waste time driving all over the countryside. Please refer to attached document written by the grandmother of a local woman's delivery ordeal and the unsuitable comments by the Acting Hospital Manager.

Staffing issues are not addressed and instead of moaning they cannot get staff these highly paid administrators need to work for their wages and start offering incentives to medical graduates like housing, vehicles, an amnesty on their hex fees if they stay in a county practice for 5 years this would create a continual stream of correctly trained medical officers some of which may decide to remain permanently in Rural Practice. The Hex fee could be met jointly by NSW Health and local councils. We have also as part of our redevelopment of the facility asked for a Rural Specialist training centre to be included here in Deniliquin because of its central location to Adelaide Melbourne & Sydney.

This would be a benefit to our town as well as create hands on access to training of Rural Specialists as we have a high incidence of agricultural accidents. We are a perfect location for this type of facility – this suggestion has also fallen on deaf ears. NSW Government are big on decentralisation, this would prove they were genuinely interested in Rural and remote NSW. On past performance a facility like this will probably be located in a metropolitan area.

Telehealth is not the answer – it's critically needed but should not be the crutch that holds up half the state as one Specialist said to me "it will never replace hands on physical investigation nor should it, but can in some circumstances aide and assist Rural GPs to make a decision normally well above their pay grade" He said it has its place in particular as a guide to assist with heart conditions and in assisting a GP to perform a procedure not previously performed. It is not the saviour that MLHD sees as the end to all their staff shortages. In recent conversations they seem to think this will resolve all issues. The overall attitude of MLHD execs is to throw their hands in the air and whine about lack of staff, I am yet to see one of them suggest a recruitment strategy. The performance of MLHD and its supposed HR Department is appalling, and they should be taken to task regarding their lack of action. While they rely on skewed figures and data they will not recruit. As far as I have seen they have no strategy regarding recruitment.

H)

Ambulance NSW in rural areas are well and truly under-resourced. The introduction of Ambulance providing a more Medical level of care and the lower care transportation falling to privatisation type government funded institutions like Intereach to provide community transport for medical appts etc along with further eradication of the Hospital based community transport has left a massive void in the system. We now expect ambulance to only deal with critical type transportation and the minor or patient transport between hospitals for not so serious cases has fallen to Intereach community cars or supposedly Hospital community transport (this appears in our area to have vanished altogether) Intereach drivers here are voluntary, over 70 and under trained most do not have even basic first aid yet they are supposed to drive a car full of patients to Albury leaving at 7am drag the 4 patients to all appointments have no break and return as late as 7-8pm at night having travelled almost 500kms – the patients are probably in their 70-80's – during covid-19 because of the age of the volunteer drivers this practice ceased so none of the 2 cars or 1 people mover/minibus were available. MLHDs community transport cars used to take patients on these trips now its Intereach. There have been cases of these volunteers' older men having to assist with soiled undergarments of aged passengers - this again is a totally inappropriate practice. I have been advised that the Intereach drivers based in Griffith are paid.

Our system is so flawed regarding us all travelling off to the hub of Wagga that recently a pregnant woman who could not birth at Deniliquin due to staff shortages or complications was transported to Wagga – The ambulance left here and had to stop at Jerilderie Hospital unload her and admit her then immediately she was discharged and reloaded into the same ambulance for the remainder of the drive to Wagga – why did this happen – because the idiots that planned this system didn't allow for ambulance NSW ruling on not travelling more than a certain amount of kilometres in any given trip. The trip to Wagga exceeded this distance by 7-8 kilometres. This is how they beat the system in order to get someone from Deniliquin to Wagga where we are all supposed to go according to MLHD. And that is why we do not go.

My son recently broke his leg & was transported by ambulance to Bendigo where he underwent surgery – the break was severe and will take 12 months to heal – he will require more surgery to remove a steel rod. He was advised to keep off it and elevated for 6 weeks he was on morphine and

oxycontin based drugs when the hospital phoned and told his wife to come and pick him up saying he could lie across the back seat for the 2–3-hour journey. Originally, they wanted her to transport him back to Deniliquin Hospital – I refused as his wife was concerned about how to deal with his transportation, so I phoned his GP and they suggested they organise it and accepted him back via ambulance to Deniliquin where he was carried in one door and straight out the other to his wife's car and driven 5kms home. This took half a day to organise. Most people do not have the ability to sort this and patients have been discharged from hospitals 100's of kilometres from home and told to find their own way home. The general public are not paramedics and we should not be forced into dangerous situations we are not trained to deal with like the transportation of extremely ill small children.

The use of volunteer drivers for this community transportation is unacceptable and should also be stamped out. If that same driver tried to access an aged care facility or a school in NSW, he would require a police check and site induction – these drivers are unskilled and untrained, yet we expect them to drive non stop over 12 hours with a car full of vulnerable patients some who require assistance for continence. It is ridiculous, unsafe, and potentially an accident or lawsuit waiting to happen – that's NSW Health's answer to rural transportation of patients to their so—called major hub planning strategy. This system regarding ambulances is in dire need of urgent review. I asked Intereach to make a submission regarding transportation however they were concerned funding could be cut if they did.

I)

Please refer to attachment being letter to MLHD Execs regarding the proposed new Oncology upgrade to 3 chairs due shortly at Deniliquin Hospital.

The proposed upgrade allows for only 3 chairs, yet the stats supplied by NSW Can Assist, Fight Cancer Victoria and Peter Mac Cancer Clinic Melbourne tell us between 1000-1500 immunology, haematology and oncology patients currently reside in this area of NSW. During COVID-19 the Oncology service at Deniliquin has failed to cope, and patients gave up treatment. My husband Timothy was one such patient (he has made a separate submission relating to Oncology) his treatment which was monthly had to convert to 3 monthlies. During this period, I contacted Peter MacCallum Clinic and they offered a pop-up clinic in Deniliquin however MLHD intervened and gave Peter Mac false figures on Cancer patients in our area citing 41 patients all up. Deniliquin Hospital were unable to recruit Oncology Nurses after their last one resigned due to lack of support staff and safety issues. MLHD say they have been recruiting since 2018 yet have failed to hire anyone. That is why only 41 patients ever turned up because they were so unreliable. They now maintain they have a service – the Oncology Nurse comes from Griffith and there is still no backup. Please refer to his submission and attachments regarding this fiasco. Again, it depicts the blatant misinformation extensively used by MLHD to block or deny basic services. There was negativity between MLHD and Albury Oncology the credentialled provider – they were both at fault. What we should have is a Cancer Clinic here as the need is great – a clinic like Peter Mac proposed that they would staff and that all Oncologist services could use. The present mishandling of this issue requires urgent intervention as patients are dying because of the lack of service and their inability to access Victorian services. Eventually the need for a radiation facility in this area will become a reality. I mentioned this to a MLHD Manager at Deniliquin recently she laughed and said "Not in her lifetime" this comment was made in the presence of the NSW President of Can Assist – after this confrontation we both agreed that it is why we have no services here because of negativity and pressure from NSW Health not to exceed funding.

J)

Again, staff shortages and lack of recruitment process sees our Palliative care system short-handed. Our Palliative Nurses are amazing and because they are known to the patients we are treated beautifully and with compassion. These ladies go above and beyond what is expected of them and they are seriously understaffed. Again, their case load far exceeds city standards. They are in dire need of reappraisal and a more manageable case load. This should be a priority based on the figures provided by Peter Mac and Can Assist not on the figure provided by MLHD.

Palliative Care should have adequate support and backup staff they are a critical service provision but like everything else in Rural areas severely underfunded.

K)

Currently in MLHD the big winners in funding are Mental Health and Indigenous health and support services. There appears to be ample funding available and has been taken up by one Clinical practice creating an indigenous women's Health & Maternity Clinic. In relation to the lack of funding for basic Health services for the remainder of the Community I believe that these areas are doing reasonably well. Mental Health in Rural areas has been on the agenda for years -and related support services are everywhere advertising help is available. Greatly lacking in this area is a Mental Health Rehabilitation Clinic. As part of the rebuild of our hospital we have asked for this as well as an Orthopaedic Clinic along the lines of Epworth Rehab in Melbourne where Ortho and Mental Health share the same rehab centre but use the gym and heated pool at separate times.

Indigenous Health will always be a high needs requisite however I would like to see it combined with normal health avenues as I believe that may aide bridging the so-called gap. There should also be more educational bursaries awarded to indigenous Australians to encourage them in Health pathways and again incentives to return to their home bases once qualified.

L) Other related issues

Since becoming an advocate for Health services in NSW I have been contacted by many consumers, staff, and medical officers regarding issues at Deniliquin – many of these have been forwarded to NSW Health Ministry. Mostly the requests we made pleading with the Minister for help or recommending certain improvements all fell on deaf ears and repeatedly we received letters denying there has ever been a problem – Minister Hazzard believes we are all serviced well out here in rural NSW. I believe he has made that assumption on the data he is given by MLHD. People in this area are reluctant to complain due to it being a rural community that relies on each other for support they want to make a complaint yet do not want to be named due to past repercussions on relatives that worked within MLHD.

Totally innocent staff members are constantly bullied like this when in fact many complaints come from patients and visitors to the hospital not staff– it also displays a draconian bullying approach and an ignorant response to complaints, and it is one practised widely and for many years in MLHD. The complaint made by me was regarding the theft of an antique safe that had been part of the institution since its

establishment – it should have been disposed of under government guidelines not taken by stealth - this is a serious issue and followed similar events in the past. It was because of the relentless questioning and advocacy by us that MLHD finally agreed to the formation of a Health Advisory Group being initiated in Deniliquin and in the other hot area of complaint in NSW - West Wyalong and district. At great expense in 2019, MLHD procured the expertise of Chris Shipway Consultancy who oversaw the formation of a local and diverse group of citizens and stakeholders interested in improving Health Services in this region. Due to Covid-19 MLHD pulled out of the consultation process 12 months earlier than originally specified which is totally understandable however our Group has continued with Edward River Council approval and participation – the group has made a separate submission to this inquiry. Because that group is still monitored by MLHD it is also significantly overshadowed by the continued attendance of MLHD personnel. In other words, it was a trial group designed to encourage those advocates making a noise to join and hence become restrained by red tape. MLHD had to be seen to be addressing our issues yet we are no further progressed than we were when the group first formed in 2019. We still remain reliant on MLHD administrator's honesty in their reports to the Minister.

Our Health Action Group also carried out a community survey asking community to prioritise needs and services lacking – we received over 300 responses and the results were as follows

Question 1:		What is important to you about health
Answer	Priority 1	Doctor availability
	Priority 2	Better access to services locally
	Priority 3	Better/Local access to Specialists
	Priority 4	New/Updated Hospital facility
Question 2		What else could happen to improve Health
Answer	Priority 1	More Doctors so access was quicker & easier
	Priority 2	Rebuild or update the existing Hospital
	Priority 3	Make access to Specialists available locally
	Priority 4	Travel issues – better public transport and better community transport to enable out of town visits – most preferred not to travel or it was not possible due to physical and financial restraints

Overall, the survey indicated that our entire community were angry that they had to travel for consultation that was once provided here in Deniliquin and that those fairly basic services were whittled away over time without community consultation. A detailed report and graphs of the consultation is available on request.

Geographically Deniliquin pop >8000 is situated strategically in a central position in the southern Riverina. From its conception over 150 years ago the Hospital was known as the Regional or Base hospital that supported over 20 satellite towns in a 125km radius – it maintains that role today and is the 3rd largest Hospital in the massive MLHD area unfortunately it no longer has the staff or equipment to maintain past levels or even basic levels of care. Surrounding population equates to approx. 20000 and if Moama is added its over 30000 inhabitants. When the border closes the 30000 are forced to rely on our facility. Deniliquin has several huge events each year Easter, The Ute Muster, The Truck show, Cruising Nationals, RSL Fishing Classic some of which see the town

population alone swell to over 20000. The Edward river is a major river for water sports with the Big4 Resort winning the NSW tourism award several years running. Swimming, water skiing competitions, football soccer rugby basketball netball hockey tennis and golf have large memberships and all host major events. Understandably the inability to treat children under 16 is a disaster waiting to happen. It is inconceivable to a metropolitan parent to not have their child seen to in their local area. We are a rural area and so also have a higher rate of accidents on farms than in industrial areas.

In 1990, Deniliquin was a 109-bed base hospital with a 10 bed Maternity wing and a 12 bed children's ward complete with a self-contained flat for parent accommodation. A geriatric ward, full cardiac care, A & E, short stay ward, full theatre facilities where all surgery was performed, a permanent women's clinic with a female Doctor and women's health/breast screen nurse. Food was prepared on the premises and the facility had a fully equipped laundry service we were governed buy a local board and ran at a profit. We had access to 12 visiting specialists and surgeons and all our local GPs performed surgical procedures at the Hospital. Most surgeons flew in from Sydney Albury and Melbourne on a regular basis consulting one day and operating the next. We also performed autopsies locally. We were also a training facility for Nurses.

In 2020 the bed size is arguable, MLHD on different web sites say anything from 40-61. I have walked through and counted 28 plus 2 birthing suites, 4 beds in A & E, 6 x day surgery beds, 8 renal chairs and 3 oncology chairs. On websites MLHD lies about its actual service – their infamous catch cry being we offer "the best service at the best time in the best place" – this should be struck from their advertising or reported to Consumer affairs.

Food is prepared elsewhere and by the time it arrives in Deniliquin it is disgusting – even the water is provided in plastic bottles and arrives from Sydney 700kms away. The food and laundry should be processed here – it provides local jobs and business opportunities and would be more nutritionally and economically suitable.

There is no permanent women's clinic, a women's health nurse comes from Griffith on an erratic basis and is not advertised, it prioritises disadvantaged ethnic, indigenous, aged, and disabled women so garden varieties miss out – they can wait up to 5 weeks for a consultation at their normal clinic.

There is no children's ward and injured or ill children are moved on to Shepparton, Albury, Echuca, Bendigo or Melbourne in most cases taken by a parent and not by ambulance or hospital vehicle. We carry out no practises at the hospital on Children under 16 they are supposedly held for a maximum of 24 hours then moved on – more often they are released beforehand because there is no paediatric nurse on duty and MLHD cite reasons such as stitches and broken limbs are specialised and cannot be attended to at the hospital, this idiocy also includes children with croup and gastro. In 1998 my eldest child had an emergency appendectomy at Deni Hospital – he is still alive today. Broken bones were set and children with gastro and croup were cared for. No orthopaedic services are carried out if a child breaks a limb they are gone – if this or a wound requiring stitches happens on a weekday only one local clinic can cater to the need however if it occurs out of hours or on a weekend the patient is transferred. We have 6 local GPS capable of these procedures however MLHD deems it an unsafe practice but say its safe to allow the child to remain in extreme discomfort while they spend hours organising transport which they then fail at and so the parent has to transport a screaming ill child over 100-200kms to the next larger facility, usually unaided and whilst driving through kangaroo infested highways that local ambos refuse to travel at night. We have numerous cases of sole parents taking this trip in the dead of night alone with an extremely unwell

child – this is dangerous and life threatening we are not paramedics and should not be placed in this position. I discussed this with Premier Berejiklian she said it was totally unacceptable 2 years ago, yet nothing has altered to correct this system.

I have studied this directive regarding children made by NSW Health over the past 5 years and my opinion is that due to the inability of NSW Health to attract Australian trained GPS to country areas they then, due to the shortage, opened up the interior to inadequately trained Medical personnel from overseas countries letting them work in Rural areas for 5 years after which they could transfer to the city or elsewhere. In the case of Deniliquin their closest line Doctor or Supervisor was 200 kms away in Albury. Mistakes were made and so as not to appear racial/discriminatory in any way procedures under 16 were banned from being carried out and all relative equipment was removed. Statistically this equates to up to 3000 children in Deniliquin alone who may need to be transported out due to this directive and during events such as the ute muster there may be up to 10000 children under 16 in the vicinity. The current system relies on parental transport to get their own children up to 200kms away to stitch up a cut hand – this is absolutely absurd. The fact also bears discussion in that we are supposed to wait for an ambulance to return a child with a cut hand from 200kms away while we die of a heart attack waiting for that same ambulance. Ambulance staff maintain they do not have enough staff and vehicles to pander to this transfer of children's minor injuries while life and death situations suffer. Local A & E staff are trained to tell parents that there is not a Doctor available for hours so it will be quicker to take the child yourself. Naïve parents fall for this and so have to organise the minding of other siblings while they take a child to Shepparton for stiches or to set a broken arm.

One overseas Doctor told me he felt inadequate had no support had no idea who to refer his patients to and lost all confidence in himself he says this is common among rural placements of overseas Doctors. He and many others left for the city as soon as they could which is disappointing as we welcome this diversification in our rural areas. Our Australian trained GP's also felt undermined by this ruling and some say they lost the confidence to work on children and that their basic operative & clinical skills declined. We wrote to the AMA regarding this and suggested that these Overseas trained doctors spend 2 years in a large city establishment where the line Doctor is at their elbow then after they understand the procedures and most importantly whom to refer patients to, they then spend 5 years in rural practice – most likely they will then remain and become an important contributor to our rural communities. The current system is a mess and a total failure for both sets of Doctors and most importantly the rural community who feel they are being treated poorly and severely disadvantaged in comparison to their city counterparts. It also adds further pressure to the existing Rural GPs as most new Overseas Doctors have no hospital visitation rights and cannot admit or treat patients or share weekend duty rosters in the hospital so that falls to the Australian trained GPS. This contributes nothing to alleviate the extra hours worked by VMO's, absolutely nothing is gained by placement of inadequately underqualified Medics in rural areas. Rural GPs will tell you that a third of their income is derived from consultation with children under 16. Its no wonder MLHD cannot attract Doctors to Rural Areas while they persist with this ridiculous ruling.

We no longer have access to adequate and timely autopsies. They were once done in Deniliquin. A multi-million-dollar morgue was built at Wagga Hospital and has as yet to be used again due to lack of qualified staff. Two years ago, during the height of summer there were 7 corpses stored in inappropriate cool storage around Deniliquin waiting to be sent to Newcastle for autopsies – if this had been made public to the relations of the deceased would have been outraged. Issues like this are commonplace yet no one from MLHD will acknowledge or attempt to rectify the situation. We

have pleaded and reasoned with MLHD administration for years only to have the issues repeatedly ignored and denied going as high as the Minister who has believed his administrators and not given the actual residents a fair hearing. We feel he either does not care, he is restricted by budgetary measures or he is lied to by MLHD Administrators.

Please refer to letter from Minister Hazzard assuring us we have adequate services after he received a lengthy and descriptive discourse on what had gone wrong in the system. His answer is not acceptable and shows little or no empathy for rural NSW residents. He was also warned that current practices will result in the death of a child. Please refer to attachment regarding my grandson's recent presentation at A & E after being knocked unconscious. His treatment falls way outside standard NSW guidelines.

I trust your inquiry identifies the discrepancies in Rural and Remote Health services in NSW when compared to Metropolitan or larger Regional areas. There are many & profoundly serious discrepancies, and this relates in a nutshell to being disadvantageous to our rural inhabitants. It need not have been the case had it been managed adequately with more input from actual rural inhabitants – instead, we have been gagged and muffled at every turn. There is no consultation on major matters and if there is it is between chosen "Yes Men" and MLHD – they do not consult fairly with the wider community. I have found we are not allowed to criticise or even offer up realistic solutions as someone higher up the MLHD food chain will veto them. On the whole my experience with MLHD administrators has been challenging I have given them the benefit of the doubt for over 6 years and unfortunately at every encounter have found them seriously lacking in genuine support of creating a better rural service, they are over focused on reigning in expenditure, yet they waste massive amounts of money on agency staff instead of permanent staff. Our hospital recently ran out of drip lines one night and a terminally ill cancer patient suffered undue pain until the following morning at 9am when the acting GM was seen sprinting across the road to the nearest Medical clinic to replenish the supply -this is an outrageous situation – what if there had been a major bus crash or an emergency caesarean. We are treated like second class citizens and our facility is currently no better than 3rd world category, yet we Send billions of dollars overseas to aide underprivileged countries while our rural women and children go without basic services. I know of no other facility that was once the size of the Deniliquin facility that has been downgraded and neglected to the extent ours has been - For the past 6 years I have asked MLHD administrators what is the 10year plan for Deniliquin and district and to date they have no answer, and no forward plan appears in any of the billion-dollar glossy pamphlets they provide annually.

My recommendation to repair the situation is as follows.

Reinstate local governance boards so we have a fair voice in what happens in our district the MLHD Board has no representation from this area so a lack of resources will continue to prevail.

Rebuild or Upgrade Deniliquin Hospital to adequately service the surrounding community with the COVID-19 predicament and its future problems like border closure addressed and, in the process, implement and incorporate a regional Oncology Centre with future access to radiation services, an Orthopaedic rehabilitation centre with a heated pool, a Mental Health Rehabilitation Facility and a Rural specialist training facility for both Doctors and Nurses. Rebuild adequately sized Child and Maternal services.

Instruct MLHD to replenish staffing shortfalls in allied health services & work with allied health services and not hinder and obstruct basic levels of service like reinstating our local community health service to be the phone intake service for its respective area not a receptionist in Wagga

250kms away who does not always answer the phone. Basic service like the phone should not be outsourced to Wagga it has been tried and is an unmitigated failure in providing prompt service for locals yet a winner in support of MLHD saying there is no one out here requiring service.

Staffing and hiring issues need to be addressed urgently MLHD has a disgraceful recruitment process and again I believe it suits them to not fix this issue – the example being the pathetic recruitment process that has taken 2 years in Oncology to find a replacement and 4 years in Maternity all the while not considering the needs of locals urgently requiring these services. Major incentives need to be offered to medical personal to come and work in rural areas they have twice the workload of their city peers, so they need to be remunerated accordingly

We need separate processes and guidelines different to other areas of NSW Health if we continue to be managed by Victorian Health services – directives aimed at Sydney & Wagga institutions like Oncology creditalisation are not applicable to Deniliquin area. We are 700kms from Sydney and 300 from Melbourne -its not rocket science that NSW guidelines may not suit this area.

Greater effort is required by NSW Health to address real issues in rural NSW as stated the pathways so far created have failed and a fresh and new approach needs to be taken to reinstate services that in the future may no longer be available to us in Victoria.

I have attached 5 documents those are

1 Minister Hazards response to concerns raised

2 consumers letters sent to Minister detailing inadequacies in service

3 Stats for children under 15 and transport stats – both sets of figures from 2018

4 Quick fix solutions sent to Minister Hazzard in 2018 – he never responded

5 Letter sent to MLHD executives in charge of current rebuild of A & E and proposed oncology services redevelopment

I would like to thank the Committee for asking for submissions and trying to address our rural, regional, and remote needs in NSW it is a fabulous step forward and I would hope in the process your committee could sit in Deniliquin to see for yourselves our situation and then make judgements based on firsthand observations