REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

CURRENT AND FUTURE PROVISION OF HEALTH SERVICES IN THE SOUTH-WEST SYDNEY GROWTH REGION

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Tuesday 14 July 2020

The Committee met at 9:20

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Emma Hurst
The Hon. Natasha Maclaren-Jones
The Hon. Walt Secord

PRESENT VIA TELECONFERENCE

The Hon. Wes Fang

The CHAIR: Welcome to the first hearing of Portfolio Committee No. 2 – Health inquiry into the current and future provision of health services in the South-West Sydney Growth Region. Through this inquiry the Committee will examine the adequacy and efficacy of existing health services in the region and consider the future health infrastructure needs, including the feasibility of a new hospital to service the region's growing population. Before I commence I would like to acknowledge the Gadigal people, who are the traditional custodians of this land. I would like to pay respects to Elders past and present of the Iora nation and extend that respect to other Aboriginals present and those who might be joining us on the internet.

Today's is the first of two hearings we plan to hold with respect to this inquiry. We will hear today from a range of witnesses including the local hospital medical staff councils; mental health, community service and primary health providers; unions; and health consumer representatives. Before we commence I would like to make some brief comments about the procedures for today's hearing. While Parliament House is closed to the public at this stage, today's hearing is a public hearing and it is being broadcast live via the Parliament's website. The transcript of today's hearing will be placed on the Committee's website when it becomes available.

I would remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing and so I urge witnesses to be careful about any comments you may make to the media or to others after you complete your evidence, as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the committee secretariat.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. Witnesses are advised that any messages should be delivered to the committee members through the committee staff. To aid the audibility of this hearing I remind committee members and witnesses to speak into the microphones. The room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. Finally, could everyone present please turn their mobile phones to silent for the duration of the hearing.

SETTHY UNG, Chair, Campbelltown and Camden (Macarthur) Hospital Medical Staff Council, affirmed and examined

KARUNA KEAT, Deputy Chair, Campbelltown and Camden (Macarthur) Hospital Medical Staff Council, affirmed and examined

RICHARD CRACKNELL, Director, Emergency Department Campbelltown and Camden Emergency, sworn and examined

The CHAIR: I will shortly invite a short opening statement from each of the two organisations. So that witnesses are aware, I want to make it clear that there are committee members who are present via teleconference—the Hon. Wes Fang is currently attending via teleconference and the Hon. Lou Amato may be dialling in shortly. Other than that, the committee members present will engage in questioning after you have made your respective opening statements. Would you like to make an opening statement?

Associate Professor CRACKNELL: Yes, thank you, Chair. Good morning. Thank you for the invitation to address the inquiry and for the opportunity that this inquiry represents to openly discuss issues regarding the planning and provision of health services in south-west Sydney. I am the emergency department [ED] director at Campbelltown-Camden and the executive clinical director for the two hospitals as well. I have been working for 23 years in south-west Sydney. Across that time I have had multiple roles. I have been the director of most of the emergency departments in south-west Sydney at various stages and held other representative positions in the hospital, the district and working with the Ministry of Health in many different roles and on different projects.

The ED at Campbelltown and Camden is a busy unit that is dedicated to the provision of health care to the large and growing local community in south-west Sydney. We certainly understand that hard work is an integral part of that process and we accept that challenge gladly. What we do not understand is the apparent inequity of resources that appear to be provided to different health services across the greater Sydney region. We are faced with the juxtapositions that are spelt out in many of the submissions that are before the inquiry. We have the highest ED presentations of any local health district [LHD], as mentioned in the Australasian College for Emergency Medicine [ACEM] submission, yet we have the lowest number of specialists. We are the second most populous LHD yet we have the lowest annualised budget. We have the highest growth rate and the highest birth rate but the lowest number of GPs per population.

We have the highest socio-economic disadvantage scores with south-west Sydney's local government areas [LGAs] being five of the bottom six for socio-economic disadvantage on the ranking and yet we have the lowest access to public and private hospital beds. We have the most mental health patients in emergency for over 24 hours—so staying in emergency for greater than a day as part of their care—and yet very low access to community health services. And so much more. It is our position that the current funding model that focuses on the provider and as such is the application of the activity based funding [ABF] reinforces and propagates the imbalance that was found in the historical block funding model. We are investing in developed services at the expense of growth and need for the developing services.

Based on the NSW Health figures in its submission, the gap between the activity based funding as it is currently applied and a population based funding is in the region of $1 billion a year—that is the gap that we are looking squarely at and that we are wanting the inquiry to address. Our workload in south-west Sydney is growing faster than in any other part of New South Wales. We do not have the capacity or the investment to keep up with this demand. I commend to you the submission from the Campbelltown and Camden Emergency Department Executive and those of other health services such as the medical staff councils from both Campbelltown and Liverpool. I hope that in our discussion we can shine some light on these issues and I look forward to providing further information to the inquiry this morning.

The CHAIR: Thank you, Associate Professor. That was a very helpful opening statement. I acknowledge the submission that has been received—a most detailed submission, thank you very much. It is submission No. 25 to this inquiry. As you would be aware, it has been published on the inquiry's website. Moving across to the Macarthur Medical Staff Council, would you like to make an opening statement, Dr Ung?

Dr UNG: Thank you. Honourable members of the upper House Committee, thank you for inviting the Macarthur Medical Staff Council [MSC] to contribute to this inquiry at this hearing. As a community of 300 senior medical officers based at Campbelltown and Camden hospitals who currently provide hospital-based services for the populations of Camden, Wollondilly and Campbelltown it is our privilege and duty to advocate on behalf of the community we serve. We provide the direct care for the established as well as the newer communities along

the growth corridor and wish for nothing more than to ensure health service developments are commensurate with the growth and needs of the region.

The MSC is grateful to the current Government for the stage two redevelopment capital investment thus far occurring at Campbelltown Hospital, but feels it still falls short of what the rapidly growing population of Macarthur will need over the next few decades. Already some of our services have seen higher activity than what was projected, with many departments constantly finding themselves out-resourced or have ever-increasing waiting times. Our recommendations to the Committee for the future of the region including the growth corridor are based on two key principles: firstly, providing the right foundation to allow service development locally by prioritising core services. These include, first, nuclear medicine, which is a fundamental cornerstone for all services to evolve and for Campbelltown Hospital to be re-categorised into a peer group more reflective of its size and activity; secondly, developing tertiary paediatric services to improve health outcomes, such as childhood obesity in order to prevent poor health in childhood and adolescence accumulating into a greater health burden for adult services to future manage. Thirdly, developing anatomical pathology services at Campbelltown Hospital to more accurately and efficiently detect cancers to allow earlier intervention.

The second key principle is ensuring equity of access and resourcing, as Associate Professor Cracknell was alluding to. All services at Campbelltown and Camden hospitals are under-resourced in comparison to counterpart units in other local health districts [LHDs]. Even taking into account proposed resourcing on completion of the stage two redevelopment, the additional bed-base is expected to still fall short of population needs. We also carry concerns the yet to be revealed workforce enhancements may still leave services inadequately resourced with nurses, allied health and corporate officers required. We merely request that the imbalance between the South Western Sydney Local Health District and other LHDs is corrected over time.

We request that no patient should need to travel long distances to access a service or procedure, especially if life or limb threatening or requiring frequent multidisciplinary support. Lastly, addressing one of the terms of reference of this Committee, although not specified in our submission, we wish for the Committee to know the Macarthur MSC believes another acute hospital near the new airport is not required. A stage three redevelopment at Camden and Campbelltown hospitals nearing completion of stage two, we feel, is a more effective solution. Thank you.

The CHAIR: Thank you very much for your very clear and precise opening statement. I acknowledge the submission from your organisation is No. 26 to the inquiry and it has been uploaded to the inquiry's webpage. We will commence questioning. We have representatives on this Committee from the Government, from the Opposition and from the crossbench. We will share the questions around and allow the questions to flow back and forth. Is that suitable?

Associate Professor CRACKNELL: That sounds great, thank you.

The Hon. WALT SECORD: Would you please convey back to your colleagues our appreciation of the work that you do, thank you. I want to put it in a bit of a contemporary situation. We apologise for the delay. A parliamentarian identified that he is from your region and he may have visited a local pharmacy that is the subject of testing. That is why we had a delay, because it is very important. What has been the impact of the announcement of the cluster on Camden and Campbelltown hospitals? What has been the impact on your staff?

Associate Professor CRACKNELL: With the cluster from Casula and the Crossroads and then down in Picton, what that means was that we were in a process of de-escalating our responses, so we had divided many of the parts of the hospital into hot and cold zones. We are working routinely in theatre scrubs and using personal protective equipment [PPE] and we are now having to halt that de-escalation—in fact, from today we are starting to move back up towards a higher level of preparedness in the hospital.

The Hon. WALT SECORD: Both hospitals?

Associate Professor CRACKNELL: Both hospitals, yes. Both hospitals operate under a single organisational structure. The emergency department [ED] is run by one group of staff. All of the services, if they are represented at both sides, are run by the single group.

The Hon. WALT SECORD: Have you noticed an increase in presentations at Campbelltown emergency department in the last few days?

Associate Professor CRACKNELL: Not in the last few days—in fact, the impact of the pandemic crisis has been to keep people away from acute hospitals. That is what we noticed in the first wave, people were, very appropriately, social distancing and being very cautious. We have not seen a change as yet, but if anything we would expect it to follow a similar pattern, where the low-acuity presentations drop down. That is a shift in the very dramatic long-term trend, which is enormous growth. We were expecting to go over 100,000 emergency

presentations this calendar year, following last year's trajectory. We are at 96,000 for the combined Macarthur emergency departments. Last year we were expecting to beat 100,000. This year we probably will not do that as part of the impact of the pandemic.

The Hon. WALT SECORD: What are medical staff telling you? With people waiting up to five hours for testing, how is that impacting on the provision of health services at the moment down there?

Associate Professor CRACKNELL: I think the impact of the pandemic very much was because we operate in a very lean organisation, so our ability to mobilise staff to address the added needs of the pandemic was tested to the limit. We are having to move staff from their normal roles to man the flu clinics, to go to the planning sessions. We are needing to do everything that we were doing under the pressure of numbers and then add the complexity factor of having to do that whilst wearing PPE. These are the major impacts of the pandemic, because thankfully for us the issue has not been large numbers of COVID cases. The issue has been all of the process required to detect and be vigilant for those cases, which are still, even with this second wave, very much a needle in the haystack when it comes to, if you are seeing 250 patients a day, one of those might have COVID. You have the complexity factor in your management of things like the ED.

The Hon. WALT SECORD: If cases are identified in south-west Sydney, are they going to be treated at Campbelltown or do they go to other hospitals? Do you have the ability to treat COVID at Campbelltown and Camden hospitals?

Associate Professor CRACKNELL: The plan was we had set up one of the surgical wards to provide for the isolation treatment of the suspected COVID patients, because in the initial phase there is no difference in your treatment of a suspected COVID and an actual COVID because you are approaching them in the same manner. One of the surgical wards had been dedicated to that. The only factor that allowed us to do that, because there is no spare capacity at Campbelltown and Camden, was the fact that simultaneously elective surgery had been cancelled for the same precautions. That gave us the capacity to manage COVID patients across the first wave. We are still in the process of judging what level of return to our initial precautions is justified for this cluster of cases at Picton.

The Hon. WALT SECORD: So when we get through the cluster down there, will there be a massive backlog of elective surgery cases? I see Dr Ung is nodding. Would you like to answer that?

Dr UNG: Yes.

The Hon. WALT SECORD: Dr Ung?

Dr UNG: I have not with me today but I have access to the waiting list for a lot of our proceduralists and they have big cohorts of patients, for example, who are waiting over 500 days.

The Hon. WALT SECORD: Five hundred days?

Dr UNG: Five hundred days for elective procedures.

The Hon. WALT SECORD: What procedures would that be?

Dr UNG: These include patients who are waiting for their colonoscopy screening for colon cancer.

The Hon. WALT SECORD: Five hundred days to wait to be screened for colon cancer.

Dr UNG: There is a group of 500-day wait list.

The Hon. WALT SECORD: Is that pre-COVID?

Dr UNG: That was accumulating pre-COVID.

The Hon. WALT SECORD: That is before COVID?

Dr UNG: But exacerbated by COVID.

The Hon. WALT SECORD: So how do you tell someone who thinks they may have colon cancer that they might have to wait 500 days to be screened?

Dr UNG: With a lot of difficulty and then you had that discussion about—this is unethical from our principles—if you have financial resources among your family or extended family, please seek them out to try to enter the private system, which often is housed in another facility outside of our Macarthur region, but those are the conversations that happen.

Associate Professor CRACKNELL: Sir, if I may—

The Hon. WALT SECORD: I was going to say, as medical professionals, what was the response when you found out that there was a COVID cluster down there yet 500-day waits for elective surgery? What is your response as a medical professional? Did you just throw your hands up in the air? What did you think?

Associate Professor CRACKNELL: So, if I may: The actual issues that concern us are that COVID has been a challenging exercise but in fact is a long way from the number one. Whilst it is our current day-to-day focus it is very much seen as a short-term challenge, which of course affects many areas. I think the things that concern us at a much greater level are just all the things that preceded and will follow from COVID. So the long wait list for surgery—when we were doing the planning for the current redevelopments, the figures were that 40 per cent of residents had to seek health care outside of our district for their inpatient needs. To say the other way round, 40 per cent of the inpatient bed days provided to patients in the Macarthur region had to be provided outside of South West Sydney for all sorts of reasons, whether it was capacity or specialty or other reasons. Four out of 10 patients that required inpatient care, that care was provided outside of South West Sydney.

The Hon. WALT SECORD: I am doing this anecdotally from memory: Would that be cases like children seeking specialist treatment, acute paediatric procedures? Would they have to travel?

Dr UNG: I can talk to that because I am also a senior paediatric clinician at the hospital. To this day, unfortunately, the child under 12 years of age who has the common condition of acute appendicitis often needs to travel more than 50 kilometres away to get a paediatric surgeon to look at them and to operate on them.

The Hon. WALT SECORD: So, what—you drive from Campbelltown to—

Dr UNG: To Randwick, yes.

The Hon. WALT SECORD: To Randwick?

Dr UNG: Yes.

Associate Professor CRACKNELL: To be treated for appendicitis. So the conditions we are talking about are common cardiac conditions, common oncology cancer conditions, childbirth and paediatric surgery. We are not talking about rare genetic conditions for whom there is one specialist available. We are talking about common, important, serious diseases that affect large numbers of the community.

The Hon. WALT SECORD: Procedures that you would normally expect at a hospital in other parts of Sydney and are provided in your region.

Dr UNG: Correct.

Associate Professor CRACKNELL: Correct.

The Hon. WALT SECORD: I have one last question.

The CHAIR: One last one, yes.

The Hon. WALT SECORD: The reason that I keep referring to COVID is that I understand your view is that eventually there will be an end point.

Associate Professor CRACKNELL: Yes.

The Hon. WALT SECORD: But it will impact massively on the way you guys rebuild, recover and restore. What has happened to all the patients for whom the pause button has been pushed right now? What is happening to them? If you have appendicitis, you have colon cancer, what are you doing if you live in Campbelltown now in the COVID period?

Associate Professor CRACKNELL: It is all of the conditions that do not have the immediate—so if your appendix ruptures, of course you are still receiving care and you are presenting and you have been transferred for your surgery. It is all the other diagnostic and other interventional processes we were discussing whilst waiting outside about your ability to have an EEG to detect epilepsy among other things or nerve conduction studies—all the things that do not have an immediate life threat that have just gone on pause and is now unfinished business. When those systems open back up, the wait list will be much longer and the balance between capacity and demand shifts in the wrong direction. The demand of course will even further strip capacity.

The Hon. WALT SECORD: With the indulgence of the Committee, I have just one last question. I just want to get a sense of this: What was the response—you seem to be very committed and dedicated medical professionals—discovering there was a cluster down there with all the problems in the health system down there? Was it the last thing you wanted to see? Did you just think, "Oh my God, this is not what we want to happen." What was your response as a medical professional?

Associate Professor CRACKNELL: It is certainly, you know, very disrupting because we are struggling to keep up with our day-to-day business without this additional burden of the complexity that the COVID pandemic adds into our health care.

The Hon. WALT SECORD: Dr Keat?

Dr KEAT: I suppose when you hear about it, you just deal with it. It is what we do on a daily basis anyway. It is just one other thing you have to deal with. We see patients with COVID-19 who are in ICU in Campbelltown. We do not transfer them out; we manage it with the resources. I suppose, if you look at the positives, even with this lack of funding, et cetera, which is all true, people still live, get out of hospital, get better acutely, but it is all relative. When clinicians hear this, okay we are going to have to deal with it and we will just have to compensate in other areas. You have to adopt that pragmatic approach if you work in South West, otherwise—

The Hon. WALT SECORD: But other doctors in Sydney do not have to do that.

Dr KEAT: True. But that is the reality.

The CHAIR: We need to move on. Thank you, doctor.

The Hon. EMMA HURST: Thank you, Chair, and thank you all for joining a see today. Dr Ung, you just mentioned before when the Hon. Walt Secord was asking about the length of travel for children and you mentioned 50 kilometres. In your submission you talked about the issue that some children need to travel up to an hour for emergency services. How does that affect patient outcome and even potential mortality rates?

Dr UNG: Fortunately, as one does when faced with challenges like that and having to deal with a system that clearly is disadvantaged, the clinicians rally together and develop resources to combat that. For example, we are the only level four paediatric service that has close observation beds, which are high dependency beds. For example, last week we had a seven year old who had already ruptured appendix. To put her in the back of the ambulance would be akin to writing her death certificate. So we begged our general surgeon to operate on her, which he did, and the whole unit looked after the one patient post operatively as an intensive care unit patient; not that that is standard of care, not that that is the norm, but that is what we rallied to do.

The Hon. EMMA HURST: So it sounds like the medical staff are expected to go above and beyond, which they are, but in very unfair circumstances.

Dr UNG: And it is not sustainable, correct.

The Hon. EMMA HURST: So it is not sustainable and if things get worse or increase with the number of patients, it could hit a point where you are not able to go above and beyond?

Dr UNG: Yes and, unfortunately, we are not unfamiliar with the Coroner's Court.

The Hon. EMMA HURST: You also see in your submission that at Campbelltown—

The CHAIR: Sorry, Deputy Chair. What was the point you are making there?

Dr UNG: The point I am making is that we are pushed and we unfortunately do not have successful rescues or positive outcomes every time we try to rise to meet this challenges.

The CHAIR: Right.

Dr UNG: And we have staff who are dragged through the Coroner's Court all because the outcome was poor and we were not able to provide the standard of care you expect in other parts of Sydney.

The CHAIR: Sorry, doctor: Does that happen frequently, or that is just something that you are aware of has happened?

Dr UNG: Over my last decade of service to Campbelltown, it has happened three times. I have been there as a support expert witness each time. We have lost a doctor each time.

Associate Professor CRACKNELL: Of course there is no acceptable incidence of appearing in the Coroner's Court to review the death of a child. We provide excellent care to the maximum of our capacity on a daily basis, but when you are trying to provide services that don't exist in the hospital, such as paediatric surgery, you don't have an expert in that field who can review at the bedside, every level of the process is delayed. The diagnosis can be delayed, then you have transport times and then reassessment times. This inevitably impacts upon patient outcomes.

The Hon. EMMA HURST: What are the priorities to try to make sure that doesn't happen again?

Dr UNG: We have been trying to negotiate with the Sydney children's health network to develop services at our facility. We acknowledge that the Hon. Peter Garling, QC, did make a recommendation in 2008 or 2009. Not that we think that in this day and age that is the right solution, but we have been trying to negotiate with the children's health network to create a solution to improve the level of servicing and safety for our children in Macarthur. Unfortunately, as I'm sure many of you know, the Sydney child health network has got issues amongst itself. We are the one capital city in Australia that still has two separate children's hospitals trying to work under one governance. That is despite the successes of other States like Victoria, where their Royal Children's Hospital has a comprehensive and consistent service for children of its State, at least.

The Hon. EMMA HURST: Professor Cracknell, you mentioned in your submission that Campbelltown Hospital has more mental health patients—and you mentioned it in your opening statement as well—spending greater than 24 hours in the emergency department per month than the entire Sydney health district has per year. This is a very concerning statistic. What needs to be done to fix that?

Associate Professor CRACKNELL: That is true. That information came to us from the whole-of-hospital program about a year ago. You can see in my submission that we have on average 54 patients per month that spend greater than 24 hours in emergency with a mental health presentation and diagnosis. This is someone who has presented with an exacerbation of illnesses like schizophrenia, severe depression or suicidality who are assessed and admitted to hospital and then 24 hours later are still in emergency. As mentioned in my submission, this statistic minimises because you get counted once. Most of these patients will spend several days in emergency. We will still be caring for someone who has presented with depression or suicidality on day four since their presentation in emergency in that very noisy, chaotic environment that is far from therapeutic and far from what they need. We need greater access to mental health beds—inpatient beds—and greater access particularly to the high dependency mental health beds.

We need more mental health clinicians. We still have parts of the week where there is no psychiatric-trained registrar available to review patients in emergency. There are still parts of the week where there is no-one on service, no-one in the hospital who can come and review patients in emergency. Simultaneously, we need to develop our community services. I understand that in general there is a long discussion regarding community primary preventative care versus hospital-based care. Unfortunately, that binary doesn't work in an area like south-west Sydney because neither services are developed enough. We need to develop our community-based services to prevent and manage exacerbations when they can, but we also have a desperate need for our inpatient services as well.

The Hon. EMMA HURST: You also mentioned a particular concern about Camden Hospital, which has been underfunded with no substantial capital investment despite a 383 per cent growth in population. Why do you think there has been a failure to invest in Camden Hospital? What impact do you think this will have on the health services accessible?

Associate Professor CRACKNELL: I acknowledge the discussion around Camden is incredibly complex. Over the previous two decades, a lot of the discussion has been regarding how to manage low-volume units. It was a relatively small population and it was the old model of the hospital doing everything—childbirth, surgery, emergency, everything. I accept that the decisions over the last 20 years have been driven by health outcome concerns to make sure we don't have low-volume units operating at places like Camden. It has been moved into a predominantly rehab, palliative care-type inpatient model with a small emergency department that we run in the building as well. But that is no longer the pattern that is going forward.

The projection is that Camden LGA will be the second most populous in the south-west Sydney region at the end of this planning envelope, so it desperately needs investment. It's not going to be met purely by what is already planned for Campbelltown. We need to develop the Camden site, or somewhere near there as well, otherwise all of these patients—all of this community—will be forced to travel either to Campbelltown or further just to receive basic health care. There is a desperate need.

The Hon. WALT SECORD: Did you say that people with acute mental health issues were waiting up to four to five days in the emergency department?

Associate Professor CRACKNELL: Our record is 100 hours for a patient from time of admission in emergency before they left emergency. Greater than 50 per cent of patients admitted to the mental health services at Campbelltown Hospital will go home from the emergency department having never seen the inside of the mental health unit.

The Hon. WALT SECORD: So people who are suffering incidents of schizophrenia and suicidal people spend four to five days not getting a bed and being sent home?

Associate Professor CRACKNELL: Eventually they will be treated to some level in that time, of course, but they will be discharged from—

The Hon. WALT SECORD: It's not a reflection on the treatment.

Associate Professor CRACKNELL: I know, I accept that.

Ms CATE FAEHRMANN: I wanted to go back to when you were talking about certain deaths and coroner's courts and what have you. Are you suggesting that because of the lack of resources and funding discrepancies, if you like, this is costing lives within Campbelltown and Camden hospitals? And that if these patients were somehow treated at different hospitals with different levels of resources, they may not have died?

Associate Professor CRACKNELL: I have been involved in a number of cases where our inability to get an ultrasound—at Campbelltown, like almost all of the hospitals in south-west Sydney, if it is after 4.00 p.m. on a weekday you cannot get an ultrasound in the hospital. The lack of ultrasound services, which is one of our prime diagnostic tools for conditions such as appendicitis or intussusception, we don't have that information.

Ms CATE FAEHRMANN: Is that because there is one person who does the ultrasound and they leave at four o'clock? What is the four o'clock cut-off for?

Associate Professor CRACKNELL: The imaging service is only funded to provide business hours ultrasound services.

Ms CATE FAEHRMANN: So it shuts down but it is still there?

Associate Professor CRACKNELL: Well, there's an ultrasound machine in a room with the light out.

Ms CATE FAEHRMANN: But it is only funded until four o'clock?

Associate Professor CRACKNELL: Yes, Monday to Friday. It is something that is driving things such as point-of-care ultrasound, where clinicians train themselves how to use ultrasounds to try to work around these issues. If you combine poor access to the diagnostic imaging service with a lack of access to a paediatric surgical registrar, you then have a pattern that will inevitably lead to poorer or delayed outcomes, and occasionally—and these are still thankfully rare—tragic circumstances that will result in death.

The Hon. WALT SECORD: Do you want to add something, Dr Keat?

Dr KEAT: I think Richard Cracknell is right, it comes down to funding. Ultrasonographers are very expensive. They get paid more privately after hours. You need a good ultrasonographer. They are trained. They are very hard to keep in south-west Sydney. Even if you do train one, they can leave. It is an ongoing issue. If you do train someone up, you lose them and you lose the funding as well.

Ms CATE FAEHRMANN: Okay. So just to go on this particular issue a little bit more—and it is frustrating that we do not have you all here for longer because I feel like we could be asking you questions for the whole day, given what has already been revealed—what are the ramifications? What is a practical example of not having ultrasound services available after four o'clock? Was there a particular example you were referring to, Associate Professor Cracknell, that you want to expand upon?

Associate Professor CRACKNELL: This is a daily occurrence. We have as part of our daily management plans a sort of a mental clock that works so we try to understand, "What time of the day is it? What services are available at this time of day? Oh, it's three o'clock now. We're never going to get an ultrasound so how are we then going to manage?" What that means will be a number of things.

The Hon. WALT SECORD: So what do you do?

The CHAIR: Walt, he is explaining.

The Hon. WALT SECORD: It is extraordinary!

Associate Professor CRACKNELL: You may delay the imaging.

Ms CATE FAEHRMANN: Flabbergasted! Gobsmacked!

Associate Professor CRACKNELL: You may have to transfer to another hospital just to get this basic investigation so we are one of the biggest exporters of children, particularly, into the various children's hospitals for this type of diagnostic assessment. You might shift your modality. So you might move a child from having an ultrasound into having a computerised tomography [CT] scan, which includes radiation exposure and contains another risk to that child. Those are the types of decisions we have to make on a daily basis, trying to work around the lack of that resource being available.

The Hon. WALT SECORD: And you have been there 23 years.

Associate Professor CRACKNELL: Yes.

Ms CATE FAEHRMANN: I have a lot of questions. That is okay. I think we are all champing at the bit. In submission No. 25 you talk about the fact that with the stage two redevelopment. It is these hospital avoidance measures that I want to focus on. There is some part of the submission that says:

> … during the redevelopment planning process the allocated number of ED treatment spaces (based on population and evidence) was reduced by 8%. The rationale for this reduction was the expectation of large scale—

And you even have inverted commas here—

> 'hospital avoidance' measures.

What does that mean?

Associate Professor CRACKNELL: This is details from our current planning process, where population projections said we were going to require this number of beds based on population and then the planning process says, "Well, we will try to get the number of people coming to emergency down." Originally the discussion was 15 per cent. We said, "Well, that's impossible." And then it was settled on 8 per cent again. There is no example of anything other than a pandemic that has resulted in that volume of patient drop into an emergency department in the developed world.

There are numerous very boutique examples of small scale interventions that divert some chronic obstructive pulmonary disease [COPD] patients away from needing to be hospitalised quite as often but not that is going to impact upon 8 per cent of our presentations there. And I can understand the drivers because in the planning inside south-west Sydney we have so many needs. We want to spread the $630 million that was stage two as far as possible so we are trying to do everything because we have this pocket of money. So I do not begrudge the motivation but the outcome is that everything gets trimmed again and so we once again go into the next stage so lean as to be behind before we start.

Ms CATE FAEHRMANN: Thank you. A very helpful graph on this page which shows the actual presentations. In 2019 the actual—

Associate Professor CRACKNELL: That is our 96,000—

Ms CATE FAEHRMANN: Yes. The actual presentations are ballooning out already in 2019.

Associate Professor CRACKNELL: Yes, already.

Ms CATE FAEHRMANN: But then you are somehow supposed to get the actual presentations in 2020 and 2021 below the adjusted projection.

Associate Professor CRACKNELL: Yes. That will not happen.

Ms CATE FAEHRMANN: I do not know what you call that.

Associate Professor CRACKNELL: Wishful thinking.

Ms CATE FAEHRMANN: To say the least. Another question was around the 500 days wait for colon cancer patients. I am sure there are many other examples. Can you give an example of a comparative for the eastern suburbs and north shore hospitals and what would be the situation there for that same patient?

Dr UNG: Yes. I have been privy to receive a couple of nights ago the minutes of a Sydney-wide meeting of gastroenterologists and a report that reveals each of their units' wait times and projected wait times, even considering COVID. Most if not all of the units report that they will catch up with their wait lists by the end of July. South-west Sydney is the only health district that will still have patients on the wait list, and some up to 500 days still waiting.

Ms CATE FAEHRMANN: I feel like we are hearing what seems to be a certain group or part of Sydney being treated blatantly as second-class citizens.

Dr UNG: Correct. Thank you for the terminology.

Ms CATE FAEHRMANN: If you are saying that other hospitals in potentially wealthier areas but also that receive more government funding for their hospitals and their wait list is—you are talking about a discrepancy of 400 per cent, 500 per cent or something if you work that out in waiting days.

Associate Professor CRACKNELL: The Western Sydney Regional Information and Research Service [WESTIR] report that was commissioned by the Liverpool Hospital Medical Staff Council goes into a lot of these

details. It shows the compounding effects of the lack of the public hospital services as they stand but then the compounding effects of lack of community services such as general practitioners and also the very low rates of private health insurance. I am confident anyone here in this room, had they a need for an intervention, would be able to sort it out within a matter of weeks between the various public and private services that are available to us all.

But if you do not have private insurance, if you have all of the precursors to health inequity such as being from a culturally and linguistically diverse background, poor health literacy, low level of income, high socio-economic disadvantage, then poor access to a GP and community services and long hospital wait lists, it is a perfect storm for poor health outcomes. We challenge the notion that we should continue to fund based on a provider basis, which is essentially the way we apply the activity based funding. It funds the people who are providing the service, not the area where the patient is, so it continues to build on the existing services which are based back in historical Sydney that was clustered around the cove, where everything was centralised. But I say in a few of my things it may be naive and simplistic but the centre of Sydney in its demographics, its population, is Parramatta and yet what is west and south-west of Parramatta is very different to what is east of Parramatta.

Ms CATE FAEHRMANN: So wouldn't common sense dictate everything you have just said in terms of the challenges faced by the south-west Sydney demographic and health problems that you should be getting more funding to deal with these issues rather than less?

Associate Professor CRACKNELL: Yes.

Dr UNG: Correct.

Associate Professor CRACKNELL: That is right. The additional challenges mean there should be an affirmative action type approach where the health service is compensated for the other challenges that it faces.

The Hon. NATASHA MACLAREN-JONES: Thank you for coming today and also, as a colleague said before, thank you very much for all the work that you are doing. I just want to clarify a couple of things that you said earlier. There was a comment made about childbirth and that you were not able to do childbirths at the hospital. I just want to clarify whether you were saying complicated births or all childbirths.

Associate Professor CRACKNELL: Oh, no, sorry. I apologise if I gave that impression. Campbelltown Hospital has actually one of the highest numbers of childbirth of any hospital. We have a very high birth rate and a very high hospital rate. But the capacity of the maternity services is pushed beyond its ability to manage and so there are active programs trying to work out how to farm out people from different regions to push further into the south-west of Sydney, to push into the north of Sydney. But the number of beds and midwives for the births is not keeping up and is not equitable with the same ratios in the eastern and northern parts of Sydney.

The Hon. NATASHA MACLAREN-JONES: The other one I want to clarify is in relation to staff numbers. Comparatively the number of staff is less than any other hospital, although looking at another submission, it shows that south-western Sydney actually has had a 16 per cent increase in staff over the last four years, which is the highest of any local district. I wanted to clarify why you think that south-western Sydney has had less staff numbers, when the figures show it has actually had a 16 per cent increase.

Associate Professor CRACKNELL: Absolutely. If you take the relative approach of saying where you have a growth of this per cent, what that does not acknowledge or it hides is the base from which we have come. The focus in lots of the NSW Health submission refers to growth or increases given in per cent values. It does not refer to the volume of the quantum compared to the demand. The overall staffing numbers in one of the NSW Health graphs makes it look like it is the same. However, the difference in the population base and the demands in the different health services are so vastly different that it should not be the same. Affirmative action to meet the needs of the population means that south-west Sydney and western Sydney should have far more staff than anyone in the central or south-eastern districts.

The Hon. NATASHA MACLAREN-JONES: I want to clarify, when you have the time to look at the graph, that it shows that in 2015 there were 9,412 staff employed and in June 2019 there were 10,917, an increase of 1,505 staff. This is compared to the east, which only had an increase 792, and compared to north, which has actually had a decrease because of the change with the new hospital. Sydney had only 902. It shows that south-western Sydney has had a significant number more staff employed in the hospitals. I wanted to clarify that and say it is a good opportunity to have a look at the comparative numbers of all the hospitals.

I want to ask about mental health services. I note that for your area $6.5 billion is being invested into the hospitals and there will be the second redevelopment, which will focus on acute mental health services. Do you feel that the plans and what is being projected to be filled will service the needs that you have?

Dr UNG: If I may, firstly, we are very grateful for the stage two redevelopment, particularly investing in mental health capital works. However, we are yet to the see the recurrent expenditure to actually staff this whole tower of a mental health building. I am quite pessimistic about the capacity to recruit to staff this building as we already have shortfalls in profile and we struggle to recruit on a day-to-day basis.

The Hon. NATASHA MACLAREN-JONES: What strategies are you implementing to recruit staff now? What would you plan to do in the future?

Dr UNG: I think that is a question probably better answered by our chief executive, when you meet her later. As a medical staff council, we spend a lot of time trying to encourage our colleagues in the various specialties to come and work in the Macarthur region. Unfortunately, the economic forces are such that, if there is any vacancy or deficiency in inner Sydney or the east, a lot of doctors will stay living and working in the east.

Associate Professor CRACKNELL: If I may, it is a tragically recurrent experience that when we have had people who have come to us from other hospitals, they express a level of dismay regarding the workload and the lack of other resources that they are used to. People vote with their feet. We cannot rely on a sense on altruism to staff the hospitals in the needs areas, but so often that is what we are expecting of our senior staff.

Dr KEAT: I suppose psychiatry senior staff is a prime example of this in terms of recruitment. At any point in time, for senior staff in psychiatry making decisions across the district, we are a third short. Recruitment is an ongoing issue in the south-west. In terms of strategies that the district and clinicians are doing, apart from recruitment, western Sydney has a medical school at Campbelltown. We may not get the numbers but over the years we will potentially get some coming back as psychiatrists et cetera.

We have looked at visiting medical officer [VMO] contracts as opposed to staff specialist contracts to try to recruit, but if you were to look at the staffing ratios and the turnover of senior staff in psychiatry, as a prime example, they will not come here because of the workload and they do not have the support of senior registrars. They go, "Why would I do this? I'll go to a private practice where I'll get paid more, have less stress. I don't have to deal with the acute workload and the burden. Or I'll go east of here and get a cushy job. I'll see the patients, I'll manage them, but I don't have to deal with everything else." Registrars are a prime example in terms of providing support to senior staff. They do the dog work in any hospital. They are key and if you do not have the trained staff and trained registrars, it is easy, especially in psychiatry, to go east.

Associate Professor CRACKNELL: To illustrate finally on this point, all of next week I am interviewing via Zoom or some video platform doctors internationally to work in the emergency department at Campbelltown Camden because I cannot attract enough local graduates to fill more than 20 per cent of the positions available in the ED, so 80 per cent of the middle-grade staff at Campbelltown Camden are international medical graduates we have had to actively recruit from overseas.

The Hon. WALT SECORD: From where?

Associate Professor CRACKNELL: Sri Lanka predominantly.

The Hon. NATASHA MACLAREN-JONES: The next thing I want to mention is the increase in telehealth, particularly with the pandemic. I am interested to get your views on the more integrated healthcare delivery working with local community services and others. I have read about the integrated health neighbourhood strategy, which is quite predominant in the south-western Sydney area. I want to hear your views in relation to how that is working.

Dr KEAT: Telehealth means greater health. It is something that I have been ranting about for about 10 years. COVID-19 has brought it about in terms of the lack of ICT support to allow this to happen. Telehealth is not everything. It is different to seeing a patient in person, but it helps in terms of COVID-19. We did not have the infrastructure and support from ICT to allow these sorts of things to happen. We did not have video monitors or headsets.

The Hon. NATASHA MACLAREN-JONES: Do you have all of that now?

Dr KEAT: We are getting it, but there has been a lot of pressure.

The Hon. NATASHA MACLAREN-JONES: Moving forward, with all of that being rolled out, what is the future of that?

Associate Professor CRACKNELL: I think that there absolutely has been a quantum leap forward in embracing aspects of telehealth in areas that were just aspirations only a few months ago. That has been great, particularly in outpatients and follow-ups and some of the inter-hospital reviews of patients. All of that has taken a big step forward. I still think that its applicability relates far more to the long-term chronic management of patients. It is hard to assess acute health needs and you cannot intervene very easily over the video link.

Processes such as the health neighbourhood and collaborations between the LHD and primary health networks [PHN] are certainly things to be greatly applauded. That type of collaboration is very evident in the south-west and it is excellent. It tries to bring forward the principles of integrated care where we focus health care around the patient. I say that to draw it in contrast with our funding model, which still, despite integrated care being one of the major platforms of the health care we are aspiring to as we do planning, we are funding providers; we are not actually focusing the funding where the patient is. I think that is a historical flaw and we have not yet broken that mould. Activity-based funding was supposed to be the great leveller, but it ended up being treated with so many caveats and complexity factors and other loadings that in the end it resembles what it replaced, which was the historical block funding.

The CHAIR: I agree with Ms Cate Faehrmann; we have probably underdone the time allocation for you. We have gone beyond what we had said—it was a late start—but there is still much we would like to cover. I think that will be reflected in the questions on notice that will probably arise from members reading the evidence today, which has been particularly useful to set the framework for this inquiry. On behalf of the Committee, I thank you all for coming along. The secretariat will liaise with you respectively in terms of the questions on notice and work to a 21-day timetable to turn those around. Thank you so much for coming along today in what is a difficult set of circumstances we now face in south-western Sydney with respect to the matter of the COVID emergency. We thank you generally for the outstanding work that you do on behalf of the citizens of New South Wales who live in that part of Sydney. We wish you all very well for the challenges ahead with respect to COVID.

Associate Professor CRACKNELL: Thank you, Chair. We welcome any further questions.

(The witnesses withdrew.)

(Short adjournment)

GARRY A. HELPRIN, Head of Department of Medicine, Fairfield Hospital, sworn and examined

MIRIAM LEVY, Chair, Liverpool Hospital Medical Staff Council, affirmed and examined

AMY LAWTON, Author, *Condition Critical*, Western Sydney Regional Information and Research Service, affirmed and examined

The CHAIR: There will now be an opportunity for opening statements. Is there a single opening statement?

Associate Professor LEVY: We haven't spoken to each other. I certainly have one.

Dr HELPRIN: I have got one as well.

The CHAIR: We will be flexible in that regard.

Associate Professor LEVY: I am sorry about that, we did not appreciate that we needed to have one.

The CHAIR: That is okay, we can work with that. Ms Lawton, do you have an opening statement as well that you would like to make?

Ms LAWTON: Yes, I have one prepared.

Dr HELPRIN: Fairfield Hospital is a 220-bed university teaching hospital in south-west Sydney. There is a highly diverse multicultural community. The main facilities are acute general medicine, coronary care, intensive care—but not at a high level—general surgery, orthopaedic surgery, obstetrics and paediatrics—but not at a high level—rehabilitation and geriatrics. There is a busy emergency department with approximately 35,000 attendances per year, of which 20 per cent are children. There are 10,000 ambulance presentations per year to Fairfield Hospital. We are getting busier and busier with lots of complex patients and increasing patient expectations. Patients have multiple illnesses, that is comorbidities. Despite this heavy workload, we have had virtually no enhancements. We have heard about Campbelltown Hospital having a $600 million enhancement, Liverpool Hospital having a $700 million enhancement and Bankstown Hospital being rebuilt. Even Bowral, which only has 13,000 people, has had a $50 million upgrade, but we have had virtually nothing—only $7 million for the emergency department. We have only had 1 per cent of what these other hospitals have had despite being extremely busy.

We feel that we are very much left behind. We have no MRI. We have no functioning outpatient clinics. We need separate intensive care and coronary care facilities. We need conference and educational facilities. We need more medical staff, such as registrars, in training programs. We need extra operating theatres—we need a whole new building. Even if someone gave us $3 million for an MRI scanner, there is nowhere to put it—there is no building. There are deficiencies in a number of areas—for example, no advanced trainees in medicine and paediatrics and no anaesthetic registrar after about midnight. Operating theatre equipment is old and needs upgrading. As I mentioned, outpatient facilities are virtually non-existent. We need an urgent plan. We need a vision. We need a new building with a car park—we suggest about $150 million for this. Finally, our kidney specialists have wanted me to mention to the Committee that patients with kidney failure have been cut back on their dialysis treatment from three times a week, which is the normal, to two times a week.

Associate Professor LEVY: Thanks for the opportunity to participate in this submission as a witness. I am the chairperson of the Liverpool Hospital medical staff council. I am head of the Department of Gastroenterology and Liver at Liverpool. I am a first-class honours graduate from the University of New South Wales. I have a PhD from the University of Sydney. Liverpool Hospital is full of high-calibre staff, outstanding departments with nationally and internationally recognised experts in clinical care and research. We educate large numbers of medical students from two universities and I am proud to work in south-western Sydney. We choose to work in this area and we are committed to serve the underserved. We are egalitarian and support NSW Health's equity principles that good health care should be available, within reason, near to where you live.

Our submission reflects a decades-long frustration about a great inequity in resources to support our work—inequity between ours and other local health districts. This we know through all the connections in medicine, junior and senior staff, who work across all the hospitals. We can't deliver unless the Government is genuinely behind us. To achieve an objective assessment, we commissioned Western Sydney Regional Information and Research Service [WESTIR] to investigate health care resource allocation. There is much in the report that was submitted. One example is that we get a much lower price per national weighted activity unit [NWAU], meaning for the same work we get less money. There are many reasons why we should get more money per NWAU to adjust for complexities in caring for patients. Because of this less funding, we actually all have to work beyond our capacity.

Our submission provides many examples that I listed—just examples of the funding consequences of the funding deficit. This is actually unjust. As the population grows it will become unsafe. Bricks and mortar will not solve the problem. A new aerotropolis hospital in the future will not fix this problem. We need increases in our operating budget. We need bums on seats, we need hands on deck; in other words, we need money for FTEs—doctors, nurses, allied health staff in admin, finance, pharmacists, radiographers and interpreters—people who can actually do the work,

The Western Sydney Regional Information and Research Service [WESTIR] report triggered our own root cause analysis to determine why on earth this ongoing inequity continues. It stems from a flawed original assumption in the activity based funding [ABF] model that essentially has us screwed. At the beginning of ABF, all local health districts [LHDs] had to agree that their base funding was sufficient and thereafter further money would come according to growth. But our base funding was not sufficient. We were a district hospital. That meant that to become the tertiary hospital that we are today, all funding increases that should have for our growth we had to dedicate to actually build elements of a tertiary hospital—a genetics department and non-invasive respiratory ventilation.

Money poured into specific things to build the elements of a tertiary hospital. That means, for example, that in the last 18 months, our Clinical Council has debated. We have robust debates about what the priorities are for funding enhancements as they come, and we decide on a triage of the most urgent priorities that should be funded. But for the last 18 months none can get funded at all. There is just no money left after building the units of the different health services.

I hope there is a will to solve this construct error. Funding for a hospital to develop itself and change must need to be supported separately from this ABF growth funding model. Last year our district received 0.1 per cent more than the State average. Money was spent, as I said, on developing a few specific services that other hospitals have had for decades. As said, there was nothing left to support the work. Unfortunately, I really worry that old school attitudes drive this inequity.

The funding inequity was recently defended by a statement that money does not come to South Western Sydney as it flows to the patients and they vote with their feet and want to go to where experts are in town. Would sick people really want to travel 40 kilometres away from home, family, friends and work to have chemotherapy, major surgery or to consult about a serious medical problem? It is just not true. We have expertise to treat them and I do not think there is any evidence that they do not want to be treated locally. In my opinion this justification serves only the status quo. If this attitude could be changed I believe we could find solutions. I hope I have been clear. This is complex stuff. I am obviously happy to answer any questions. Thank you.

The CHAIR: Thank you, Professor. That was a very helpful opening statement, which will set up the questioning that will follow.

Ms LAWTON: Good morning, I am one of the authors of the 2018 report, *Critical condition: an insight into the pressures that impact Liverpool Hospital staff in servicing the needs of the community,* submitted on behalf of the Liverpool Hospital Medical Staff Council.This morning I would like to reiterate some of the report's findings that align with the terms of reference and hopefully I will be able to support my colleagues here this morning. The south-west Sydney region is home to over a million residents as of 2016 and it has been growing by 10 per cent since 2011. It is expected to grow to 1.4 million residents by 2036, with large growth particularly in older age groups.

When we did the report and compared it to other local health districts [LHDs] in Greater Sydney, the south-west Sydney population experiences greater challenges on basically every demographic indicator that we examined. This included high socio-economic disadvantage, unemployment, low levels of English proficiency, high rates of humanitarian settlement, higher rates of disability and need for assistance, higher birth rates and rates of lifestyle-related diseases. That is just some of them. These factors obviously make it more difficult and costly for the healthcare system and to meet ongoing community need.

The report also highlighted that the South Western Sydney Local Health District [SWSLHD] has one of the lowest annual expense budgets per resident in the LHD and also when compared to other regions. The report also showed that while the LHD can provide a cost-effective service, it often does not have the funding to deal with complex needs for the residents. As highlighted in the submission the relative funding is often used to provide money for base services as opposed to growth. We suspect that there would be very little funding to manage current growth as opposed to future growth as well.

The report also showed that the SWSLHD had a lower number of GPs, resident medical officers and select specialists per 10,000 residents when compared to other LHDs in Greater Sydney. This is also exacerbated by a generally lower number of healthcare services compared to inner city areas, lower levels of private beds and

private health insurance, which also increase reliance on the public health system. Thank you for the opportunity to speak. I also welcome any questions that may assist.

The CHAIR: Thank you, Ms Lawton. Thank you for those excellent opening statements. Can I just confirm this that with respect to submissions that have been received—of course, yours have been sent and received—and with respect to the Fairfield Hospital Medical Staff Council, the submission is No. 37 and that has been incorporated as a submission to the inquiry and is on the inquiry's web page. With respect to the Liverpool Hospital Medical Staff Council, which is submission No. 10 and is a very detailed one, for which I thank you, I indicate that that also has been incorporated and forms part of the evidence given to the inquiry. That is accessible via the inquiry's web page. With respect to the very detailed report co-written by Ms Lawton, the title of that is *Critical condition: an insight into the pressures that impact Liverpool Hospital staff in servicing the needs of the community* and is dated December 2018, it is an attachment to submission No. 25 to the inquiry. By being an attachment, it forms part of the evidence as well and is available through the inquiry's web page. I thank you all for that.

If you are agreeable, we will share the questions around. We have members on the Committee from the Opposition, crossbench and Government. If you are agreeable we would like to share the questions around and do that in the time available. Given that we started a bit later, if it is okay with you and you have the time we will run over it a bit as well to make sure that we get maximum time. We will begin with questions from the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Chair. Dr Helprin, you mentioned at the very last segment of your introductory remarks dialysis. What did you say about dialysis and the state of dialysis at Fairfield?

Dr HELPRIN: I sent out a consultation email to my colleagues about anything they would like to mention to the inquiry and our senior renal physician rang me up and said that his dialysis patients, the ones with end stage kidney disease who are on kidney machines, normally get dialysis three times a week and it has been cut back to twice a week because of a lack of resources. He asked that the Committee be made aware of this.

The Hon. WALT SECORD: I do have some knowledge of this because before my father died he was on kidney dialysis. How many times a week should you receive kidney dialysis if you are at the stage—

Dr HELPRIN: Well, the haemodialysis, which is done by the blood route, is done three times a week, normally.

The Hon. WALT SECORD: So what happens if you go down to two?

Dr HELPRIN: Well, you will get a less quality dialysis. Dialysis does not completely give you back normal functions. It is not like a heart transplant where you get a new heart and you are functioning normally. Dialysis just takes the edge off kidney failure. Dialysis removes the toxins. People with dialysis are borderline chronically ill. They are still anaemic, they still have urea toxins there, they still have disturbances of bone metabolism, so their quality of life and probably their medical problems will not go in the right direction, I think, if you are only having once a week dialysis.

Associate Professor LEVY: This is a district-wide problem. In our submission we also referred to that there are at least 50 patients since 2016—up to 50 patients at any one time—who are having rationing of their haemodialysis, which is what it is called. That does happen in other places like Pakistan and other developing countries but it is not normal practice and there is an additional number of patients who, to get three dialysis sessions, have to travel to other districts.

The Hon. WALT SECORD: So you are saying that there is rationing of dialysis and this occurs in Pakistan. Where do they go if they have to travel 40 kilometres? Do they have to come to the east to Sydney?

Associate Professor LEVY: To Prince Alfred or Concord where they have a lot more resources.

The Hon. WALT SECORD: What is the reaction from patients when you tell them?

Associate Professor LEVY: It is terrible. Can you imagine? It is horrific.

The Hon. WALT SECORD: I know.

Associate Professor LEVY: The renal department has been struggling against this. There have been little temporary stopgaps—for example, commissioning dialysis beds in private facilities temporarily. It is an emerging problem as the patient population ages. The demands of dialysis are extraordinary but it is disproportionately felt in our local health district. There is just no money and we will not go over budget. Despite endless stories like this we never go over budget.

The Hon. WALT SECORD: What do you mean by that?

Associate Professor LEVY: What I mean by that is that I understand that other health districts sometimes when needs become critical have gone over budget to meet a critical patient need. I am not advocating that we solve this by going over budget but it is extremely difficult to work when you have to ration health care against what you think is appropriate.

The Hon. WALT SECORD: You are rationing—

Associate Professor LEVY: The renal physicians—that is an example.

The Hon. WALT SECORD: In what other areas of health care in your hospitals are you being forced to ration care?

Associate Professor LEVY: We function at probably about 105 per cent capacity all the time and the implication of that is that we are full and that therefore trickles down to the emergency department. Doctors in the emergency department have to sometimes assess patients with chest pain in the waiting room. We have had patients who have—I mean, there are so many stories. The thing about individual stories is there are individual stories everywhere. When you drill down to individual stories it can get really murky and then they can be unpicked and defended so I am a bit reluctant to go down the individual story route to evidence the problem.

The Hon. WALT SECORD: Okay. But I was very shocked and very surprised when you actually said—and I wrote it down—"We are being 'screwed'." I was surprised that a professor, head of the medical staff council, would use such language dripping with frustration.

Associate Professor LEVY: Yeah.

The Hon. WALT SECORD: So can you—

Associate Professor LEVY: Can you imagine what it is like to have—we are really busy. Because of the lack of general practitioners and specialists in the community a specialist at Liverpool Hospital has to deliver a huge amount more in the outpatient let alone the inpatient sphere to try to keep people well and out of hospital. When we work really hard, when we spend the time to turn up at our clinical councils in good faith and debate which of the priorities should be funded—and we debate robustly because we know that there is not much money. But, for example, stroke work has increased extraordinarily.

Interventional radiology, which is an incredible service at Liverpool—they do things like biopsy lumps that you can see but you cannot get to diagnose a cancer, after which you can get your chemotherapy—there are such delays to get a biopsy in our district so we debate, "Should we get a second room open in interventional radiology or is it more important to get neurologists or shall we get non-invasive ventilation?" But actually to end up with a list of priorities and be told, "This year we are just going to have a consolidation year because we do not have any money," and, "Don't worry. We are going to look at what we do and try to work out where we can save money and maybe then we can fund the things that you say you need," it is incredible to work in that environment when we are all specialists. We grow up together. Within gastroenterology I know the specialists in my specialty and our junior doctors move in their training from one hospital to another, so we know, and we know that we are grossly underfunded at Liverpool. Heaven help them at Fairfield. And when you talk about a 16 per cent increase, you asked Richard Cracknell, how does that—

The Hon. WALT SECORD: I did not ask—it was the Government members.

Associate Professor LEVY: How does it happen that you have gone up in your staff? That sounds like you are doing okay but it comes back to this core concept of if you do not have—when I started at Liverpool there was no gastroenterology service and I came from hospitals where there were gastroenterology departments with six specialists. If you then say, "Well, we are not a general hospital any more. We want to have sub-specialty departments," which is appropriate, you need to employ a number of specialists all at once and endoscopy nurses et cetera, et cetera. The same is true. So those per cent increases are not meaningful. It has got to be a comparison between districts—how many bums you have on seats to do the work. Yes, we are screwed.

The Hon. WALT SECORD: Dr Helprin, I cut you off. I apologise.

Dr HELPRIN: That is alright. I would just like to expand on your question about rationing of services. We at Fairfield have zero service in a number of areas. For example, Professor Levy is talking about gastroenterology—she is a gastroenterologist. We have zero gastroenterology service. You cannot ration a service that is zero.

The Hon. WALT SECORD: So what do you do?

Dr HELPRIN: We have no proper referral pathways. And there are other things that we have zero services. For example, Professor Cracknell was talking about services for mental health patients. We have no

mental health staff. We have a nurse that can maybe come over from Liverpool Hospital. That is our whole mental health service—a nurse who sort of pops over from time to time.

The Hon. WALT SECORD: Dr Helprin, what do you do if someone shows up with an acute mental health episode to your emergency department?

Dr HELPRIN: If there is an acute mental health episode usually they will need some sort of medication for that and they may need to be scheduled under the Mental Health Act and we will have to send them to Liverpool because we are not allowed to keep scheduled patients. But they may be just in the ward and we just settle it down with maybe the social worker to come and see them or something like that. Maybe the mental health nurse might pop over from Liverpool to see the patient.

The Hon. WALT SECORD: Do you redirect patients? Do you say to patients, "We don't have those services. You will have to go to another hospital?"

Dr HELPRIN: These sorts of patients are not very amenable to following instructions and they need to be treated where they are or shipped out. Probably not our major problem but it is just an illustration of how the services are so poorly developed.

The Hon. WALT SECORD: You mentioned something about anaesthetists—there are none after midnight.

Dr HELPRIN: Yes. That is a big problem because if you need an emergency caesarean section or something like that we have to call people in and it delays emergency operations, obviously.

The Hon. WALT SECORD: And you said no MRI.

Dr HELPRIN: Yes. We have no MRI at Fairfield Hospital and we have nowhere to put an MRI. Even if you wrote a cheque for us there is nowhere to put it.

The Hon. WALT SECORD: Why has there been no investment in Fairfield Hospital? You said $7 million compared to—

Dr HELPRIN: It is $600 million or $700 million for the other hospitals.

Associate Professor LEVY: It is building.

Dr HELPRIN: Building and resources, yes.

The Hon. WALT SECORD: Professor Levy, is that the problem that they have? Are they just building the buildings but not putting staff in them? Is that what is happening?

Associate Professor LEVY: Well, for example, not having a sufficient operating budget means that you cannot do the work that needs to be done. Over the last few years we have had 30 beds open but not funded. That means that we cannot employ staff to look after the patients in those beds except temporary staff, agency staff, which is a very expensive way to run 30 beds. We did not need to build a building. We needed enough money in the budget to fund the staff to look after those 30 beds.

And, finally, after two years of negotiations we have now had a budget allocation that has funded those 30 beds. But that is an example of where a building does not fix problem and a building is a long way away. We need to service—and I listed a lot of examples. For example, if we have a root cause analysis about a neonatal death that says you need a head of a birthing unit, it is a big obstetric unit and you need somebody, a specialist of my calibre, working to coordinate best care, but there is no money to employ such a person.

The Hon. WALT SECORD: But the Government says that Liverpool Hospital is a teaching hospital, is one of the largest hospitals in New South Wales.

Associate Professor LEVY: Yes, it is.

The Hon. WALT SECORD: They always point to it.

Associate Professor LEVY: Yes, it is, but actually if you look at how we are funded—in fact, it has been laughable or insulting, depending on the day of the week and your mood, to be told over the last few years that we are the cheapest hospital in the State, "Great job, well done!" but what does that mean? That just means that we are—

The Hon. WALT SECORD: You cannot provide service.

Associate Professor LEVY: Yes. We want equity. We want the same type funds as districts that do not have the challenges we have. We want equity in funds. We want our population to be able to come and see us. To

do that we need to employ staff. Clinical council has currently a list of 30 things that we could recruit for tomorrow if we were given a chance. But after 18 months of being told that there is no money for anything, we stop putting things up that we need. We start to think about how we can just contract service. But it is morale-sapping and, as Dr Halprin said, it can influence your ability to recruit. That then becomes even more wasteful of resources if people start leaving.

The CHAIR: Can we share the questions?

The Hon. WALT SECORD: I have one more question; I'm not very good at sharing.

The CHAIR: I noticed that.

The Hon. WALT SECORD: Do you have situations where you are sending patients from Liverpool to Sydney's east or the north, where logically a hospital of your size should provide those services?

Associate Professor LEVY: I suppose how to answer that is the fact is there are many different types of health literacy within our population. But if somebody needs a hip replacement, they could go to a specialist at Prince Alfred Hospital and find that they only have to wait 20 days to get that operation, whereas they may have to wait 300 days at Liverpool. They will still come in under a target of appropriate safe wait for a hip operation, but is that equitable? Is that what we want. If you are an orthopaedic surgeon, where do you want to work? Do you want to work at Liverpool, where your patients wait 300 days, there is hardly anybody with private health insurance and your own income is going to be frustrated, or do you want to work at Prince Alfred, where your patients only have to wait 22 days, you will also have a list at the private hospital et cetera et cetera? In fact, patients sometimes are voting with their feet, but then the surgeons will vote with their feet and the clinicians.

We are a great bunch who work in south-western Sydney. We just want the Government behind us to achieve equity and, instead of defending their position, to actually look at it. Come and walk around because you only have to walk around the emergency departments in these hospitals and then the emergency departments in inner-city hospitals and see with your own eyes. It is smoke and mirrors and we are not financial experts. It is hard for us.

The Hon. EMMA HURST: We have talked about, in your submission, Dr Halprin, the neonatal death and the recommendation for a head of the birthing unit. I am also particularly interested, Professor Levy, in you talking about a priority list but never being able to tick one box off. Is that potentially threatening lives? Do you have examples of issues where that has come into play?

Dr HELPRIN: I cannot speak for Liverpool Hospital. Certainly, in Fairfield there have been some problems with obstetrics and there is a health department intervention in that regard. I am not privy to all the details of that, but probably the CEO of the area or the general manager of the hospital can provide more details.

The Hon. EMMA HURST: We might be able to put some questions on notice. Is that specifically based around the funding?

Dr HELPRIN: Resources in general, I would say—models of care and resources. Yes, you could put that as a question on notice and I will get the administration to respond.

The Hon. EMMA HURST: Thank you.

Associate Professor LEVY: It is a really tricky area for us because the clinicians have discussed at length the risk to us reputationally of giving implications to the community that the care is not safe at Liverpool. We all work really hard and the risks are often to staff in burnout in trying to deliver care. When an emergency department is full to overflowing and there are long waits, we know that that is a metric where there are risks. But we would not want to give the community ammunition to think that their care is not safe.

The important message is about access. We want equitable access and we work really hard to try to make sure that there are no safety risks, but, as you may know, there were a number of suicides of junior doctors in the last few years, disproportionately in our area. The reality is that if you are a junior doctor working in these kinds of places and you have 25 patients, maybe a third who do not speak English, spread over many wards because there are not enough beds and you are running around trying to care for them, that is a risk to you and the patients. Whereas, if you work in other hospitals, literally there are teams where junior doctors look after 10 patients. This goes on year after year after year. Is that a risk? Are there stories?

I can remember as an intern crying in a corridor because there were two chest pains, one in either direction, and I did not know which one to go to. As an intern you thought that you have to get there quickly in case they have a heart attack. The number of patients compared to the number of junior staff is an incontrovertible, unarguable disparity and it is totally to do with money. It should not be so. We had two ENT registrars, just as an example, on call across a district, not just a hospital, every second night. Then one of them took some leave,

unrelieved. They were sleeping in their car in between shift. It makes it safer for staff and patients if you have sufficient resources to meet the demands of your service.

The Hon. EMMA HURST: Thank you. That answers another of my questions about inadequate staffing and junior doctors. Ms Lawton, in your report you note that while Liverpool can deliver cost-effective health care, they are being impacted by their ability to deliver timely and effective care to patients with complex needs. Can you tell us what you mean by complex needs?

Ms LAWTON: I suppose I can only talk from the demographic perspective. I would have to leave it to the doctors to talk about medical complexity. Certainly, one thing that comes out a lot is the cultural complexity of the area. It is a highly diverse area in terms of culture. I am sure that my colleagues could talk about the demand for services such as interpreting and translating and the impact that has on the length of stays and the care that patients receive.

Certainly in terms of as the report states, they can provide a cost-effective service. As Associate Professor Levy said, that is a credit to them being able to provide that service within the budget, but it is almost like the funding models at the moment do not take into account those other complexities demographically, whether it be cultural. To an extent it does look at sort of—I did see some of the funding models do look at socio-economic but there is a much bigger story beyond just those indicators. I think the funding that is allocated needs to take into consideration the whole story and it does not always do that. Cultural indicators, for example, are just one example. There are many others that we could talk about.

The Hon. EMMA HURST: Dr Helprin, you also talked about culturally and linguistically diverse people in your submission. I think you actually mentioned that the formula for funding the hospital has not been adjusted for that. For the benefit of the Committee, can you explain on a ground level why that should be included?

Dr HELPRIN: I did not actually refer to the funding model. That was not in my submission but, you know, you will need interpreters for people from diverse backgrounds. These people, you know, have come in with more advanced morbidity, worse illness, and they are going to have dates presentations. You know, care has to be delivered in a culturally sensitive way. There are certain religious requirements of people. Even areas for grieving, you have to be culturally sensitive for all that sort of thing. In the hospital a lot of nurses come from a diverse background, which is very good. A lot of the people who work there means we can have informal networks. The other day a pharmacist who spoke Arabic sort of helped me with a little question, which is good. We can get the formal interpreters. Now pleasingly a lot of our junior doctors come from a culturally diverse background so that is one thing that is very good as well.

The Hon. EMMA HURST: And it is interesting that this kind of reflects what we heard from the last witnesses; that it is requiring the staff to really step it up and to really go above and beyond to actually hold everything together.

Dr HELPRIN: Well, that is right. Particularly a social worker intervention may require a formal interpreter so you may have to book three days or five days and that is just going to keep the person in for three more days or five more days unnecessarily while you wait for the interpreter. Often at the bedside the family members will do the interpreting and that is often the patient's preference, actually, but if it is a very sensitive matter then you need to use an interpreter.

Ms CATE FAEHRMANN: Thank you, Chair. Thank you for coming today and for all the work you do. It sounds like incredible work, actually doing many things with limited resources. There has been a fair bit of discussion obviously in recent months in relation to COVID and the response to COVID. One of the reasons for shutdowns, if you like, is to ensure that our health system can cope. We were hearing of course in the early days that if COVID cases and numbers kept growing, then our health system would be overwhelmed. There was the Premier and the health Minister and others saying, "We don't want our health workers to get into this situation where"—the unthinkable situation, if you like—"doctors are in some ways having to prioritise patients." It kind of sounds like in some ways you are having to do that anyway, not talking about leaving patients in corridors but it does sound like you are already having to make decisions around which patients to treat, which health services to prioritise.

Associate Professor LEVY: Absolutely.

Dr HELPRIN: Yes. I think that is correct, yes.

Associate Professor LEVY: Every single day. I mean, in gastroenterology we look after liver cancer, which is managed by interventional radiology. Interventional radiology and all our endoscopy services literally day by day have to examine the list of people who need things done and try to work out when we can squeeze them in. It is a common word—I would hear that phrase; junior doctors would use it multiple times a day—

"Maybe we can squeeze them in." "Maybe we can squeeze them in." That does not mean they do not ever get done that but there are risks. There are length-of-stay implications. There are lots of implications of not being able to deliver acute care in a timely way.

We have more emergency surgery that needs to be done than hours in the day allocated for emergency surgery and the same is true for urgent endoscopy and interventional radiology. I mean, for example, I have a 12-centimetre liver tumour in a patient and we are hoping we can hopefully get that embolised so that it does not rupture—hopefully next week, but maybe the week after. That is a standard conversation and it is not because they are not working incredibly hard, but if you do not have a second interventional room open because you do not have the staff—and you need nursing staff, radiographers, the interventional radiologist—you do not just need to physical room. We have got the physical room.

Ms CATE FAEHRMANN: But the reality is that that situation, if somebody in a different part of Sydney—say, someone who lived in, let us just say, Lane Cove who had a 12-centimetre liver tumour—they would probably be able to get in to get that treated. Embolised—is that the word you used—

Associate Professor LEVY: Yes.

Ms CATE FAEHRMANN: —sooner than two weeks. Would you expect that?

Associate Professor LEVY: Yes, I would expect that. We have more resources than our other colleagues in other hospitals in south-western Sydney but we are a referral centre from those hospitals. If you wanted on notice to look at the waits for those urgent things, they are not measured. The surgical targets do not measure urgent inpatient waiting-for.

One-third of our patients coming through the emergency department are overseas-born. About a quarter of them do not speak English and you know you are a junior doctor trying to work out if you are patient, who is waiting for an endoscopy because they came in with a bleed, is going to be done today and trying to communicate that and they are not even on your ward and the endoscopy room is already full because they take patients from Campbelltown and sometimes Fairfield—sometimes Fairfield goes to Bankstown. We are too thin and a building will not fix that. We have enough rooms. And, look, you know the chief executive tries her best to listen to what is the most pressing thing but there just is not an equitable slice of the pie.

Ms CATE FAEHRMANN: So the staff in your respective hospitals must be under such extraordinary stress already, given the decisions that they are having to make and given the treatment that they would like to be able to give their patients that they have to wait for, and potentially that is a life-or-debt situation. That is without COVID.

Associate Professor LEVY: Oh, yes. We were concerned that this parliamentary inquiry would be overtaken by the issues of COVID and that it would seem less important but, actually, I think under-resourced hospitals are going to struggle even more. Intensive care beds, enough intensive care beds per population—

The CHAIR: One last question and then we will move to the Government member for questions.

Ms CATE FAEHRMANN: I have one last question. I am interested in the forums to ask for increased funding from Government. You are at a parliamentary inquiry and no doubt for many years you have been dealing with this awful lack of funding. What is the way in which you are requesting additional funding from Government? Has either of you been in any of those forums?

Dr HELPRIN: I have not been in a forum. We tend to just bring things to the attention of the administration of the hospital and the administration brings it to the attention of the area, but we have stopped bringing things to the attention of the—because, as Professor Levy said, there is just no extra money to do things. But we do bring things to the attention of the administration who brings it to the attention of the area, who in theory brings it to the attention of the health department, who in theory brings it to the attention of the Government.

The Hon. NATASHA MACLAREN-JONES: I want to ask about the $790 million Liverpool Hospital redevelopment that will include an integrated cancer centre, critical care services, emergency department, intensive care units, neonatal intensive care along with radiology and renal transplant services. You have raised a number of challenges you are facing currently with delivery of services. How far will the $790 million redevelopment for Liverpool Hospital go in addressing the concerns that you have raised today?

Associate Professor LEVY: Thank you for that question. So this is what I tried to emphasise in my opening about the difference between bricks and mortar and operating expenses. And in fact some of those elements of this current redevelopment, which is still in the planning phase, were actually supposed to be in the original redevelopment from about 10 years ago but there was not money. But actually in my experience, because I have been at Liverpool for 18 years, it takes a long time before—we had two endoscopy rooms before the last

redevelopment and then we had two endoscopy rooms in a five-room endoscopy place for about three or four years afterwards because there was not any money for the staff to actually use the other rooms—eventually that happens.

The redevelopment is obviously important for the future but it is a very separate question and should not be a smoke-and-mirror disguise for the problems that we have. It is way too far away. We need pharmacists. Our pharmacists—they have so few compared to other districts, just as an example, and the pharmacists have not even got a look-in to what might have been a priority even though we all know it is an incredible priority. That is just an example. How do you keep medicines? We hear in the newspaper about iatrogenic errors of prescribing in hospitals but pharmacists are key to that. If our pharmacists are so lean and so busy it is a risk and it should not be like that. We should not be expected to be so lean for so long and the new building will not fix that. An aerotropolis will not fix that. But they need to happen as the population grows. But it is a different conversation.

The Hon. NATASHA MACLAREN-JONES: You talk about additional funding. I noticed across south-western Sydney on average over the last, I think, five or six years they have had a 5 per cent increase each year across the area. How much more are you wanting? I understand that is quite a large amount for the other areas.

Associate Professor LEVY: No. Actually we have approached government about this since we got the WESTIR report. We went to ministry. We went to Minister Brad Hazzard. And in fact he wrote back to me when I have put these issues to him. He said that we got $85 million in the last budget but actually the maths on that is that was a 4.7 per cent increase compared to the State average of 4.6 per cent. This is a district where we have hospitals that do not even have the sub-specialty medical departments in place. That should be growth money. That should be what we get to grow our departments so that pharmacists who had four pharmacists before can get five with growth and everybody gets a little bit and you grow. But the fact is that money gets diverted.

Last year the one enhancement we got at Liverpool was non-invasive ventilation to allow patients who are in respiratory failure to not have to go to intensive care but to be able receive positive-pressure ventilation that can be done on the ward. It was a $1 million enhancement that was required to actually have that service so that those patients did not have to use intensive care beds. Every other hospital in Sydney has had that for a decade and we had to use our growth money to put that essential component of a tertiary hospital in place, which meant that there was hardly anything left above the consumer price index [CPI] thing.

The Hon. NATASHA MACLAREN-JONES: Sorry, I should clarify. When I said a 5 per cent average, the information actually shows that south-western Sydney in 2012-13 got a 6.1 per cent increase, in 2013-14 a 4.88 per cent increase and so on up to again 5.94 per cent in 2016-17 and the last financial year was actually 4.9 per cent, which is again above the average. I think we have actually run out of time, because we are behind.

The CHAIR: We are a little bit but you can keep going.

The Hon. NATASHA MACLAREN-JONES: I am happy to stop there.

Associate Professor LEVY: I think I should answer that. I mean it sounds like a lot but actually that is missing the point and that is the problem until the Government understands that that is not a meaningful difference if that money is not used to fund our growth. That money is not used to fund our growth. We just get 5 per cent busier because there is no money left once the chief executive decides, appropriately, that Campbelltown—Campbelltown is emerging from a district hospital into a specialist hospital. It is sucking up huge amounts of that so-called growth money. That is the problem.

If you are at Prince Alfred or a hospital like that where you have every service fully established and you get 5 per cent growth, you spend it—and we know it because they are our colleagues—and you get one more gastroenterologist and you get one more interventional. You get these things and then you keep meeting the growth with your staff and then you have a sane work environment. Whereas we get nothing across the board because there is nothing left. Go and look at what the 5 per cent was spent on and you will see that that is not translating into growth because we are not established hospitals. It is like if you are renovating your house and you have one more baby. You use a little bit of money—that is your growth money—and you pop a room on the top for one more child in the family. But we are using growth money, money that should be used to build one room, to build the rest of the house. We do not have a built house and we cannot seem to get that message—

The Hon. NATASHA MACLAREN-JONES: You are getting that with the upgrade of Liverpool Hospital. You are getting quite a lot of services as well.

Associate Professor LEVY: I am talking about people. It is a metaphor for people. It is not about the building. It is a metaphor for a built house. Sorry, but I appreciate it.

The CHAIR: That is okay. On behalf of the Committee, we thank you all very much for coming along. You are all obviously extraordinarily busy with respect to your professional duties but you took the time to come along, Dr Helprin, Associate Professor Levy and Ms Lawton. The evidence has been extraordinarily useful—the evidence via your submission augmented by what you provided today orally. We thank you very much for that. There will probably be some questions on notice. If you are agreeable, the secretariat will liaise with you following the hearing in regard to those. We normally have a 21-day turnaround time for dealing with those. On behalf of the Committee, thank you so much for the outstanding professional work that you are doing in these most difficult times.

Associate Professor LEVY: Thank you for your time.

Dr HELPRIN: Thank you very much.

The CHAIR: It is greatly appreciated. Thank you very much.

(The witnesses withdrew.)

(Short adjournment)

Dr CHOONG-SIEW YONG, New South Wales branch committee member, the Royal Australian and New Zealand College of Psychiatrists, sworn and examined

PAM BATKIN, Chief Executive Officer, Woodville Alliance, affirmed and examined

RUTH CALLAGHAN, General Manager—Community Initiatives, Woodville Alliance, affirmed and examined

The CHAIR: Do representatives of the Woodville Alliance wish to make separate opening statements?

Ms BATKIN: Yes, if possible, and they are both quite short.

The CHAIR: Okay, that is fine and then we will progress to questions from committee members. We will start with the first opening statement.

Ms CALLAGHAN: Thank you, Mr Donnelly and the Committee, for having us here this morning. The main issue identified in our submission and consistent with our colleagues at the college and its staff is that our region of Sydney is unique. In looking at investment in the health district and the local community there are numbers of very specific issues that need to be considered in a way that are not as significant in other parts of Sydney. The Committee has before it a lot of data and evidence, which we do not need to go through, but it does clearly demonstrate that government investment in health services especially, in our view, in community-based prevention, early intervention and primary care has not been commensurate with emerging health outcomes or economic and population growth and projections in south-west Sydney.

This is a social justice issue; it is an economic one. We were talking in the foyer about the significance of social determinants of health and how it never seems to get traction that investment particularly in children and young people and those early determinants of mental health has not taken place. Through our work experience we know that people under 18 years in our health district are significantly impacted by depression and anxiety. We have seen this coming through with COVID just in the last three weeks, where we have had a presence back in the office doing some appropriately balanced face-to-face work. We have had a 50 per cent increase in referrals for non-clinical case management from school counsellors and community liaison officers from local schools, as well as from Karitane and Headspace Liverpool.

The majority of our clients and their families are from culturally and linguistically diverse [CALD] backgrounds. We often find that people who live in poverty and experience the complexities arising from settlement and trauma do not have their basic needs met. It is a bit academic trying to work with people around their mental health issues and we often find that in our casework the first step is dealing with really practical things, like the teenager who was not attending school. One of the reasons she was not attending school, in addition to her anxiety, was her social embarrassment because she had to take cereal in her pocket for lunch. At her first meeting with our caseworker, she asked if we could provide her with sandwich bags to put her cereal in.

That is a real case and it is also an example of how we initially engage with people, because having met some basic needs that young woman then did some very good casework for six months and eventually reconnected with school. In that example, we absolutely support the college's recommendation two about the importance of wrap-around community-based case management and holistic services. It is also our strong operational experience that working relationships with other community agencies—local schools, community mental health—are critical to engaging people early on in care. Often the system talks about CALD communities like south-west Sydney as if they are a minority or special needs group and only require especially targeted services. Our experience working in south-west Sydney is that the demographic reality of communities belies this. The population is diverse, and we know that where appropriate services engaged through bilingual workers, culturally appropriate approaches to casework we get very good outcomes. This is much broader than translating pamphlets and educating workers in cultural appropriateness. It has to be lived and breathed in service design and delivery. Thank you.

The CHAIR: Thank you, Ms Callaghan, for your very good opening statement.

Ms BATKIN: I would also like to thank the Committee for the opportunity to attend today. I would like to bring to the Committee's attention an important public health and wellbeing issue that has generated increasingly high levels of community concern in south-western Sydney over the last couple of years. The issue is the significant impacts on local health and wellbeing of gambling harm. A recent study for the Victorian Responsible Gambling Foundation in 2018 took a public health approach and identified the following gambling-related harms: negative impacts to the person's health; emotional or psychological distress; financial difficulties, including bankruptcy; reduced performance, including the loss of a job or study; relationship conflict or breakdown; criminal activity and neglect of responsibilities; cultural harms; and life course, generational, and intergenerational harms.

This study reported that an important feature of gambling problems is comorbidity with a range of other harmful behaviours, such as alcohol use and depression. These behaviours can interact with one another. Gambling, for example, could be a coping mechanism for those vulnerable to other problems, and vice-versa, with the long-term impact that exacerbates both gambling and non-gambling harm. Perhaps it is worth saying that the harm also extends beyond the individual to the family, friends and community.

It is our very lived daily experience that we see all of these impacts in our work in south-western Sydney. In Fairfield we are particularly concerned about the significant loss of over $1.3million each day on over 3,800 poker machines in the Fairfield local government area [LGA]. As the Committee would be aware, Fairfield is one of the most disadvantaged LGAs in Sydney. As we have sought to better understand the impacts of such a large daily loss of money on a profoundly community, we have begun to understand that there was little local research to support our work.

We also realised that whilst we can and do refer people seeking help for a gambling problem to a gambling counsellor we did not routinely ask any of our new clients whether gambling harm was a contributing factor. We did not know, for example, if women experiencing family violence were also impacted by gambling harm as a comorbidity. When we did informally ask our clients, we were shocked by the very high percentages of people who identified gambling harm as a comorbidity with a number of the issues we see people for.

Particularly to support this work we have been involved in a research project that has been funded by the New South Wales Office of Responsible Gambling and we have worked closely with the local primary health network and the local health district. The project has developed and is in the process of piloting a culturally sensitive screening tool for gambling harm for use by GPs and also by community workers. While the number of screening tools administered so far is very small—I think the last count I heard was about 115—by using that tool we are seeing unexpectedly high reports of gambling harm by the people who have been screened—gambling harm both as a result of their own gambling and gambling harm of people close to them. We are very keen to continue the work of this pilot and trial the screening tool in other communities across western Sydney but we need further funding to do that.

From our experience working at the local level in south-western Sydney we would respectfully urge that this Committee identify gambling harm as a key public health issue which needs particular attention, such as local research, to better understand its impact on local communities. And, most importantly we need resources to develop culturally appropriate strategies to reduce gambling harm in south-western Sydney. Thank you.

The CHAIR: Thank you, Ms Batkin, for that very powerful opening statement. Dr Yong, do you have an opening statement?

Dr YONG: Thank you very much for an opportunity to address the Committee. By way of introduction, I am a consultant psychiatrist and I work substantively with the South Western Sydney Local Health District and also part time with the Murrumbidgee Local Health District. As such, a lot of my clinical work is around the Bankstown and Campbelltown areas so I can speak with some experience about the needs of south-western Sydney.

The CHAIR: That will be very good.

Dr YONG: I am here today representing the New South Wales Branch Committee of the Royal Australian and New Zealand College of Psychiatrists. I commend our submission to you which we compiled with consultation with many of my colleagues who work both in the private and public sectors across south-western Sydney. I will just make a few basic points from the submission of note. I think, firstly, we have argued that planning for mental health services in general in New South Wales is somewhat haphazard compared to some of the other disciplines within health and medicine so one of our pleas is for a better planning process in the complex area such as mental health where there is a variety of services. There are not only the public mental health sector services where I work but there are private psychiatry services and there are obviously non-government organisations as well.

One of the things that has bedevilled mental health planning in Australia generally and in New South Wales in particular has been the lack of coordination between those different sectors. Even the most recent reports by mental health commissions, both nationally as well as in New South Wales, I would argue have failed to take account sufficiently of the huge contribution private clinicians such as private psychologists and private psychiatrists make to mental health care in New South Wales. This is particularly compounded in outer metropolitan areas of Sydney such as south-western Sydney. We have got data in our submission from the mental health psychiatry workforce showing that there are at least three tiers of staffing in New South Wales. There is a very good level—benchmark, if you like—staffing within the eastern and northern areas of Sydney and then there

is greater western Sydney and south-western Sydney, which are one step down again in terms of the number of psychiatrists and the numbers of other mental health clinicians, and then there are the regional and rural areas.

The point of this is that it reflects historical sort of funding and resourcing of health services in Sydney and in New South Wales in general where services outside of the east and north are forever engaged in catching up with the benchmark and always being below. At the same time, as you know—I am sure other submissions have shown this—the growth of population and the high needs in terms of mental health care and health care in general are higher in outer metropolitan Sydney. So you have a double problem of historically low levels of funding and resourcing with a faster-rising need. In general most of the increases in funding have not been to the public sector in mental health: They have been towards private and non-government sector areas. So the burden on the public mental health service arguably has been greater than other parts of Sydney and New South Wales.

We just wanted to make that point because we think that a significant increase in funding needs to take place. There is an opportunity in planning for the south-western corridor, particularly around the airport, to make this right for an area that is fast growing and is projected to grow much faster than many other parts of New South Wales. The other point I wanted to make just about the complexity of having to provide mental health care in south-western Sydney being somewhat greater for some of the reasons that my colleagues on my right here have pointed out and that is certainly reflected in what we see generally in the public and private sectors.

The CHAIR: Thank you, Dr Yong. That is very helpful. Indeed, submissions from both organisations have been received. The submission from the Royal Australian and New Zealand College of Psychiatrists is submission No. 22. It has been incorporated and is available through the inquiry's web page. The Woodville Alliance submission is submission No. 53. Thank you very much for that very good submission and it is also available through the web page. This is more for the information of Committee members. We will do questions in 10-minute blocks, which will take us through until 20 past or thereabouts. We have one more tranche of witnesses to do before 1 p.m. So 10, five, five and 10: Is that okay?

The Hon. WALT SECORD: Thank you, Chair. Dr Yong, in your opening statement you talked about almost a three-tier system—Sydney and northern Sydney, greater western Sydney and south-western Sydney and rural and regional areas. What is the gulf between Sydney's east and the north with their provision of psychiatric services and mental health services compared to Sydney's south-western?

Dr YONG: If I just mention—I cannot give you all of the figures but some of the figures are in our submission. For instance, in terms of the number of psychiatrists per head of population, the Sydney and north Sydney and south-eastern Sydney numbers of psychiatrists are about 11, nine and seven per hundred thousand of population. In south-western Sydney and western Sydney it is down to six. That is the establishment. I can tell you the reality is about recruitment: It is harder to attract psychiatrists to those areas and retain them. That figure tells you the relativities in terms of the numbers but it does not tell you the fact that it is harder to get people to stay in western and south-western Sydney.

The other part of this is the type of services supplied. For instance, there are many specialised services on top of the basic ones that exist in some of the better-resourced areas of Sydney but do not exist in our area. For instance, in the Concord Hospital there is a specialist service around metabolic health for patients with mental illness. We have some access from south-western Sydney to that clinic but we do not have one of our own, despite the fact that arguably we probably have greater levels of metabolic illness within south-western Sydney than the Sydney local government area [LGA] does. But that is a reflection of the relative kind of establishment services and resources within those two different parts of Sydney. That is just by way of one example.

The Hon. WALT SECORD: At the very end of your submission you touched on the complexity in south-western Sydney. What were you referring to when you said "complexity"?

Dr YONG: I think it is about particularly the ethnic and cultural diversity in south-western Sydney, which is a degree above even greater western Sydney. I have worked most of my career in either western Sydney or south-western Sydney. Comparing even those areas for their needs it is quite marked how much more diverse south-western Sydney is.

The Hon. WALT SECORD: Can you give me an example of the complexity? What are you referring to when you say the complexity?

Dr YONG: It is in terms of language groups and ethnic groups. As I said, one of my main roles is working in Bankstown, which is as you know a very diverse part of Sydney. The challenges for us have been around psychoeducation, engaging families and patients to work with us in mental health. We get lots of referrals and yet, for instance, in Bankstown the attendance rate to clinics, to seeing psychiatrists and other clinicians in the area, is relatively low, despite the fact that there are lots of referrals to our service. One of those issues is around the stigma associated with mental health in particular cultural groups.

The other issue that has occurred that has been a particular challenge since the COVID pandemic has occurred has been access to interpreters. We are now dependent on phone interpreters only in an area where, for many of my colleagues, their whole clinic would be one where they need interpreter services for the bulk of their patients. All that has to be done over the phone. That means that things take longer to do. It is that much harder to do with a phone interpreter than it is with a face-to-face interpreter. It goes on from there.

The Hon. WALT SECORD: How does that translate into patient care? If there are lots of referrals and very little take-up and there are lots of hurdles to accessing services as well as getting past the stigma, what is the area of need or the cohort? What are the challenges?

Dr YONG: The challenges are that from the community mental health point of view and the hospital point of view we need relatively much more staffing to engage with those sorts of clients and patients. We need more specific language services to enable the right kind of education to take place, the right kind of community development. We need to work more with other community-based organisations, not just health, to promote and encourage help-seeking in an appropriate way.

It probably is also reflected in poorer health outcomes. You have probably been given evidence from others about the fact that health outcomes in greater western Sydney are poorer compared to better resourced parts of Sydney. That is partly around the access to services, but it is probably partly because the care we can give, particularly in community mental health, is somewhat more fragmented, there is less follow-up, there is less ongoing continuous care. I can tell you clinically there is a higher dropout rate in terms of people being referred to our services who we would want to see on an ongoing basis for a longer period to ensure full recovery, but there is greater dropout rate because of various engagement factors with us. Those will ultimately translate into poorer mental health outcomes overall for people living in south-western Sydney.

The Hon. WALT SECORD: This Committee will make recommendations to the Government. What action would you urge this Committee to recommend to the Government to respond to what you have illustrated?

Dr YONG: Our first recommendation is that there is a more comprehensive planning process when it comes to mental health services. That planning needs to take account of the matrix of services. There is a significant number of non-government organisations, some of which receive State and Federal funding. There is private mental health care, primarily private psychiatrists and also private psychologists, that is funded by the Commonwealth but also privately by people through their own pockets. Then there is the public mental health service such as the hospitals and community mental health.

In the past, traditionally planning has not taken account of the NGO sector or the private sector; it has only looked at what is available through the public sector. Even last year's report from the Mental Health Commission NSW, I would argue, does not take significant recognition of that factor. But in fact there are private mental health services and they are growing in south-western Sydney. There is the large private mental health hospital in Campbelltown. Patients in this area often have to travel to Sydney and to Northern Sydney to access private mental health care, because even with that the demand outstrips supply.

Planning really ought to take place looking at those three sectors and what they contribute, rather than each sector in isolation. That would be my first thing. The other point is that when you start doing the planning it will show that there is not just a shortfall in funding for south-western Sydney compared to benchmark, which might be looking at central Sydney or south-eastern Sydney, but in fact it might need more funding relatively speaking than those sectors.

The Hon. WALT SECORD: Psychiatrist and mental health workers working in south-west Sydney, are they fly in, fly out people or are they people who are locals?

Dr YONG: They are increasingly people who are locals, although if you look at psychiatrists, they probably come from all around Sydney. One of the factors that we have alluded to is a task force that is taking place in the Ministry of Health at the moment around psychiatric workforce in New South Wales. One of the factors it is looking at is what kind of factors might attract psychiatrists to work in outer metropolitan Sydney, compared to the inner west. Truth be known, a lot of my colleagues live in the leafier parts of Sydney but many of us choose to travel and work in south-western Sydney. It is things such as feeling like you are well supported from an administrative and clinical point of view, having well-staffed teams to work with because most of my colleagues in the public sector work in a team structure. Many of my colleagues in the private sector have informal alliances with GPs and psychologists and so on, so they work in an ad hoc network as well. Having those networks well supported makes our job a lot easier.

Other things are work conditions for doctors in general working in south-western Sydney—access to research, access to time for teaching, not being burdened by the ongoing onslaught of clinical work day-to-day but having the opportunity to do some of those other developmental parts that a consultant specialist medical

practitioner can do to help develop a local workforce and local services. Those sorts of intangibles are important recruitment factors. If they were given more emphasis then I think we would have less of an issue recruiting psychiatrists and other specialists to south-western Sydney.

The CHAIR: We are on a tight schedule so the Hon. Emma Hurst will now ask questions.

The Hon. EMMA HURST: Dr Yong, I want to follow on from that line of questions because I am trying to unpack the idea of how hard it is to attract psychiatrists to this area. You also mentioned that it is difficult to retain them. What are the differences in south-west Sydney compared to areas that have attracted and retained psychiatrists?

Dr YONG: I think one of the factors is around the commute time and attracting medical specialists to live and work in the local areas. I do not have figures to show this, but I would say anecdotally that many of my colleagues do not live in the areas of south-western Sydney or, if they do, it is probably more towards the Southern Highlands area. Either way, they are faced with a commute that is probably longer than someone living in inner-western Sydney and working the Prince Alfred Hospital, for instance.

The Hon. EMMA HURST: They need something to lure them to be part of these services.

Dr YONG: Yes. My point was it is not just about money. It is not about maybe paying doctors more; it is about these other things that support a more rounded career structure, if you like.

The Hon. EMMA HURST: Thank you. Ms Baskin and Ms Callaghan, thank you for coming today. In your submission you note that about 45 per cent of people in the south-west Sydney region speak a language other than English and that this cultural diversity is not adequately addressed through the current and future provision of health services in the region. What do you think are the key gaps for this community?

Ms CALLAGHAN: I think, building on the doctor's responses, one of the things about the community we work in and with the idea of that three-tier system is that I think organisations like our own that are not clinical are still often the only place where someone might engage in a comfortable way and then follow through and get more extensive services and support. For example, in my small casework team, over 80 per cent of those people are bilingual. We did not recruit them because they are bilingual. We recruited them because they are good caseworkers, but that is a skill they bring.

What we find is that our Farsi speaker has people ringing word of mouth. Our Arabic speakers are well known in communities and with clinicians. Our Vietnamese speaker, who is a community development worker, will often engage with families through our outreach in the Carramar hub and then pick up that there is some other issue and then refer to caseworkers. I think cultural understandings of what health and wellbeing are are very different. Necessarily the model we operate in as a society is a western one and it is changing, but when you are looking at somewhere like south-west Sydney, those sensitivities around wellness, illness and stigma and all that stuff is really significant and makes the difference between whether people engage with services or not.

The Hon. EMMA HURST: Thank you. You also mention in your submission the significant number of young people experiencing poor mental health in the south-western region. What do you think is the driver for that particular group? What should the Government doing to help address this?

Ms CALLAGHAN: I think there are obviously underlying social determinants for those communities. I mean you have low Socio-Economic Indexes for Areas [SEIFA], by which the Australian Bureau of Statistics [ABS] measures socio-economic disadvantage, around Carramar and Fairfield. You have got poverty. You have got people who quite often have recent settlement experiences, particularly around Fairfield. You have got young people who are newly arrived or children of migrant families so often there is a lot of social isolation. There can be cultural barriers around engaging with school and people feeling quite excluded. Resourcing community prevention and early intervention and those connections with community mental health in the health system is incredibly important because, if people's material needs are not adequate, as I said earlier you often cannot work on their mental health.

The Government's outcomes framework for human services actually talks about all of these sorts of things and provides measures for them. I think those investments and looking, as the Productivity Commission said in its recent review of the mental health system, at the interrelationships between schools who refer to us and we refer to psychiatrists. It is not that the health system exists separately from the other community services.

Ms CATE FAEHRMANN: Thank you, Chair. Thank you for appearing today. I wanted to touch on poker machines. Thanks for raising that, given I think it is quite timely given the focus over the past few days on the cases around Crossroads and some of the use of poker machines in those particular cases. This question is for both Ms Batkin and Ms Callaghan and of course, Dr Yong, if you wish to chime in, please do. Do you think that

poker machines and gambling rooms pose any increased risk to the community's mental health or health during COVID-19?

Ms BATKIN: That is a really interesting question. On the one hand many clubs were closed for quite a while. What we did hear was anecdotal evidence that there was significantly increased online gaming and gambling, but that was anecdotal evidence. At the moment what we are seeing is quite a significant return to local clubs. We are also seeing clubs moving gambling machines from the smaller areas in their clubs, spreading them out across the unused areas of their club to maintain social distance. I guess there is also potentially a larger opportunity for people going into clubs to actually come across poker machines as well. I think that issue remains to be seen.

It is like a lot of the issues in regards to poker machines and gambling: We do not have the evidence, we do not have the research, we do not understand prevalence that well and I think there is a lot of work to be done in south-western Sydney and in New South Wales to actually allow us to have the evidence so we can answer questions like that with much more certainty and without simply saying, "The anecdotal evidence is this". That is why I am particularly keen to have Health view gambling as a major community and health-related harm and to be researched appropriately in that way.

Ms CATE FAEHRMANN: Yes. I heard those stories as well about the poker machines being spaced out so that people could still gamble on them while being physically distanced from each other. At my local cafe, for example, they have removed the salt and pepper shakers because you cannot touch them whereas I am pretty sure you have to touch poker machines a lot to play them, yes?

Ms BATKIN: Yes. Well, you have to get very close. You sit underneath them. I am not aware of the cleaning regimes. I assume that clubs would have appropriate cleaning regimes for them, yes.

Ms CATE FAEHRMANN: You mentioned anecdotal evidence and I recognise why you have particularly mentioned poker machines at this inquiry, given that the health services are under increased weight because of the dangers posed by poker machines in terms of mental health and health. If you have heard any anecdotal evidence about people moving to online gambling, they have also been some stories about people having their first break from the poker machines. I read a couple of stories about people benefiting and actually being able to break their addictions. Have you come across that as well?

Ms BATKIN: Once again, it is only anecdotally as well. I think for some people that would be the break that they would need but I think we should not underestimate the addictive power of things like poker machines. They are actually designed by the people who make them to be addictive. It is diabolical. It is absolutely diabolical. The impact on people as they gamble on poker machines has been described by the medical profession as being very similar to the impact that people get from crack cocaine. So the addictive power is profound. I would imagine that that would allow a small number of people to make a break at the addictive power of a machine that so many of our clever people across the world put all their efforts to make addictive to human beings, you know, it cannot be underestimated.

Ms CATE FAEHRMANN: Is there also a worry, given increased unemployment as a result of COVID-19, that more people will become addicted because of losing their jobs and, I suppose, having more time on their hands, or increased mental health issues such as anxiety and depression anyway? Is there a link there?

Ms BATKIN: I think there is and I think that is very likely. How direct the link is I think we still have to once again get the evidence, and we simply do not have the evidence. We do not have the on-ground research in New South Wales and in south-western Sydney to be able to actually identify the prevalence in the area and how these different issues and problems exacerbate each other. I think it is quite profound. As I have sought to learn and understand more about gambling, it is really frustrating. There are some interesting studies done in Victoria but the understanding of gambling and its impacts is very difficult for people like me on the ground when the research evidence simply is not there. We need and have a responsibility to address that.

Ms CATE FAEHRMANN: Thank you. I think my time is up.

The CHAIR: Thank you very much, that was very helpful.

The Hon. NATASHA MACLAREN-JONES: In your submission you refer to:

> "11% of SWS children aged 4-15 were at substantial risk of developing a clinically significant behavioural problem compared with the 8.3% for New South Wales".

Could you expand a little more on the clinically significant behaviour? I assume that requires more intensive treatment. Could you outline that a little more?

Ms CALLAGHAN: I think we were cross-referencing some health data and the sources for that were in the submission. What we find is that for a lot of families who do not have the knowledge or resources to engage early to get their children assistance or diagnosis, the first point at which things are picked up is often at school. So if you think about the health system, when you are pregnant and have a baby there is very intensive engagement with GPs, community health nurses and home visiting, which is fabulous, in the first two years. Then, often, unless you are unwell or there is some really significant issue, families do not really engage in services until school.

What we are finding is, for example, in families where there is family violence or where there might be an undiagnosed learning difficulty with a child or an adjustment disorder because a migrant family might have come from refugee camps with a very little baby. So, for example, we have a little boy who comes to our supported playgroup. Grandma brings him because mum and dad work. He would get deeply, deeply distressed when there was too much stimulation in playgroup. So although he wanted to engage with other children he did not know how to do that and would scream and yell and grandma would have to remove him from the room. And then he would not want to leave. That is not normal separation anxiety. That is a very deeply traumatised child.

We subsequently found out through one of our African-speaking caseworkers who knows people talking to grandma that that family had had a really traumatic experience in a refugee camp when that little three- or four-year-old boy had been a baby. He is basically acting out very deep distress. We can do a lot and he has adjusted really well with supported playgroup run by an early childhood teacher. We have a caseworker in the room. He can now be in the room for up to 45 minutes and engage in play with other children but that is not going to "fix" that child. He clearly needs a deeper level of clinical support than we can give him. Because of the kinds of complexities our colleague has talked about, that free care and resource is not there in south-west Sydney and if it is there is an extremely long waiting list. The Service for the Treatment and Rehabilitation of Torture and Trauma Survivors [STARTTS], for example, do amazing work with these families but they have a limited capacity of workers and they also have to triage the cases they have.

The Hon. NATASHA MACLAREN-JONES: Maybe Dr Yong might be able to comment a little more on this. How do we reach out to these individuals or families more and what more needs to be done, also possibly looking at online opportunities and things that we can do? Anyone, really.

Ms CALLAGHAN: What I would say is that the role of community services and non-clinical services like our own are really important because often we are the first point of entry where a family feels secure enough, if I can use that language, to engage. So that family lives in Carramar. We have a community hub in Carramar and grandma just popped in one day. Things rolled from there and she became engaged with the playgroup. What we have found with COVID is that, like a lot of organisations and the clinical community, we have had to go online. So we have been doing playgroup online on Thursday.

Manik, the early childhood teacher, sits in the back room at the hub and does playgroup. And what we have found is that most of the families have engaged with that and kept coming even though that is a very unusual way to do playgroup. When she said to them two weeks ago—normally we break for the school holidays with playgroup because a lot of these kids have older siblings—"Do you want to keep going?" and the resounding answer was, "Yes." So we have actually kept doing Zoom playgroup because of that. What we have also found is families have actually now started, in a sense, doing their own community.

There is a WhatsApp group that those families on their own—nothing to do with us—have set up, where they connect with each other and have ideas about what they can do at home with the kids. That depends on the resourcing and having a phone or a laptop. We also know some of the families we worked with in COVID absolutely did not have that. We spent several weeks early on rustling up repurposed laptops with the University of New South Wales and various other philanthropic organisations because we had families with three kids who were meant to be doing home schooling that could not because the hardware was not there.

Some of it, without wanting to disrespect, is simple and common sense and works really well but you have to resource it and I think government has to engage with the evidence around why this stuff works—and we know it does. We were again talking outside. The Canadians 30 years ago with Fraser Mustard were doing this stuff and we copied it in New South Wales with Families First and now with Targeted Early Intervention. And it is a very effective way of working with families.

The Hon. NATASHA MACLAREN-JONES: Dr Yong, did you want to comment?

Dr YONG: Yes. You gave a good example about the impact at a very early age. What we need to do is provide early identification and an opportunity to provide early intervention at all levels. There are some programs around identifying, for instance, mothers at risk of mental illness and trying to provide clinical services through our perinatal mental health teams that way, also identifying children in the school now. There is a program that is

run out through schools in New South Wales to try to identify children at risk at K-2 and providing some interventions then.

So the more of these opportunities we have to do it, the better. But relatively speaking in terms of mental health clinical services there is a relative lack of those services for children under five. Most of our teams will see children of five onwards—school age upwards—but relatively speaking there is not a lot available for children under that age. Some of that is done through community paediatrics and community child and family teams and some of it is done through specialist mental health teams but it is a somewhat fragmented system that we have here. So, again, trying to join up all the services is probably something we should look at.

There are models around the world. Some are fund-holding models where there is a caseworker who holds funds and buys services for families at risk through probably the local child protection agency. That is something that people have looked at in New South Wales but it is very difficult to do given our particular government structure where things like the Department of Communities and Justice now—it used to be Family and Community Services—and NSW Health and other departments are very siloed and very separate from each other, unlike, say, in the United States where it is much more in the hands of individual fund holders to buy those services in. Whether we can replicate that kind of wraparound or joined up kind of service structure is another matter but it ought to be debated a bit more because arguably some of the results from those for families at high risk have been quite good.

The point about intervening early is that we know that, particularly under five, children's brains are still in development and the sorts of adverse experiences that they experience—particularly trauma through violence—has a profound effect on their risk of mental illness in adulthood and in adolescence and also seems to have an impact on other social outcomes such as school completion, job rates, rates of incarceration and involvement in the criminal justice system. So the more we can do for children who are identified as at risk and families at risk before the age of five, or at least before puberty, the more likely that we are going to have better outcomes for those young people as they go into adulthood.

The Hon. NATASHA MACLAREN-JONES: Can you elaborate a little bit more on the model you were referring to in the United States? Obviously most of ours is under the health model but you referred to the shared services of legal and family. Is it all under one roof or as one provider purchases services from multiple departments? How does that work?

Dr YONG: There are a couple of different models. There is one called the Multisystemic Therapy model where a tranche of funding is given to an agency with a case manager with a high-risk family. This is usually a family with one or more youth at risk. The point is to avoid involvement in the criminal justice system so this is about diversion away from incarceration. That caseworker will work intensively with a family and that young person, buy various services such as health, counselling, mental health and so on, and social welfare employment assistance. That has shown to have quite good outcomes in terms of avoidance of incarceration. Another model is called the Wraparound Milwaukee model, which works at a younger age group, again around supporting a particular family; intensive case management. They buy services such as paediatrics, health, counselling, family support and parenting support for that individual. There are some issues with those sorts of programs: They are very expensive on the face of it but on the other hand they are buying a comprehensive suite of services. There are also issues to do with accountability to make sure the money is well spent and not misspent. They are worth exploring. In a much more diversified system like the United States, I think it is easier to have that kind of model. Over here, because of our silos, we may have to look at different models, but people came out and talked about them in New South Wales.

The Hon. NATASHA MACLAREN-JONES: Thank you.

The CHAIR: Thank you very much. We have come up to the end of our time. Both your submissions in the first instance and the oral evidence you provided today have been moth helpful. Some members may wish to follow-up on some points after reading *Hansard.* Our secretariat will liaise with you if there are such questions. We normally have a 21 day turnaround time if you are agreeable to that. Once again, thank you all very much.

(The witnesses withdrew.)

Kristen SHORT, Director of Innovation and Partnerships, South Western Sydney Primary Health Network, affirmed and examined

KEITH McDONALD, CEO, South Western Sydney Primary Health Network, sworn and examined

MATTHEW GRAY, Chairman, South Western Sydney Primary Health Network (GP representative), sworn and examined

The CHAIR: I acknowledge that your submission has been received and incorporated as evidence as submission No. 36 to the inquiry. It has been uploaded to the website and is available for people to read. We invite you now to make an opening statement.

Dr McDONALD: Thank you for the opportunity to appear before the Committee today. The South Western Sydney Primary Health Network is one of 31 primary health networks geographically distributed across Australia. It is commissioned by the Commonwealth Department of Health to, firstly, increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes. And secondly, to improve coordination of care to ensure patients receive the right care in the right place at the right time. The South Western Sydney Primary Health Network is a not-for-profit company limited by guarantee with charitable status; it is not a direct service provider. Our strategic service is threefold: (1) Capacity building primary care to improve the quality of service delivery, centring particularly on general practice. (2) The commissioning of regional services according to prioritised health needs, focusing on improving access to care for vulnerable groups. (3) The integration of care pathways for people at risk of poor health outcomes and for those with challenging and complex needs

Our service catchment is identical to that of the South Western Sydney Local Health District. This region encompasses 429 general practices with 1,047 GPs, 165 GP registrars and 391 practice nurses. Noting the objectives of the inquiry's terms of reference, our submission highlights four key points: Our commitment to joint needs-based planning and strategic collaboration with the local health district to systematically develop integrated services for the region; the need for a whole-of-system long-term approach to health workforce planning; the notable constraints in particular on mental health care and suicide prevention with the burgeoning impact this is having on our communities; and inequities of access to reasonable health care driven by broad social issues including disproportionate levels of poverty, relatively limited public transport, plus extensive language and cultural barriers.

We advocate for a truly patient-centred approach to the development of integrated healthcare services for the growing communities of south-western Sydney that is not arbitrarily constrained or impeded by State and Federal divisions. Rather than focusing on capital investment in another greenfield site for a new hospital, it is our view that better value will be achieved by enabling and fast tracking the following: Predictive risk modelling and more sensitive risk stratification tools; interoperable information and communication technology to optimise clinical workflows and patient care pathways across sectors; and embedded systems and tools that support data linkage and patient tracking across sectors. Application of all the above enablers should be matched with operational investments in things such as innovative models of care that tangibly reduce potentially preventable hospitalisations, more comprehensive development and expansion of both mental health services and suicide prevention strategies, and whole-of-community strategies that overcome the barriers to access associated with widespread social disadvantage. Thank you.

The CHAIR: Thank you, doctor. That was a very good, clear opening statement that has set up the questioning nicely.

The Hon. WALT SECORD: Dr McDonald, in your opening statement you talked about not emphasising bricks and mortar or construction. Do you support other evidence it is concerning that the Berejiklian Government or the previous Government's emphasis is on a $690 million construction plan, a $7 million emergency department, but a failure to actually plan for workforce and provide medical staff to provide the services?

Dr McDONALD: It is our view that the capital infrastructure that has been committed to south-west Sydney for the growth in Liverpool, Campbelltown, Bowral and Bankstown is all important and essential; it is a growing area. You do need the bricks and mortar but you need recurrent skilled staffing and resources to maintain that. Our position is to look beyond the walls of the hospital. Look at the medical neighbourhoods, the networks of clinicians that are there and also have demands, and could have a strong and positive impact on the demand on the hospital.

The Hon. WALT SECORD: As you are aware that GPs are under the federal Medicare system and you are a federally funded arm of government, how do you interact and work with the State Government on planning for healthcare in south-west Sydney?

Dr McDONALD: We have a close relationship with our local health district. We are actually literally in the throes of finalising renewal of our collaboration agreement with them. It is a more mature version than the last one so we will be articulating some key areas where we can work together in practical terms. A good example is that since 2013 we have had an integrated care collaboratively with them which has driven a range of projects where there is co-investment, co-commitment, both in kind in finding and also drawing on other partners. For example, with the local health district we are co-signatories to a range of other partnerships such as Liverpool Innovation Precinct, Campbelltown Health and Education Precinct and the western Sydney Zoo. There are a lot of tangible activities that go on underwritten by a strategic framework and a collaboration agreement.

The Hon. WALT SECORD: GPs in south-west Sydney, I recognise that they are federally funded, but what are the level of bulk billing rates in south-west Sydney?

Dr McDONALD: The last measure was 77 percent.

The Hon. WALT SECORD: How does that compare with other parts of the State?

Dr McDONALD: It is high. In some local government areas it is over 90 per cent in our region. It follows affluence so the more affluent an are is, the bulk billing rates are lower.

The Hon. WALT SECORD: With a high bulk billing rate, how does that translate into work practices of GPs? Does it mean that they have to see more patients or do they have a larger cohort of patients?

Dr McDONALD: To be honest it probably depends on the business model and the practice model as to how they operate. It is not a direct relationship to the billing but there is probably an influence. It depends on the size of the practice, whether it is accredited, what other range of services it offers and the like. There are other variables other than just bulk billing that drives the business model but it can influence the turnover, yes.

The Hon. WALT SECORD: What did GPs in south-west Sydney tell you? As a Committee we have to make recommendations in a final report. What are GPs asking for involving the State Government and State provision of services in health?

Dr McDONALD: I may throw to a GP. One thing is that they want clear, timely, accurate information about patients.

The Hon. WALT SECORD: Can you explain that?

Dr McDONALD: Often patient information is kept in silos—the medical record, updates or new information about diagnostics or so on. It is about that continuity of care. If that can be shared in a timely, accurate and safe manner, it could make a big impact on the patient follow-up.

Dr GRAY: If I may just pick up on your last point as well, the other thing we are doing as Primary Health Network as a group from New South Wales and ACT is we have a council that meets three or four times a year and we interact with the secretary of Health as part of that. It is sort of a collaborative approach statewide to PHNs. Moving on to your question around what GPs want—yes. There is a large proportion of our day-to-day work that actually involves care of a person that does not interact with a health service during any given month or year but there is obviously a significant proportion, perhaps in the range of 10 per cent or 12 per cent a year that are moving through a health service and a general practice.

There are various touch points of general practice with the health service, the emergency department is a key one, some of the shared care programs such as antenatal shared care, or if people are needing procedural work done. I think GPs want to be able to navigate the system that is beyond their practice. They want to do it as easily as possible and they want to do it as safely as possible. Information and sharing of clinical information is one of the key things that can assist with that. I am sorry to be the first one from our group to bring up COVID but COVID has actually demonstrated what general practice is able to do through the coordinating work of the PHN as an extra ability for our State Health to both inform and we can actually help with managing people and navigating the current crisis.

The Hon. NATASHA MACLAREN-JONES: I might expand upon your comments there. In your submission you said that telehealth is now representing about 40 per cent of GP consultations—I presume relating to the COVID period. You then say that you have been provided an opportunity to look at more reform in this area. Can you outline what you envision the opportunities for State governments and in working with the GP practices? Obviously it is a Federal/State relationship but where are the opportunities in an ideal world?

Dr GRAY: Yes, I think what we recognise is that we have switched the way general practice has been done for many, many years with the advent of COVID and the ability to use telehealth. I have certainly read stuff around what patients and people think are suitable for telehealth and it has been a different way of delivering care. I think moving forward there will be a role but it will have a complementary role to the face-to-face work that is being done. Similarly, probably some of the specialist colleagues and the hospital services have also been able to adapt to telehealth. What we have been talking about in terms of envisaging for the future is—of course telehealth and other things—we are actually very interested in the ability to get real-time information.

We are familiar with the My Health Record. It will potentially be some information that is posted to an account but it is not actually a live, living piece of information. Whereas what we are talking about is, say, I have seen someone in my general practice at six p.m. and I have been concerned that they might have a gallbladder attack. I have sent them for an ultrasound that has been done expeditiously potentially outside of the hospital service but they then have a diagnoses that might need to be dealt with in hospital. They can get to hospital. That information can be accessed; it does not need to be repeated. It is similar for pathology.

Medications: An accurate list or a source of truth for medications so that we have less adverse events for medications. There are a whole range of possibilities but it does require general practice software, for example, and other primary care providers being able to interact with the software within the hospital. Keith and Kristen are much more expert at the actual techniques of that.

Dr McDONALD: The example that we put in around telehealth was to give you an example that the sector is open to change and adaptation. We have moved quite rapidly to adopt telehealth. It also showed that different models of care can be worked around. As a first cut those items were okay but were a bit blunt and already some refinement is happening to them. One of the opportunities, for example, which would be a first in Australia, is that the items as of this month or later this month can only be used on patients known to the practice for the past 12 months.

The next step to that will be voluntary enrolment to enrol to a practice if you are known to a practice. You can build packages of care around the patient and in those packages of care you can incentivise and get more continuity and coordination. The evidence around that has been shown in New Zealand, the United Kingdom and to some extent in the health medical officers [HMO] in the United States. Moving to models of care around identified registers of patients with particular needs, you can get quite innovative.

The Hon. NATASHA MACLAREN-JONES: In your submission you talked about a medical neighbourhood, the local health district talked about the integrated health neighbourhood, I assume you are referring to the same concept or is your medical neighbourhood concept bigger?

Dr McDONALD: Ours is better.

The Hon. NATASHA MACLAREN-JONES: Where can it expand on what is currently available? Where can it go?

Dr McDONALD: The similarity of the neighbourhood approach is that you have collectives of providers, a natural catchment, if you like, of providers working together around known patients. So the concept overlaps in the sense that the local health district [LHD] is talking about paying its community-based services in a hub and then that working with a range of general practices. In the medical neighbourhood model as we developed it, it is around having practices working together, sharing and re-sharing your savings around those identified patients and working with their local hospital to reduce their level of potentially preventable hospitalisations. There are synergies there.

Dr GRAY: And we are working collaboratively with them on the medical neighbourhood in terms of agreement.

Dr McDONALD: Yes, they are co-partners.

The Hon. NATASHA MACLAREN-JONES: And how are you finding the practical operations of the club? You talked about the medical hub and also the neighbourhoods as they exist now, how are you finding that operating?

Dr McDONALD: Both are literally in the establishment phase. In our case we have done the joint venture agreement with the local health district. We have the team set up, the models designed, but we now have to move on to practice and engaging and contracting practices, and then patient enrolment will follow. We are literally at the set-up stage.

The Hon. NATASHA MACLAREN-JONES: And what is that time frame?

Dr McDONALD: For the medical neighbourhood it is initially a two-year project to evaluate with a three-month rolling enrolment of practices and cohorts of patients over that period.

The Hon. NATASHA MACLAREN-JONES: And what is the number of patients you would be looking at dealing with? Or is it too early?

Dr McDONALD: In those first two years we targeted about 1,000 patients. Targeting with chronic disease—not a specific disease but specific metrics around the chronicity and the complexity of the disease.

Dr GRAY: And obviously very focused on those that are more likely to be hospitalised during that period.

The Hon. EMMA HURST: Thank you all for coming in today, we really appreciate your time. Dr McDonald, in your submission and also in your opening statement you talked about the need to reduce potentially preventable hospitalisations, can you expand what you mean by that for the benefit of the Committee? Can you also give us some indication about what the State Government could be doing to prevent those hospitalisations?

Dr McDONALD: Potentially preventable hospitalisation [PPH] is actually a defined term. It typically looks at and has been modelled on up to eight disease states where if everything worked according to the textbook upstream that person would not have been hospitalised, but at the time that they are hospitalised they need it because not everything has worked perfectly upstream. So it is potentially preventable but by the time they are there it is not avoidable. Their whole idea is that if you can invest in the systems upstream to make the quality and safety of everything upstream more effective than you will reduce the rate of hospitalisation. You will not reduce all of those because they are chronic and complex patients, typically. You will not reduce all of those presentations. However, the international evidence and some small scale trials in Australia showed that if you can reduce that PPH by 15 per cent you make a net saving to the hospital in bed days.

The Hon. EMMA HURST: From a practical sense, what could be done that maybe is not being done as well is it could be?

Dr McDONALD: As we have alluded to, there is a range of activities around having an identified risk rated register of patients so that you know what their risk is of being hospitalised. You track those patients who have a care plan built around them with a multidiscipline team and the evidence shows that if is primary care led, typically by a GP, it is more effective. You invest in that practice with a lot of quality improvement tools. The big one, which again is one thing that south-west Sydney is trying to champion, is having that real-time safe exchange of information around the patient for the primary purpose of their clinical care. Who has the clinical governance, which the modelling shows should be a GP, but then you have specialist allied health nursing. Also, possibly the big thing that is often missing is the psychosocial support for that patient outside their clinical care—the gum that sticks it all together. Often it is the patient's level of activation—being able to attend appointments and live their life in an empowered way—can impact on their health outcomes and having a care-enabling wraparound service as well.

The Hon. EMMA HURST: You mention in your submission the need for greater community-based follow-up, particularly in relation to suicide attempt as well. How do you think that would also benefit rehabilitation, particularly for people with mental health episodes?

Dr McDONALD: That same model. Again, we are looking at it as another cohort. We think probably because the trajectory of the mental health patient again depends upon the severity and complexity it could be slightly different to a person with a physical chronic disease. It may need adaptation but the concepts still should apply. It is one of the cohorts that we are thinking about applying the model to in a future role.

The Hon. EMMA HURST: We have talked about some of the problems with GPs in the area and you note in your submission that there is a 25 per cent decline in GP register placements in the south-west Sydney region area since 2016. How do you think we need to increase the GPs in the area? What needs to happen?

Dr GRAY: I will start, if you like, Dr McDonald. There are two challenges there. One is a national issue, and that is that graduates choosing general practice as a specialty has declined in recent years. You could probably all think of some reasons as to why that might be. What we also have, again, is registrar placements that are done using an RTP—a registrar training provider—of which we have one for the State, but the state is broken up into three regions—again, a federally funded organisation, GP Synergy. I guess there are a range of needs that they need to address, including our rural and remote areas—urban as well. I think in the document you will see elsewhere much of our area is outer metro—some of it, of course, rural—and potentially the corridor of workforce that is not potentially well supplied, like the inner city, and not having the incentives that the rural and remote areas have. So I think we need to look at what can be done at a State level around advocating to the Federal

Government about outer metro, but also if there are any levers the State Government itself has to attract people to those areas.

The Hon. EMMA HURST: Thank you.

Ms CATE FAEHRMANN: Thank you for appearing today. I wanted to touch on the evidence in your submission on pages 3 and 4, where you talk about the information and communication technology [ICT] systems—specifically that there is the ongoing commitment between the local area health district and the primary health networks in relation to jointly pursuing the ICT interoperability, adoption and diffusion. You were saying that this has been too slow because it has been impeded by cost, regulatory and bureaucratic barriers at the level of eHealth NSW. There is a key recommendation there as well. Could you expand on what the bureaucratic barriers are? Expand a little bit on what that paragraph means, please.

Dr McDONALD: We have been investing in a model for—it would be close to four years now, around interoperability. With that, through a submission to Health Infrastructure NSW, the LHD pursued a grant to, essentially, marry the model so it worked both ways between primary and acute care and would perfectly fit what we are trying to achieve. So there is good collaboration there in terms of what the objective is that we want to achieve and test. Unfortunately, the scope of what was to be chosen on the State side got stuck between State infrastructure and eHealth NSW, which are two statutory arms of NSW Health. So it has been bouncing around at great length, trying to pin down what their defined scope is and how they would pursue it. In the meantime, our project has now gone live and we are onselling licences to other parts of New South Wales. The risk to the State side is we could well go interstate too quick for them, and that is frustrating for us because we actually have a workable system platform, which needs interaction with the State system. The money is there but it is just—to be honest, for the nature of the work and the critical nature of what we are trying to achieve, it has been too slow.

Ms CATE FAEHRMANN: It sounds like questions we might ask future witnesses as well. One of your other recommendations is—and this has mirrored some of the evidence heard from previous witnesses this morning—that investment in existing hospital campuses is more feasible than developing another greenfield site. Just exploring that a bit more around why, then, the Government has pushed the development of a new hospital, for example—talk the Committee through the consultation processes that NSW Health and the Government would have engaged in to get the views of the local health community and yours, particularly. I am trying to grapple with why, then, this has been the Government's priority when so far this morning everybody seems to have suggested that if there is a limited health budget, which there is, potentially, that $650 million or whatever it was being spent on that hospital is probably not the best use of money right now. Do you think you have been adequately consulted as to what the needs are in south-west Sydney?

Dr McDONALD: We have a joint needs analysis with the local health district, which we developed several years ago and evolving over several years. So we were well consulted on needs. Our comment was not around the existing expansion of sites; it was around to add another site at a greenfield site. So the expansions of Campbelltown and Liverpool and Bankstown and the like on existing campuses—we do not really have a comment on that, that we think that is sufficient for the level of growth of the figures we have got till 2031. We know that we have seen some figures beyond that, but that is it within our planning.

Dr GRAY: Although, being a GP in the Camden and Campbelltown area for over 20 years, I am very confident that our area needed an expansion of its hospital services. That is my personal view. Again, I would second what Dr McDonald said, that it was not actually a comment around the existing expenditure, just whether or not another site—potentially near the airport or something.

The CHAIR: I have a couple. We have been going pretty solid almost four hours today; we started about 9.15 a.m. As I said, sorry about the delay. We have had, including yourselves, 12 very expert witnesses who have covered a number of areas and sub-areas in this matter of south-west Sydney growth and health. Not once has there been a mention of palliative care in the context of anyone. Indeed, whilst hearing the evidence, I was just going through the submissions. It is not even thus far mentioned in any of the submissions that we have covered over the course of the witnesses before us today. So it is not in the submissions and nor has it even passed their lips. I am wondering, what does that say or mean?

Is there anything that that suggests about the issue of palliative care—perhaps more broadly speaking, if you wish to comment on that, but in the context of specifically what we are looking at, the consideration of that issue of the provision of palliative care in south-west Sydney? It is not meant to be a curve ball. If you wish to take it on notice, you are more than welcome to do so. I am not putting you on the spot. But there are a couple of minutes left and as I was reflecting on this, I thought it was very interesting: a half-day of hearing and it has not even got a guernsey. What does that mean? What does it say?

Dr GRAY: It is interesting. What I would say is general practice—in a general practice like ours, palliative care provision is absolutely part of what we do in terms of the familiar line some may know around "cradle to grave" care. If my wife, who is also a GP, were here she would probably—she does a large proportion of the palliative care for our practice. It is very much an issue in the work that I do. So it is important, not just in a societal sense, but actually important to what I know we do as a practice from day to day. There is a service called PEACH [Palliative Extended and Care Home] within our community for end of life in the last seven days. That is for a package of care for those in the last seven days of life, with the aim of enabling them to die at home if necessary.

We do have an excellent palliative care service at Camden Hospital, which, again, is the one I know best, closer to where we are. What I would like to see there is better—when we talked before about information sharing and communication between general practice and palliative care at a health service-run level. I think, again, technology and information can actually assist with that. I do know—and Dr McDonald will be across the details more—we actually are doing some work around medication prescribing during the end of life because we are aware of and we have faced issues around access to medication after hours, et cetera. That is, again, that collaboration with our LHD.

The CHAIR: In terms of pain relief, specifically?

Dr GRAY: Yes.

The CHAIR: Dr McDonald?

Dr McDONALD: Possibly my only other comment to add to Dr Gray's comments is that I think the palliative approach is critically important and should be recognised, not just the specialist palliative care services but for aged care, primary care and across. There is even a role now for the ambulance in palliative care, with certain instruments. Possibly my only comment is perhaps why it has not come up this morning is personally I did not see it asked for in the terms of reference, in the way it was structured.

The CHAIR: No, nor was it specifically in the terms. But we have, as you might imagine, over four hours covered quite a broad number of matters health, and some of the submissions have been very specific in terms of particular thoughts about provision of specific matters, which they see as deficiencies. I was just curious that the palliative care did not seem to—

Dr McDONALD: It is certainly not ignored in our region.

The CHAIR: No, please, nothing to be implied from my question. That was not the purpose of me raising it. It was just a reflection that it had not been articulated specifically by any particular witnesses. I was just curious whether you had some thoughts about why that might be the case. Thank you all very much. It has been very helpful to provide us with the opportunity to ask you questions following on from a very useful submission. There may be some supplementary questions arising from the members once they have had a chance to read the Hansard. If you are agreeable, our secretariat will liaise with you. There will be a 21-day turnaround time to provide that information back to the Committee. Thank you very much for your evidence and thank you for the great work that you are doing in pretty challenging times out there in south-west Sydney.

Dr McDONALD: Thank you for your time. We appreciate it.

(The witnesses withdrew.)

(Luncheon adjournment)

GRAINNE O'LOUGHLIN, CEO, Karitane, sworn and examined

JORGE AROCHE, CEO, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, affirmed and examined

FRIEDBERT KOHLER, Director of Medical Services, HammondCare Health, sworn and examined

The CHAIR: Thank you. We will invite each of you to make an opening statement. We have received your submissions. Karitane's submission stands as submission No. 32 to the inquiry and is accessible through the webpage. The submission from the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors [STARTTS] is submission No. 54. That has been received and incorporated onto the webpage. HammondCare's submission is No. 48. It has been received and incorporated onto the webpage. You can take those submissions as read; the Committee members have read them. With your opening statements, you do not need to go through the content in detail, but perhaps set up the overall position you want to articulate and put to us. Once that is done, if you are agreeable we will open it up to questions from the Committee members. We have members on this Committee from the Opposition, the crossbench and the Government. We will share the questions between ourselves to elucidate further information from you. We will move from left to right. Mr Aroche, we will start with you.

Mr AROCHE: STARTTS' job is to address the impact of torture and refugee trauma on the mental health and psychosocial adjustment of refugee populations that are settling in New South Wales. That is to enable them to regain their capacity to live full and fulfilling lives in health and dignity. We have assisted over 70,000 people since the service started in 1988—just 22,195 over the past three years, and 11,500 of those from the areas of south-west Sydney that we are talking about. We are not qualified to comment on the first point in terms of whether we need another hospital. What we certainly feel qualified to point out is that increased resources will be needed in that area. We can certainly see that now. The resources, given the demographics of the area, need to be community based as much as possible. Being proactive and providing services that are culturally sensitive and trauma informed is crucial when we are dealing with a population with a large percentage of people from very diverse cultural backgrounds and one that every indicator would suggest may include a large number of refugees. That number may increase as communities settle and begin to act as sponsors for a community.

We believe that services that are proactive in terms of getting where the people are—in schools, in communities, the places and the networks through which they congregate—are most effective. I think that is a much more cost-effective way of providing services and ensuring that things do not get to the point where they need hospitalisation and more acute services. Our experience indicates that if we can do that, the results are much better. There is also a need to ensure that when we go to one of the other points of reference in terms of a workforce, I think it is important to ensure that the workforce is trained so that it can be culturally sensitive, trauma informed and also, as much as possible, that it has the skills, both linguistic and cultural, that enable them to relate to what is likely to be a very diverse client population. That, of course, includes resourcing—not just the mainstream health as a whole in those areas, but also ensuring that specialised services, like ourselves and refugee health service, are able to provide a credible and well-resourced service in that area as it grows and as the refugee population in that area grows.

The CHAIR: Thank you, Mr Aroche. That is a very helpful opening statement and sets up some further questions for us. Ms O'Loughlin, would you like to provide your opening statement?

Ms O'LOUGHLIN: Yes, thank you very much. My opening brief will really focus on elements (c) to (h) in your terms of reference. I do not have much commentary around (a) and (b). Thank you very much for our invitation to appear and to have a discussion today about the relative provision of health services in south-west Sydney. It is of particular interest to Karitane. We are a specialist provider of perinatal and infant mental health and child and family parenting services, servicing some of the most vulnerable families, parents and children from across our State. These include—particularly in south-west Sydney—young parents in custody, parents struggling with mental health, trauma backgrounds, child protection, family violence, drug and alcohol and people with complex social issues, often struggling to preserve children in their care.

Whilst we are a State provider of specialist parenting services, our main physical footprint is in the heart of south-west Sydney. We are located at Fairfield. Approximately 75 per cent of our funding is directed to services within the South Western Sydney Local Health District, and the demand certainly grows. I know that from many of your presentations, you will be very aware of the key demographics of the district. Obviously, there is significant population growth, a high proportion of children and young adults, higher birth rate compared to New South Wales, and high rates of social disadvantage, as well as the high rates of humanitarian settlement in the south-west. These factors combined contribute to an increase in demand for and complexity of parenting support

for our families. Certainly, the evidence is very clear that early intervention and prevention provides long-term benefits and better mental health and social outcomes for these most vulnerable babies and young children.

Our staff numbers have not increased in the last six years that I have worked at Karitane. Our activity has reached ceiling levels and our waitlists have continued to grow. An external review of our funding, which was conducted by O'Connell Advisory services in late 2018, demonstrated that Karitane's activity levels, as measured through the Activity Based Funding model, represented an underfunding of 52 per cent, which equated to $2.7 million per annum at that particular point in time. In an effort to address our funding gaps, we have proactively engaged in strategic communications with all points of government at the local health district [LHD], ministry and Minister level. We have provided letters, evidence-based, rigorous academic studies and return on investment [ROI] reports that demonstrate and support the impact, efficacy and efficiency of our work. We have aligned our work to the NSW Health strategies, principles of the NSW First 2000 Days, and value and outcome-based care.

As a registered charity, Karitane has also continued to raise almost $1 million per annum in philanthropic funds to support services and fill the significant recurrent funding gaps. These moneys have also funded the expansion of other statewide services. We have innovated and established telehealth and integrated care hub models in the community to improve efficiency and access. We certainly appreciate the recent increase in government funding which has been provided; however, this new funding is far outweighed by the increased demand for our services and population growth. Just having a look from 2014 to 2019, our total operating revenue has sat at $11 million or thereabouts. At 2019, it was still at $10.6 million.

Our waitlists have continued to increase, with over 170 young children as at March 2020 with significant mental health and behaviour conduct issues on our books waiting 10 weeks for treatment. Our residential unit beds for parents requiring complex parenting support have a waiting list currently of 16 weeks and our maternal mental health services have a 14-week waiting time. We fully acknowledge the funding challenges across the health sector and especially during COVID-19, which has seen an unprecedented spike in demand, with a 95 per cent increase in Karitane's referrals since March 2020.

We continue to face challenging decisions to rationalise and reduce services in south-west Sydney as demand outstrips our funding. The processes of accessing growth or additional funding allocation for secondary and tertiary services like Karitane remain somewhat ad hoc and we would welcome equity in distribution to service providers across LHDs that is transparent and proportionate to local demographics, level of vulnerability and expertise of service providers.

The CHAIR: Thank you, Ms O'Loughlin. That opening statement was clear and precise.

Associate Professor KOHLER: I thank the Committee members for inviting HammondCare to present to this forum. We have a long history of providing aged care services to the community. We have been doing so for over 90 years and more recently, over the last 10 years or so, HammondCare has acquired what used to be Hope Healthcare. That is the majority of the Hammond health arm. Braeside Hospital in south-west Sydney is a service provided by HammondCare. HammondCare, as all of us who deal with ageing are faced with the challenge of our own success: We live longer; we are able to survive significant morbidities and comorbidities as we age; we survive serious accidents and have disabilities from these; we are also affected by the many challenges of modern life that result in psychological disease, psychiatric disease, and the consequences of dementia.

The three areas in which HammondCare works in the healthcare sector is rehabilitation, palliative care and psychiatry. I will start with aged care psychiatry. The demand for aged care psychiatry is almost endless as the population ages. The incidence of dementia goes to 40 per cent for those who reach an age of 90 or older, 28 per cent if you are 85 plus, it is obviously a little less, but it is directly related. Dementia itself is not a problem per se apart from needing care and other people need to help you, but you also have some behavioural consequences and some behavioural disturbance that goes with it which needs specialised treatment. In all areas, including south-west Sydney, that service needs to continue to be developed. The particular challenge in south-west Sydney is that we come from a low base in south-west Sydney. Predominantly in the outer suburbs of Sydney it was a younger population.

The population is ageing. Some of the parents or grandparents who are looking after the grandchildren are moving into the area and that causes significant demands. There are population projections of a 125 per cent increase in the 85 plus population in south-west Sydney. There is a considerable demand that is not unique to south-west Sydney but exacerbated in south-west Sydney because of the historical trends that will require ongoing management and provide ongoing challenges. Palliative care is an issue which is well addressed in many services around the country, but try as we may people will continue to die, it is inevitable. To provide a comfortable and supportive environment during death is essential. The resources to do that are also essential. The palliative care services that Hammond provide to south-west Sydney is a 16-bed unit as well as outpatient services, but there are

many other components to palliative care services both in south-west Sydney and across this State. That needs continued attention to ensure we keep up with demand.

From the point of view of rehabilitation, south-west Sydney has the second highest number of clients accessing the national disability insurance scheme, which is probably the best meter of how much disability there is in the community. There is a particular aspect to disability in south-west Sydney which is related to the migrant population and particularly the refugee population, the high intake and the high settlement in south-west Sydney of refugees brings with it a particular challenge that many of them have disabilities and medical conditions and comorbidities that have not been addressed adequately in their country of origin or in the intervening countries where they have stayed. They then come to us with significant functional challenges, which in some cases can be dealt with through additional rehabilitation and in some cases can only be dealt with by providing appropriate services.

There are the challenges which we face on the point of view of providing those services. There are some unique opportunities in that HammondCare works very closely with south-west Sydney local health district and has a very good relationship and it also provides services in the aged care space. So, both residential aged care as well as community aged care packages and we have the opportunity to actually look at the effects and we have combined projects to outline how to minimise presentation of people in the community to the hospital. We can provide care in the community to the residential aged care sector. Braeside Hospital has some experience with this model of care, some innovative experiences with the model of care of providing services in the community, which are very efficient from the point of view of cost effectiveness, but provide nonetheless a very high quality of care that is equal to in-hospital services. Health services, from our perspective, are both the in-hospital services as well as the community-based services.

The CHAIR: Thank you for those opening statements.

The Hon. WALT SECORD: Associate Professor Kohler, you made mention of palliative care, what is the demand or need in South Western Sydney? You said you have a 16-bed facility, is there a waiting list? What is the demand for your services in the area of palliative care?

Associate Professor KOHLER: We have a 16-bed palliative unit at Braeside.

The Hon. WALT SECORD: Sorry, did you say 16 or 60?

Associate Professor KOHLER: Sixteen, one-six. We have a 16-bed unit at Braeside, there is also a palliative care unit at Camden, there is also a palliative care unit at Liverpool Hospital, and there is in-reach palliative care service in Bankstown. There is access to palliative care services at Bowral, to be complete, from the point of view of south west Sydney local health district. As well as that it is complemented by community palliative care services that is generally run on a sector basis, but the service is coordinated. So, Braeside palliative care service is part of the bigger south-west Sydney palliative care service. I think currently the demand is reasonable, looking at the bed occupancy.

We do not generally have prolonged waiting periods across the district, but of course that fluctuates. COVID has certainly decreased the waiting period for a whole lot of other reasons that we do not fully understand. There is room for further investment into palliative care service in the community. New South Wales has some very innovative models to provide care for patients at home. The vast majority of patients actually tell us that they want to die at home, so it is not just in-hospital services which are important but the in-home services. There is probably a reasonable balance, but some further development is required.

The Hon. WALT SECORD: Does HammondCare provide support for people who wish to die at home?

Associate Professor KOHLER: HammondCare does supply support for people who wish to die at home, but I have to qualify that because from Braeside we have an outreach service, or a community of palliative care service and then there are also packages to support people at home which in south-west Sydney is called the PEACH service, palliative extended and care home packages. That is run by the South Western Sydney Local Health District and the competitor service, if you want, in New South Wales is actually run by HammondCare, but it does not supply south-west Sydney.

The Hon. WALT SECORD: Can I take you to community care packages. As you said in your evidence, there is a desire for elderly people to remain in their homes as long as they possibly can. What is the scale of community care packages in Western Sydney and is there any unusual aspect that you would like to draw to our attention?

Associate Professor KOHLER: Community care packages from the point of view that the actual community care package for elderly people is, of course, provided and funded by the Federal Government. These statistics speak for themselves. There are other better authorities than myself; there seems to be a long waiting list

to access them and many people do not have access to them. That has a secondary flow on to the health requirements of those individuals because sometimes the health service is seen as the fallback position, in fact not sometimes but often it is seen as a fallback position. That is another challenge of dealing in the aged care space, the fragmentation compartmentalisation of service provision.

One of the essential things we need to address more and more and that is currently in vogue is to have a much more comprehensive integrated care delivery. This is particularly true for the elderly, but it is equally true for the rehabilitation service, the divide between health and the NDIS applied services has been well documented and it is also true for aged care psychiatry services. So, in all cases in the subacute sector the coordination and integration across many different players is essential and can be improved.

The Hon. WALT SECORD: How many beds or places does HammondCare have in south-west Sydney?

Associate Professor KOHLER: Seventy-two beds.

The Hon. WALT SECORD: That would be called residential aged care?

Associate Professor KOHLER: No, they are subacute hospital beds. You have now asked me about beds and I now need to make a correction. It is actually 20 palliative care beds at Braeside Hospital, the 16 beds are aged care psychiatry beds. I apologise for the mistake.

The Hon. WALT SECORD: The hospital subacute beds, the composition of people who use those beds, are they from culturally and linguistically diverse backgrounds? I am trying to understand the unique demographic makeup.

Associate Professor KOHLER: At any one stage 50 per cent of the patients in those 72 beds would come from non-English speaking backgrounds and I cannot give you exact percentages of how many would need interpreters, but it is a significant proportion. Every ward round we need to have interpreters or communicate by alternative means rather than direct English to English conversation.

The Hon. WALT SECORD: I understand that as people age they revert to their original mother tongue.

Associate Professor KOHLER: Yes, that is a common scenario.

The Hon. WALT SECORD: Mr Aroche, you mentioned there were 1,150 people who have come through your service who live in south-west Sydney at the moment. What is the composition, what areas, countries or regions would they come from?

Mr AROCHE: It is actually 11,108 that we saw in the last three years from the area.

The Hon. WALT SECORD: What regions or areas would they come from?

Mr AROCHE: I currently have people from 100 countries around the world. The regions, certainly Afghanistan would be one of the biggest sources, but others that are very well represented are Burma, Iran, Sudan, in particular South Sudan, Vietnam and Latin America.

The Hon. WALT SECORD: Has that changed in recent years?

Mr AROCHE: It is constantly changing.

The Hon. WALT SECORD: How do you respond to the constant changes? Do you respond with a different workforce, how do you respond to the changes?

Mr AROCHE: It is an ongoing challenge and it involves a mixture of an evolving workforce. On the one hand work is very specialised in working with trauma and understanding the context with torture and other traumatic circumstances that happen. On the other hand, cultural and linguistic skills are very important. When we advertise we usually advertise for community language and familiarity with particular cultures as one of the additional skills that we look for and that has worked very well. Roughly 60 per cent of our workforce speaks another language and there is quite a high level of representation.

We have developed training for cultural counsellor positions where we have taken in people that have not had the qualifications that we needed but were on a pathway to acquiring them or had similar qualifications back in their country and would prefer to complete their studies here. The traineeship assisted them. We use a lot of interpreters and sometimes given the demographics of our client group, we are a statewide service, it is not possible to also use psychologists or social workers with a particular language with all of the people from that background, so we often have to use a mixture. People with other languages may have to work with interpreters. It is a constant challenge and they have all been one as different refugee groups come into the country and settle in different areas. It is a very mobile group.

The Hon. WALT SECORD: Excuse my ignorance, does STARTTS receive State funding?

Mr AROCHE: Yes.

The Hon. WALT SECORD: What is the funding breakdown, the composition of State, Federal and private?

Mr AROCHE: The composition is we get roughly about 60 per cent from the Commonwealth and about 40 per cent from the State and mostly from the New South Wales Department of Health. But we probably have recent funding from about 20 different bodies, many of them for smaller projects. The biggest funder overall is the Commonwealth Department of Health through the Programme of Assistance for Survivors of Torture and Trauma [PASTT].

The Hon. WALT SECORD: Ms O'Loughlin, you said there was a 95 per cent increase in referrals during the COVID?

Ms O'LOUGHLIN: Yes.

The Hon. WALT SECORD: What were the nature of those referrals?

Ms O'LOUGHLIN: The nature of those referrals were families needing early parenting support for adjustment to parenting.

The Hon. WALT SECORD: For the uninformed, what is "early parenting support"?

Ms O'LOUGHLIN: Things like people coming home with new babies that need support with breastfeeding, sleeping, settling, those sorts of challenges. The next biggest group of referrals were for young children with behavioural and conduct disorders. We had a lot of parents working from home with children in their care who have behavioural challenges that escalated into referrals. Later as COVID progressed a number of families with social isolation and mental health issues such as depression and anxiety.

The Hon. WALT SECORD: How would a referral get to you? Would not someone simply call the Department of Community Services, why would I pick up the phone and call Karitane?

Ms O'LOUGHLIN: Most of the families that we would see are classified in the New South Wales health system as level 1, level 2 and level 3 depending on their needs and the complexity of their issues. Level 1 might be someone with sleep and settling problems, home with a new baby, first baby; level 3 might be someone from a trauma background, multicultural, child protection and on the cusp of care where the Department of Communities and Justice may be involved with caseworkers. We would operate predominantly in the health area as a secondary and tertiary health provider in the health domain.

Where a family would go and see their GP or obstetrician at the four to six weeks or a universal home visit from a nurse where things are not looking fabulous and they are not able to be supported in the universal system they would traditionally be referred to Karitane. What happened during COVID was that GPs were not providing care because they were closing down clinics and a lot of the universal home visiting stopped. We opened to self-referrals where families could self-refer they just came in in droves. They went on to our website and self-referred, told us they had an issue, and needed support.

The Hon. WALT SECORD: With counselling, would assistance occur over the telephone?

Ms O'LOUGHLIN: With the infection control issues we switched to virtual care. We had already been providing virtual care, supported by Minister Hazzard, for the last three years across the State. We trained from 15 staff up to 85 staff during COVID to respond with virtual home visits and virtual residential stays and the like.

The Hon. WALT SECORD: You mentioned three sets: 10 weeks for treatment; 16 weeks for parents; and 14 for another group. Are those waiting periods?

Ms O'LOUGHLIN: Yes. When the referrals come in they come in to a central intake, we contact the families, we triage them and determine the severity, we ask them pertinent questions and then we put them on the waiting list according to their triage category and the waiting time.

The Hon. WALT SECORD: If you have a baby that is not settling—I remember 29 years ago when I had a baby—10 weeks would be a hell of a long time

Ms O'LOUGHLIN: Correct. Timely accessible care is part of our issue. We have a very small bed base and a long waiting list. What we have tried to do with the virtual care is offer interim support such as a virtual home visit or a telephone call whilst families are waiting for this complex care. Sometimes that abates the need for the complex care but sometimes it just holds the family and supports them while they are waiting for this more complex wraparound.

The Hon. EMMA HURST: Ms O'Loughlin, you speak in your submission about the lack of coordination and collaboration between the different government departments for funding into early childhood intervention. Can you talk a little more about some of the specific problems you have experienced because of this lack of coordination?

Ms O'LOUGHLIN: Yes, certainly. We receive funding primarily from NSW Health and within that there are two branches that would deal with Karitane, there is the health and social policy branch and there is the mental health branch. Even from those two branches the level of communication, all families traverse branches, so it is not very clear which branch will fund a particular activity. Alongside that we do see funding from the New South Wales Department of Communities and Justice and they would be the families at the more vulnerable end of the spectrum traditionally and target early intervention programs. The communication if I approach the Ministry of Health they say go and talk to DCJ and DCJ say go and talk to them.

Then we have some Commonwealth DSS fund which is very postcode specific to very vulnerable families particularly in south-west Sydney where a number of NGO providers are engaged. Having a bird's-eye view I can see that some areas are receiving funding to multiple organisations to provide services to a similar cohort of families where there are gaps in other parts of the district. Coordinated care between DCJ, DSS, NSW Health and the NGO sector to have a really functional integrated care model is what I see as required.

The Hon. EMMA HURST: Will that require increased funding to fill the gaps or are there funding overlaps where it could be moved around?

Ms O'LOUGHLIN: I think there is probably capacity for some redistribution of funds if it was coordinated well. I think there are some unique gaps for specialty and niche areas certainly in the young child and infant mental health space. I think that is across the board quite under resourced. I think there is a lot of care crossing the Medicare divide between brief interventions by psychologists for people with mental health issues and for families with secondary and tertiary level, those short interventions are not sufficient.

The Hon. EMMA HURST: Mr Aroche, in your submission you mention the mental health community living support for refugees, which was a program that you ran successfully in the past. Can you tell us a little bit more about that program and what is needed to expand the program to reach more people? Is it a matter of funding or are there other things that are needed as well?

Mr AROCHE: It is essentially a new program. It only started, we have been running it now for a year. It was announced at one of our functions, at the opening of our Fairfield office, as a program by the then Minister for mental health. We worked quite a lot with the department for the program to be shaped into something that would fit the needs of the refugee community. The program usually operates to provide people with severe mental health issues with the additional support that they require. We have many clients that fall into that category. The composition of the clients and the problems that they have are quite different. If provided with the right level of care, they tend to have a better prognosis than most of the clients that benefit from the CLS as a whole.

During this year what we found is certainly that once we were able to publicise the program and let people know about it, particularly let mental health services know about it, we had quite a high level of demand. We found that the program has been very well received. So far the evaluations—mind you it is the first year so we are still learning as we go how to provide the program better. It has been a very strange learning curve because half of the program, when we would have expected it to really take off, was when COVID-19 came, which imposed a whole lot of restrictions on what we could do.

Strangely enough, we were able to provide people in that most vulnerable situation, the kind of people that find it hard to deal with a lot of everyday challenges because of the amount of, I suppose, problems associated both with the trauma but many of them have secondarily acquired mental health issues. If we are able to provide the containment and make their life easier then they are much more able to then access some of the more intensive services that we are able to provide for the more acute and more symptomatic group.

Once we do that we tend to find that people can improve a lot more. In the past what used to happen is that there was a continuous source of frustration for our counsellors that we had the tools to help people in their client group but they could not access the services, organise themselves to attend services on a regular basis, to sort out transport and so on, to make it to the appointments that they had to attend. This has been extremely helpful. We do not have the whole of the State, we have about 60 per cent, but we have the area of interest to this inquiry.

The Hon. EMMA HURST: You also mention in your submission that it would be useful to increase the employment of community members with the refugee backgrounds to help with the New South Wales health developed target health strategies. Are you aware of any programs to try to get recruitment of these individuals?

Mr AROCHE: I have been aware of many programs over time. I am not aware of which programs have been implemented at the moment.

The Hon. EMMA HURST: Is there more need in that space?

Mr AROCHE: Absolutely. Particularly in the area of refugee resettlement. We are dealing with a constantly changing group. People who go into the service and are assisted to acquire the skills that they need to be active in the service certainly continue to contribute, but to begin with there is often a bit of a barrier that you need to overcome in terms of helping people get their qualifications recognised and adapted to the Australian system, overcoming language barriers, and that translation of skills and the right way to improve the skills so that they can fit into the workforce here.

The Hon. EMMA HURST: Associate Professor Kohler, you said in your submission that there is a need to establish a network of palliative care hospice units within residential care homes and it makes economic sense for the Government to invest in that type of unit. Can you tell us little more about your vision for this and why it is so important?

Associate Professor KOHLER: It addresses this desire of people not to die in hospital, they want to die in the community. Particularly people in nursing homes want to die in nursing homes and people in the community want to die in the community. Nursing homes by and large do not have the expertise to deal with prolonged end of life. They provide very good care for people who need it, but there are some special skills required to deal at the end of life and with people who have got pain, in particular, and the pain management.

That is really a focus that palliative care tends to offer, as well as the psychological support for the families who see their loved ones going through significant suffering. That is not routine management in nursing homes. It is offered in some, but it is for us to develop that service more broadly. That is something that has been done at the Hammondville nursing home. It will actually pay off, because it actually means—economically, it will pay off—it means that a larger number of these patients could in fact be cared for in their place of living, their nursing home for a longer period of time, or until death, and some of the patients who currently would need to go to hospitals could also be looked after in more appropriate circumstances, given a better home-like environment.

Ms CATE FAEHRMANN: I might go to Ms O'Loughlin to begin with, just to explore this issue of the waiting lists that you referred to in your opening statement. You talked about the waiting list for, I think, children with mental health issues as well as families who are needing the parenting support, particularly for vulnerable families obviously needing parenting support. You have already had a waitlist, but then you spoke of the increased demand since COVID, since March.

Ms O'LOUGHLIN: Yes.

Ms CATE FAEHRMANN: Therefore, prior to COVID, what were the waitlists? What did they look like?

Ms O'LOUGHLIN: The usual waitlist for the residential unit, the intensive inpatient support, was probably hovering around five to six weeks. For women's maternal mental health it was around 12 to 14 weeks, so that has been pretty consistent. The children's behaviour program has gone from 120 to 170, so it has increased in demand also.

Ms CATE FAEHRMANN: That is days, when you say 120?

Ms O'LOUGHLIN: Sorry, young children referred for services.

Ms CATE FAEHRMANN: Numbers of—

Ms O'LOUGHLIN: Some 120 to 170. Yes, that has probably stretched from about eight weeks to the current sixteen weeks.

Ms CATE FAEHRMANN: Okay. To get a sense of the services in the area that Karitane services, when a family is told that they have to wait 10 to 12 weeks, or a mother to get support, are there other options for her or that family to try?

Ms O'LOUGHLIN: That is why we have tried to introduce these virtual and digital, you know, phone care-line support and online support resources. Usually we find that the universal services are at capacity. Certainly during—do you want a usual scenario or a COVID scenario?

Ms CATE FAEHRMANN: I think both.

Ms O'LOUGHLIN: Okay. The usual scenario is that in that nought to six weeks when parents come home there is a universal home visit with a child and family health nurse and you go and get your baby weights,

height and measures and things like that. If there is an issue there that the family needs additional support with they are then referred on to a service like Karitane, where they wait. If the wait is long, there is not very much support in that waiting time, so the parent usually waits. Karitane has tried to intervene earlier and hold for people on that waiting list running groups, virtual care—whatever we can do whilst they wait to come in. Sometimes that averts the need to be admitted and sometimes it just supports them whilst they are waiting.

During COVID-19 a number of the universal and child and family health nurses were redeployed into other essential frontline activities, so those families came straight in. Probably families that may not have otherwise met a threshold for our services came straight into our care, but ourselves and our colleagues at Tresillian who also provide similar services across the State both agreed to do a self-referral mechanism during COVID to cope with the increased demand.

Ms CATE FAEHRMANN: Is it fair to say that the waiting times are reflected across other organisations providing the same services within the south-west?

Ms O'LOUGHLIN: I have not checked factually, but that would be my understanding. We have networked phone calls and the demand has certainly increased during COVID for similar services, but I could not comment on the length of waiting time.

Ms CATE FAEHRMANN: Are you able to speak of some of the impacts of such long waiting lists on families and vulnerable children?

Ms O'LOUGHLIN: We collect information and feedback from our families around the waiting time and their client experience and feedback. We do receive client feedback that the wait is really arduous. When you are a parent who feels at the end of their tether in those moments you really want to speak to someone and see someone right there, right then. That is why we introduced the holding pattern, so people do feel that wait—either they outgrow the issue or they take the first available—they often sit on multiple waiting lists and will go to the first person who can pick them up in the system. Frustration, deterioration: what was not such a complex issue can become a much more complex mental issue, particularly.

Ms CATE FAEHRMANN: What then does relief look like for Karitane? I think in your opening statement you mentioned a couple of million dollars, I think, of doing an assessment. Does it look like there is any relief financially for you to deal with these waiting lists, and how is the organisation planning to reduce those waiting lists? I am assuming the virtual consultations and everything is only since COVID, is that right?

Ms O'LOUGHLIN: We actually had adjusted to a blended model of virtual care about three years ago, so treatment really around admission avoidance. We recognise that these beds are highly specialised beds and that only the really most vulnerable families should be coming in. We believe that virtual care models could treat people in their homes. We also advocated for integrated care hubs in community and place-based support, like in shopping centres and places like that, so that we could catch people early and keep them out of the beds where possible. That has been in place for three years. As I say, we scaled it up because of COVID, but we were then able to rapidly transform because we had a significant experience already delivering virtual care. That is not just phones; it is two-hour virtual video conferences, coaching families live in the moment.

Ms CATE FAEHRMANN: Thank you. That is all for me at the moment.

The Hon. NATASHA MACLAREN-JONES: I might also continue on with Ms O'Loughlin. I just wanted to touch on funding, which you have already covered off, but in your submission you actually give some example—I think it is the Washington State Institute for Public Policy and other types of funding models. Can you elaborate on your experience or your knowledge of other types of funding that may be of benefit, or that the Committee can look at?

Ms O'LOUGHLIN: In terms of revenue streams for Karitane?

The Hon. NATASHA MACLAREN-JONES: Yes.

Ms O'LOUGHLIN: Sure. I think everyone who is in the health business is looking around value-based care and outcome-based care and return on investment, the number of people we serve and the quality and the outcomes and efficacy of the treatment interventions. Through State funding through the Department of Communities and Justice [DCJ] and NSW Health, they are the mainstay of our families that get supported, and through the Department of Social Services [DSS] we have looked at whether Medicare funding is a suitable method of funding for some of our services.

There tends to be a shortfall, in that they are brief interventions, and the families that we are seeing often need more than six plus four interventions. Certainly the parenting child interaction therapy that has got the return on investment is about a 14- to 16-session treatment, so you would only get families three-quarters of the way

through with a Medicare-funded model, and if they do not turn up or they cannot come you have still got to pay your staff member, et cetera. We are looking at blended models of Medicare funding where we can and where that is billable, but some of our child and family health nurses are not eligible for Medicare billing—they do not have an item number.

The Hon. NATASHA MACLAREN-JONES: You also mentioned in your opening statement the need for more transparent funding across the local health districts [LHDs]. What did you mean by that?

Ms O'LOUGHLIN: I suppose there is not a mechanism currently that we are aware of where health organisations are made aware of growth funding or extra buckets of funding. When we look at how tenders or submissions are called for, that has not been an experience that I have had at Karitane. There is a lot of I would say unsolicited submissions and negotiations that happen and funding sort of appears. It is seeking that dialogue about when funding is becoming available, what the commissioning process is for services, what tendering services might be and procurement.

The Hon. NATASHA MACLAREN-JONES: Can you also then expand on where you referenced in your submission needing to address regulatory problems and burdens? What is your recommendation of what needs to be done?

Ms O'LOUGHLIN: Because we are a statewide and tertiary service, when we get funding from DCJ, DSS and NSW Health the regulatory burden is the high acquittals. We get grants from all sorts of places. We get different buckets of funding, different key performance indicators [KPIs] and quality reporting. For very small organisations the back-of-house support functions become quite high in order to be able to meet our reporting requirements. For one service we might have 12 acquittals at the end of the year to different funding bodies that all have a burden of reporting.

The Hon. NATASHA MACLAREN-JONES: We had a witness earlier this morning who spoke about some models in the United States and also the United Kingdom where providers were able to access various departments but all under one roof. Is that something you are aware of or had any experience with?

Ms O'LOUGHLIN: That is not something that I am aware of, but certainly something I alluded to with your colleague around the collaboration amongst the departments for all the providers engaged in this particular community care provision.

The Hon. NATASHA MACLAREN-JONES: Could you elaborate on the work that has been done with the integrated care hub—just a bit of background on it and how that is operating at the moment?

Ms O'LOUGHLIN: Yes. An example of that in south-west Sydney is the Oran Park care hub, where you have a multidisciplinary group of health professionals. It becomes sort of a one-stop shop: families come in and see their GP; they are quickly referred to child and family health nurses and multiple allied health staff. Karitane has co-located in that space. It is in a shopping centre, so it is where people frequent, there is parking, it is accessible, it is visible and you have got very rapid response teams, if you like, that are all co-located and can communicate. We also see that as a way where we can catch people early and prevent them progressing into a more tertiary level of requirement needs.

In terms of resource intensity, for example, it would cost Karitane about $4½ thousand for an admission for an admission for a residential bed, but if we can see a client and a family in an integrated care hub it might cost us $72. We have done some return on investment studies that show it is cheaper to see people with a lower level of need in the community than have people refer these families into intensively resourced beds.

The Hon. NATASHA MACLAREN-JONES: What are the other providers that are based there?

Ms O'LOUGHLIN: There are not many that are health-funded providers. There are a number of NGOs that would work more in the out-of-home care sector, where the children have been removed, and they are more in the DCJ system. But at the moment Karitane would be the sole provider in this space in south-west Sydney.

The Hon. NATASHA MACLAREN-JONES: Do you work across each other, being in that hub? Is that the aim of it, and is that working well?

Ms O'LOUGHLIN: Yes, it is working extremely well. I know it is something that the South Western Sydney Local Health District would like to replicate. I think it has highlighted a number of different sites where an integrated care hub would work. We have extrapolated that model to south-east Sydney colleagues, and shortly through philanthropic funding we will go down to Shoalhaven-Illawarra to another vulnerable service population there.

The Hon. NATASHA MACLAREN-JONES: Associate Professor Kohler, are you familiar with the community packages and also the Hospital in the Home care or any of those—have you used any of those packages?

Associate Professor KOHLER: Yes.

The Hon. NATASHA MACLAREN-JONES: How have you found those services?

Associate Professor KOHLER: Hospital in the Home means different things to different people and it varies depending on where you work and how it is implemented. Essentially, in the acute health sector Hospital in the Home means that there are acute conditions which get treated out of hospital in the home by providing the same quality of service. In the rehabilitation sphere itself, Campbelltown or Macarthur currently have a trial program of Hospital in the Home—or Rehabilitation in the Home, as it is dubbed. It is very effective, because obviously what you do when you remove the nursing costs—the 24-hour hospitality costs of a patient staying in a hospital—and treat the patient in their own home it can be very effective from the point of view of cost efficiency, as long as the patient does have enough support in the community so that the care needs are looked after and that they actually have all their needs met.

An example of a very effective subacute model of care that would be akin to Hospital in the Home is what they do in Germany, where the rehabilitation is often provided in a rehabilitation outpatient setting and the patient actually then stays in the hotel. It removes all of the nursing care costs and is significantly cheaper. Of course, that is only available for a percentage of patients, because if you have medical needs or nursing needs you cannot necessarily do it at home.

The Hon. NATASHA MACLAREN-JONES: Have you found that it has reduced readmissions of lengths of stay?

Associate Professor KOHLER: Yes.

The Hon. NATASHA MACLAREN-JONES: Or is it too early to tell?

Associate Professor KOHLER: No, it absolutely reduces lengths of stay. In south-west Sydney in the 1990s we embarked on a program of treating amputees at home: discharging them without a prosthesis, if we could do that; that they could go home either in a wheelchair or walking around mobilising on crutches, if we could safely do that, and then provide them with prosthetic training as an outpatient. Obviously that is a very cost-efficient model. When we did the study in the 1990s we saved something like 50 hospital days with the same outcomes medium to long term. Obviously it took slightly longer for them to get their first prosthesis and walk, but the medium- to long-term outcomes were very good. In south-west we really focus on hospital avoidance in general, because it is a very effective way of treating. We have over the years a population that has always been a step ahead of the health growth, as you would generally expect. We have got some very innovative models to deal with that.

The CHAIR: Associate Professor Kohler, with regard to the HammondCare submission, specifically on palliative care, if you have got your submission there can I take you to the last paragraph of that heading on page 6, which is immediately above the conclusion heading? The paragraph begins, "Establishing a network"—it is the last paragraph under the palliative care heading on page 6.

Associate Professor KOHLER: Yes.

The CHAIR: "Establishing a network"—you have got that?

Associate Professor KOHLER: Yes.

The CHAIR: With respect to residential aged care, of course, that is a matter of the Commonwealth having the funding, essentially, for the provision of that and the funding of that. I am wondering, in the context of that, is there little scope there for the State of New South Wales or the New South Wales Government to try to make some inroads into the proposition that you are articulating here? This is something that really needs to be engaged with and, I guess, ultimately if it is to come to pass, be negotiated with the Commonwealth.

Associate Professor KOHLER: I think the State-Commonwealth divide has been really well bridged in the way we have dealt with COVID. It is almost non-existent.

The CHAIR: Indeed.

Associate Professor KOHLER: If we can do it with COVID, why can we not do it with aged care? Why can we—

The CHAIR: I am not arguing—

Associate Professor KOHLER: —not do it with palliative care? The answer is that I think we always run into this problem. It is different buckets of money. It is the same in the health system between Medicare funding and hospital funding, aged care funding. I am of the firm belief that we have enough people who are committed to making the system work that we can do it, and that we will do it because the need is there. If we do not do it, we just keep passing buckets of water around that are filled to various capacities, but we never have a full bucket because we are not working together well enough.

The CHAIR: I might foreshadow a question on notice that I will have directed to you to articulate in a bit more detail how that might be brought about, to allow the Committee to have a bit of a think about it. Thank you very much, Associate Professor. I thank all the witnesses very much. That has been most helpful. The evidence was great. It added nicely to your submissions and will certainly inform this inquiry. We appreciate it very much. I thank you for the great work that you are doing and wish you a safe trip back to where you have come from—I hope it is not too wet out there for you. I expect there are going to be some questions on notice arising from once the members of the Committee have a chance to read *Hansard*. If witnesses are agreeable, our secretariat will liaise with you respectively. We normally set a 21-day turnaround period to have the information come back to us, if that is agreeable. Once again, I thank you very much.

(The witnesses withdrew.)

GERARD HAYES, Secretary, Health Services Union NSW ACT QLD, sworn and examined

BRETT HOLMES, General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

LESLIE GIBBS, WHS Professional Officer, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: Thank you for joining us this afternoon. I acknowledge and thank both your organisations for the submissions that they have provided to the inquiry. The NSW Nurses and Midwives' Association [NSWNMA] submission stands as No. 46 to this inquiry. It has been received and incorporated as evidence and is available through the Committee's webpage. With respect the Health Services Union NSW ACT QLD, its submission—also a very good submission—stands as No. 52. It has been incorporated as evidence and is also available for those wishing to view it via the Committee's webpage.

I now ask both organisations represented here this afternoon if a representative from each could make an opening statement. There is no need to go into detail as to what is in your submission—it should be taken as read by Committee members—but instead to set up your position that you would like to articulate this afternoon. Once that is done, if you are agreeable we will then follow with some questioning of you for the duration, sharing the questions between members of the Opposition, Government and crossbench. Mr Holmes, shall we commence with you?

Mr HOLMES: I will defer to Mr Gibbs.

Mr GIBBS: I thank you for the opportunity to address the parliamentary inquiry. The NSWNMA represents almost 70,000 members. A good deal of those members are actually in the local area, with almost 7,000 members in that area. I really enjoyed the opportunity to put this submission together. I actually reside in the area, in Oran Park, and have lived in the area for some time. I have worked in Sydney south-west, in Liverpool and at Macarthur and the like—and Fairfield, even. In saying that, I have seen the growth in the area and it has been exponential in recent times. Sydney south-west has always struggled to get provision of service. Even when we have had expansions, by the time we have finished the expansion we are at capacity. That happens on a continual basis. Staff are constantly experiencing psychosocial stress from trying to deliver equitable health care with the resources that they have actually got.

The constraints appear in several areas, in particular in aged care, mental health and community health services, as well as paediatric services, which are not well provided there. It is exemplified in our submission. Today I actually got some urgency disposition groups [UDGs] data, which is the urgency data for emergency departments [EDs]. It is an extrapolation of data for looking at the different levels of acuity that come into EDs at different levels and given a rating. Liverpool Hospital has got the highest rating, above that of Royal North Shore Hospital, which comes next. Campbelltown Hospital is seventh on that list, and it comes well before other supposedly bigger EDs such as Prince of Wales Hospital, St Vincent's Hospital and Wollongong Hospital. They are very busy emergency departments.

The CHAIR: Thank you very much. That is a very good overview.

Mr HOLMES: Mr Chair, if I could just add to that, there is an area that we did not cover in our submission that is an area that I think is reflective of some of that which Mr Gibbs has raised: the growth of the area and its capacity to keep pace. An area in which we have had a number of problems is in terms of the delivery of maternity services out of Campbelltown and the supply of midwives. We are currently running at a 10.6 full-time equivalent vacancy. That has been a common theme for a number of years. Despite lots of efforts by the management at Campbelltown, the recruitment and retention of midwives is an example of what will need to be addressed in this growth area. If you cannot even retain and recruit enough midwives to look after an area that has the highest growth rate in terms of deliveries then you are going to have future problems. Our midwives at Campbelltown have experienced this very heavy workload, this very high level of responsibility and the inability to meet their prescribed numbers that are even within the award.

We understand there have been efforts made by management to try to recruit, but it demonstrates that the incentives to go to south-west Sydney—particularly Campbelltown, as an example, and other areas have some difficulties, not quite as acute, but there need to be additional efforts. If this is an area of expansion then there needs to be some concentration on how it manages to recruit and retain—particularly retain, because just in the last few numbers we have got a 10.68 full-time equivalent vacancy. The consequence of that is in the figures in terms of the outcome for successful breastfeeding, for instance. If you have a shortage of midwives, you have less than suitable outcomes because the midwives are not there to deliver some of the care that is needed by the children of the community.

Early breastfeeding, of course, is a positive indicator. The fact that they suffer lower numbers at Campbelltown is an example of the concentration that will need to be made by the Ministry of Health, the district and, of course, the Government in what we do to make sure that if we are expanding this health service and we are expanding this area of the city that we are able to supply the numbers of staff that are needed to service that community.

The CHAIR: Thank you to you both. That is a very useful set-up of information for the Committee, and I am sure members will follow-up with some questions. Mr Hayes?

Mr HAYES: I have been before a few of these inquiries. Sometimes we think it is a little bit routine in what we do. I think this inquiry is probably one of the most important inquiries that this State will have going forward. This gives the people of New South Wales the opportunity to look at a rapidly growing area on the back of the COVID-19 pandemic that we currently see. We are seeing health institutions under stress across the board and while at this point in time things have been successfully managed, it is always a moving feast and it is never over. I have seen the anxiety of paramedics, of cleaners and of allied health professionals some three months ago. We have seen the issues of the lack of personal protection equipment [PPE]. We have seen the issues of lack of services.

At the Bankstown hospital not so long ago there was an awful traumatic situation for a family and their children there. Our members were involved. Our members were in positions that they should not have been in because cannot make or fund what is appropriate needed to make a health system work—a health system that should be a collaborative health system that mutually supports each other right the way through: so putting people in positions that they should not be in, not having positions filled. We used to look at juvenile diabetes but our health promotions office generally are the first people to go when you are cutting funds. Then we will deal with those children through the emergency department or other areas for which the back end of Health will pay more for something that could have been dealt with easily in the first instance as proactive investment as opposed to reactive cost. We look at the going area in relation to the Campbelltown Hospital itself—a growth in the last 35 years of 36 per cent, the second highest in the State compared to Blacktown Hospital.

My colleague here lives near Oran Park. Once, you know, you would get a lot of people there on a Saturday or a Sunday once a month. Thousands and thousands live there every day. Paramedics: We have seen in the last 10 years increased deployment of 10 per cent. We have seen growth out there of 18 per cent we have seen response times increased by 20 per cent, and still it has not been dealt with. In Bankstown we have seen the answer to ambulance services is that we will bring them all together, like a centralised base, and we will close places like Fairfield and those areas. But unless you can change the geography of the city or how people can get to serious life-threatening incidents, you have got to get through traffic, and response times consistently blow out. There is a range of things we can do but I go back to my point: This is such an important Committee because what can be reflected here to the wider State and probably nation is something that I think we can all learn from in the future.

The CHAIR: Thank you very much. Thank you for that statement. We will commence with questioning now. Are you okay with sharing of questioning between the members? I will commence with the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Chair.

The CHAIR: You have about 12 to 13 minutes.

The Hon. WALT SECORD: Okay. Mr Holmes, you mentioned the difficulties involved in retaining midwives. What is the problem? Is it the lack of number, lack of training? What is the reason that it is difficult to retain midwives in the region?

Mr HOLMES: I suppose they go to some efforts to try to provide post-graduate experience for new midwives and they certainly get a lot of experience on the floor, but of course they then work out that they are working in an unsafe environment. They are putting their professional lives at risk where they see that they are working alongside supplementary staff, non-midwives. So there is quite a heavy use on a shift of either registered nurses or assistants in midwifery or assistant in nursing [AINs]. So there is a burnout rate where the midwives will work extraordinarily hard to cover that shortfall that occurs as a result of having to provide the care and to oversee the care of others who are not as qualified as they are.

We then see them go on to other areas of shortage and midwives are in short supply so there is plenty of opportunity to move. There needs to be some sort of incentive to make sure that you get the numbers right and you keep them rights to match the growth. That has been the challenge for Campbelltown and Campbelltown management—being able to keep up with that growth rate that is there—because the consequences of psychosocial stresses, going to work and knowing that you are on a knife's edge as to whether you have done the right thing by these mothers and babies or not, will eventually burn you out.

The Hon. WALT SECORD: So what do they do? Do they leave the profession or do they just go to another part of the system, or do they live and go to another region?

Mr HOLMES: We understand a lot of them move on to other facilities that might be better staffed, so if you can secure a position in a facility that has better staffing, then you reduce your professional risks working alongside more staff. You are not as stretched.

The Hon. WALT SECORD: If I handed you a magic wand and said, "Mr Holmes, this is what you can do to support midwives, young mums and young babies in Campbelltown, Camden, Liverpool", what would be your response? How do you keep them there? How do you make it safer?

Mr HOLMES: I think you have to make their job safe and you also have to, I suppose, meet their aspirations for delivery of the best possible care to their mothers and babies. Some of that is about the models of practice, models of care. Because of the short staffing then there has been pressure on those advanced models of care that they like to deliver. Therefore that then draws them away to other areas where they can do group practice, for instance—midwifery group practice—where you get a continuity of care model, which is far more satisfying to the midwife. It is things like that that: You need to be able to expand your midwifery group practice but at the same time make sure that you have got the numbers in the general maternity unit so that you are not taking from one to provide for the other.

Really the crisis was serious enough that we went to the Minister and made a number of suggestions. What we got out of that was an additional clinical midwifery educator. Unfortunately COVID-19 came along and that clinical midwifery educator was then moved on to do some work that was necessary around COVID-19. So you need educational support. You need to satisfy their aspirational and professional ideals. You need to make sure that the rewards are there for them. If you want to move people from other areas of the State or other areas of better supply, then you are going to have to think out of the box in terms of: What are the incentives to get people to move to an area? This is an area that is more stretched and if you are asking if there is a better supply in north Sydney, people are going to travel a certain distance before that becomes too difficult.

The Hon. WALT SECORD: To give a bit of context, you said a 10.68 vacancy so with that big 10 per cent? What is the size of the actual work pool? That is 10.68 full-time equivalent [FTE] positions vacant at this moment in the region.

Mr HOLMES: That is as I understand it. They were forecasting so I have not got—the latest numbers I have got were confirmed in May. We have had difficulty getting numbers since then. If all of the advertisement went well, then they should have got down to 6.68 but they had a notional five full-time equivalents moving out. It is a significant proportion of their staff in that it leaves the midwives working on shifts with four out of the seven staff on a shift being midwives. The rest are supplementary—either registered nurses or assistants in midwifery, which could be student midwives or at worst they could be using enrolled nurses or others. But that differential so that you are free of your staff that you are overseeing and taking responsibility for the midwifery care that they are delivering, but not as midwives.

The Hon. WALT SECORD: Mr Hayes, how are your members faring and holding up during the COVID crisis and especially in south-west Sydney?

Mr HAYES: The membership has been under enormous stress at this point in time, particularly in the two months of the COVID crisis. What I am very pleased to see though, now, is that cleaners are now being recognised as an essential part of the workforce. Many people who work particularly hard and who are not on great rates of pay have been able to take pride in the fact that they are keeping COVID down, or the potential of COVID down in a hospital, and it is helping to keep other workers, visitors and patients safe in hospital. Our paramedic group in particular in that area are very concerned that at the front end of this pandemic that we have the ambulance service is so understaffed. I say that not only in the short term but in the projected longer term. But at one stage seriously they were putting third-year students in uniform to face the onslaught of what could happen.

The Hon. WALT SECORD: Third year students? How would they be?

Mr HAYES: This is the ambulance service that is doing this. They are third-year students of a paramedic degree so probably young people in their early twenties. It is one thing—and I spent 15 years as paramedic on the road and it is a pretty daunting job when you have had that experience to actually build, and to throw young people into something that could have been—and we have seen in the United Kingdom over a 109 health practitioners have died—to put people into a position like that with very limited training is just so grossly unfair on them and also on the senior officers who would be supporting them. It is a stressful job in its own right. The pandemic that this whole community is in at the moment brings it to a different level.

The Hon. WALT SECORD: I will not ask you to give geographical details and that but have you had members who in fact are working in hospitals and health facilities infected or affected by COVID?

Mr HAYES: We have had one member who has been in ICU and who has been intubated.

The Hon. WALT SECORD: ICU?

Mr HAYES: Yes. I am not suggesting that comes from the cause of the particular profession but that was a significant issue for our organisation to realise that we had just committed $365,000 into research in conjunction with the Bill Gates Foundation and the Sydney Children's Hospital to try to protect all health workers, irrespective of our members or others, if they should contract COVID-19. That seriousness—and this is what people, irrespective of what profession you are in—you think about in the back of your mind every day. While clinicians and technical people understand those risks, what really worries them is the risk that they take to their families. That is an additional risk that none of us have ever had to deal with.

The Hon. WALT SECORD: You mentioned in your opening statements anxiety of paramedics and anxiety of cleaners because of a lack of PPE. Has that been resolved? Has it been addressed? Has it improved?

Mr HAYES: Over the past three to four months we have met with the Ministry of Health—Brett Holmes, myself and people from the Australian Salaried Medical Officers' Federation [ASMOF]—on virtually a daily basis at one stage. It was really touch and go, quite frankly, in my view that if that surge had come, that there was the ability to have the appropriate PPE let alone the appropriate fitting PPE and a whole range of things. This then goes to my point that this Committee is so important. We are projecting for the future. We are not offshoring our responsibilities overseas for PPE or we are not utilising or neglecting some of the young people who want to develop into roles. We are seeing more and more allied health professional roles decrease while allied health assistant roles are increasing. That is not fair on either end of that equation and certainly is not fair to the community.

The Hon. WALT SECORD: I will and with one last question and I will ask the same question of Mr Holmes, but I would like your view, Mr Hayes. One of the terms of reference here is about whether there should be an additional hospital in Sydney's south-west. What is your view? Without leading you, I will give you two options: A new hospital, another hospital, or in fact an injection into existing hospitals. I would like both you gentlemen to tell me your views on that part of the terms of reference.

Mr HAYES: I would suggest that since 2014-15 to 2018-19 Campbelltown Hospital has seen its admission rate grow by 32.9 per cent. Campbelltown looks like it is bursting at the seams already. That is the area south and west of Campbelltown. Thinking of Badgerys Creek coming online at some stage, there is going to be a huge population there. Parramatta will take over as the main CBD into the future at some point in time. South-western Sydney is such an important area of New South Wales and I think it is only sensible to develop that level of facility. We have seen in the early 2000s that there has been significant enhancements to the Westmead Hospital and also the Liverpool Hospital, but society has creeped further our from there or run further out from there, so I think it is a bit of a no-brainer.

The Hon. WALT SECORD: Thank you Mr Hayes. Mr Holmes?

Mr HOLMES: In our submission we say that at the very least land should be preserved at the aerotropolis for a new tertiary level hospital. It certainly makes sense that you would look at that area for the amount of growth that is expected to come out of that new airport and then linking a new hospital that has access to airport, rail and road. The model of care that we seem to see about regional health care is that it is a lot of pick up and carry and transporting of critically ill people out of regional New South Wales into our hospitals. Some of that goes directly to heliports on top of hospitals but that does not cater for fixed wing, for instance, which is still used in aeromedical transport significantly. So there is some logic in saying that there will be both a growth in population and workers and then the provision of future tertiary services could well be a wise option to consider and to prepare for in the future. As we see, the current hospitals are being expanded and expanded but it then becomes, you know, a choice in the city as well how you pick up and run for the ambulance services: Is road or air a better option, or is access to closer facilities a better option where you have sufficient population to sustain it?

The CHAIR: Thank you. Deputy Chair Hurst?

The Hon. EMMA HURST: Thank you, Chair. Mr Hayes, I know that Mr Holmes already has unpacked this a little bit in regards to midwives, but your submission really focuses on the impact of funding shortages. I just wanted you to briefly summarise what some of the main impact have been for your members in regards to workload on staff morale.

Mr HAYES: Morale is very low. I think from the survey we did it was the 2,000 people who responded to the survey of which about 25 per cent of those people were from Sydney's south-west. Clearly the highest 25 per cent are indicating that unreasonable workloads, lack of staff, and the next best thing to that is then lack of consultation on change and change is ongoing. We accept that change is ongoing but having the resources to be able to deal with that, the amount of injuries we see particularly in cleaners and manual handling-type areas has increased consistently. What we are also starting to see now is the psychosocial injuries that are coming forward. People are starting to feel comfortable that they can say that they are feeling these stresses and these anxieties. It is something that I think SafeWork would even indicate through their figures is increasing throughout society.

Those sort of pressures are in place and let us say without COVID people are struggling with workload, particularly the cleaners. But what I am thinking is disgraceful and unfair from a professional point of view is that people like occupational therapists [OTs], speech pathologists, physiotherapists are being downgraded—and it is no disrespect at all to our members who are allied help assistants; they have a vital part to play—but it gets to the point where we ran a work value case in the commission and allied health assistants got a 9 per cent increase because they are doing the work of a higher skilled person. That is good that we are lifting their opportunities in life but those people have done their degrees and have committed their life to allied health then find that they can get jobs because it is seen as a luxury item not a necessity. But I would argue that if you can keep people out of hospital and prevent them coming back to hospital, which is clearly a community health-allied health nursing area, that takes a lot of financial drain off the Government, whichever government of the day.

The Hon. EMMA HURST: Do you think that some of these poor working conditions are going to cause further recruitment issues down the line?

Mr HAYES: Very much so. When we see people in a vital job like cleaning, the pay rates are, in my view, very unsatisfactory. I would like to be able to run a work value case but I cannot. I would like to have a meaningful discussion about modernising awards and looking at productivity and efficiencies instead of utilising awards that are 50 years old, but I cannot. I think there are some great opportunities that we can invest in people but health generally—and has been for the past two, three or four decades—is one-third of the State budget and it is trying to do the most it can with what it has, and what it has just is not enough. How do we make what is not enough enough to be able to invest in people so that they enjoy coming to work, so that they get a sense of satisfaction? I can tell you now that we have got cleaners who are so proud of what they do every day and they get such great satisfaction out of it but they are sort of saying, "I can't afford to live on this money, so I've got to look at some other way of doing something, or having a second job and potentially a third job."

The Hon. EMMA HURST: Do you think that some of these staffing issues are also affecting patient care? Have you heard examples of that?

Mr HAYES: One thing, there are delays. Consistently we have seen that come often through the ambulance service. I do not know if you have heard of the term ramping and those sorts of things, particularly in the winter season. It is really quite interesting now in the COVID-19 era we have seen that the common flu has decreased so the pressure on the hospital system this winter has decreased dramatically compared to what we normally see. Look, due to lack of staffing across the board, whether it is nursing people, our people, doctors, if you have an ambulance backed up trying to get a patient in and cannot get someone off their stretcher for an hour or two hours, are the diagnostics there to be able to assist the medical staff and the nursing staff?

Are there appropriate porters or cleaners there to be able to clean and move people through the facility? Can we get people out of bed so that we can free up the bed in a reasonable time so we can actually get that flow going through? I do not think there would be any area of a hospital setting who would say that they are comfortably working with staff that they have. But we are also mindful that there is a big financial issue, which we would like to engage with to work towards the future.

The Hon. EMMA HURST: Mr Holmes and Mr Gibbs, you mentioned in your submission that nurses often raise concerns about their safety when working in the mental health wards. Can you please tell us what some of those main concerns are and what you think actually needs to be done to be able to address nurse safety?

Mr GIBBS: Occupational violence is rampant in mental health. We have had a recent death in Liverpool where a mental health nurse was charged and he hit the floor. That is still under investigation. That type of thing happens not only there but across the State. This is the second death we have had in mental health. The last one we had was just recently in November last year in the community in another area health service. Nurses are fearful. Staffing and skill mix. They are two of the primary concerns. Again, it is about retention of staff as well. Our experienced mental health nurses are all getting to that age that they are retiring and they were actually mental health trained. That sort of training no longer exists. They very much learn on the job. There is further education that they are doing and they are working towards that. But it is the occupational violence that is the concern.

The Hon. EMMA HURST: Is it a bigger concern in south-west Sydney because of the reduced staff and the other issues that you have highlighted?

Mr GIBBS: Yes. That and the demographic. You see the waiting times in emergency departments [EDs] and the design of our EDs. The EDs have often got mental health clients that are waiting in the ED for prolonged periods of time before they can actually get up into a ward, if they ever get up to a ward, and that does happen. It is not only at Campbelltown. It happens at Liverpool and Bankstown as well. Some of the other hospitals do not have provision for mental health such as Fairfield or Camden.

The CHAIR: Thank you very much. Ms Cate Faehrmann?

Ms CATE FAEHRMANN: Thank you very much for appearing before today's Committee. This morning we heard quite alarming evidence actually about a lot of the shortfalls in relation to many of the health services provided in Campbelltown Hospital, Liverpool Hospital, Fairfield Hospital as a result of the lack of funding. For example, we heard that ultrasound equipment is only available until four o'clock. After that, people cannot get ultrasounds even if their health conditions say that they absolutely need an ultrasound. We have heard of kidney dialysis machines where people with diabetes have to have, instead of three treatments a week, two treatments a week, which is obviously not ideal in terms of their care.

We heard a range of other extremely concerning evidence. In fact I think one of your submissions—I think it is the Health Services Union [HSU] submission—you refer to the fact that Campbelltown Hospital has recorded the second-highest growth in admissions over the past five years with a 32.97 per cent increase in hospital admissions. I suppose what I am getting at with all of this data is that on the other hand the Government is very keen, of course, with the South West Growth Centres to see Campbelltown and surrounding suburbs in the Macarthur region have a huge increase in population in terms of new housing developments. Does the Government have the right balance here? Do you think the Government should be ensuring that the health services are sufficient first before continuing to expand on housing developments? Should they just pause and say that their health services are not keeping up with current demand and get them right first before plonking however many hundreds of thousands of people into the South West Growth Centre? That is part of the crux of what we are looking at here as a Committee.

Mr HAYES: Can I jump in on that one? I think that is the smartest thing I have heard in a long time. Having the appropriate infrastructure in place to build around it, it just makes sense. I understand that there is pressure on a growing city and so forth but if you do not have the infrastructure there, irrespective of what that infrastructure is—schools, law enforcement or health—you are going to fall over at some point in time and we are not seeing that infrastructure there. Even with Badgerys Creek coming on at some stage, where is the plan to be able to move people? New South Wales needs to be able to move people to be successful. I think it is very important to have a pause on these things as opposed to people being subject to serious negative health outcomes because a huge development has been put in place that paramedics cannot get to, hospitals cannot cope with or someone who may, sort of, be palliative to some degree, who then has to be moved many suburbs away, away from their families, to be able to be cared for with dignity. I think it is an important issue.

Mr GIBBS: One of the things I have seen is the hospitals get the wards upgraded; the emergency departments [EDs] are left behind. Liverpool is a good example. It had a massive expansion. I was part of that growth. It was a fantastic project and we had some great people there but the ED did not get extended yet it is the biggest trauma. It got an extra helipad so there is two helipads now servicing it. The same thing has happened with Campbelltown. Its first growth was actually to get the wards, and the ED is the next stage. The EDs are integral. You heard this morning about the number of admissions that come from the EDs and we need to actually have those EDs functioning so that they can actually get patients out of the EDs and up on to those wards.

Ms CATE FAEHRMANN: Therefore, do you think that the qualified staff are there as well? We heard today of some recruitment processes where 80 per cent of applicants were from overseas because there was not the—

The Hon. WALT SECORD: Sri Lanka.

Ms CATE FAEHRMANN: Yes, from Sri Lanka. I cannot remember the exact positions though. That implies that as difficult as it is to fill these positions now, surely the Government needs to be focussing on fixing right now the gaps instead of bringing just the increased demand now with that these growth centres will make, I would think, a worse system. If the system is unable to cope now, how are you feeling about having, like, all of these additional developments?

Mr HAYES: Can I just say that, I think, there is a strategy within the health bureaucracy that if you want to employ someone that process can take three or four months. By the time you select the candidate they have gone and you start it again, so you are playing catch up. From an allied health and a paramedic point of view

we are seeing allied health professionals working as allied health assistants because they cannot get these roles that are needed. We are seeing paramedics come out of four-year degrees with no opportunity, no chance of a job in Australia, let alone New South Wales. We are putting these younger people through good degrees. They are spending a lot of money which has ultimately got to be paid and instead of investing in the health system these people then do not have anything more than debt. They cannot finish their post graduate year. This is something that our allied health professionals and paramedics have been raising for some time. I am not too sure how it works with the nurses but it is certainly a significant issue. Those opportunities are there but the will has got to be to be able to utilise the staff, or the potential staff that are available.

Ms CATE FAEHRMANN: How many more trained paramedics are graduating compared to positions available?

Mr HAYES: We are seeing every year approximately 2,500 paramedics graduate and there is probably a chance one-third will get the job. Across the country there is probably about 20,000 paramedics.

CHAIR: Twenty thousand who are not working?

Mr HAYES: Employed paramedics. But the opportunities are just not there and yet the universities keep pushing these young people out. Again I think it is something else that needs to be focussed on because it is grossly unfair to push people's expectations, to get a financial commitment and at the end of the day there is no job.

Ms CATE FAEHRMANN: Have any of your staff—one of the submissions raised this matter—been asked to create efficiencies of service? Can any of you report to the Committee around what specifically this means? Obviously within various departments we always hear about the whole efficiency dividend scandal, really, compared to when you consider the shortfalls about which we have heard today. Are you hearing that that is playing out across hospitals? I think it was Mr Hayes' submission.

Mr HAYES: Yes. We see the efficiencies are consistently in place. I do not think they are efficiency, they are just not funding particular roles. The role is needed. The work is required but it has got, in my view, nothing to do with efficiency at all because it is not contributing to the health output. I think there is a big difference in that. We see Health share now—every three years they have to go through a market testing approach. The people who they are market testing against do not have all the responsibility of health. They do not have the bigger picture, and this has been going on for many, many years. So while an outside body can cherry pick, if you like, particular parts that they want to be involved with, health and the Government always hold the responsibility of the outcome. I think this makes it very difficult. We see this cost cutting—I would not call it efficiency because there is no positive outcomes in it.

The Hon. WALT SECORD: May I jump in with one last question?

CHAIR: Are you able to put it on notice?

The Hon. WALT SECORD: Unfortunately yes.

CHAIR: On behalf of the Committee I thank you gentlemen for appearing today and for your submissions. I also thank your members for their outstanding work. Without having an emergency before us, which adds additional challenges to them, as always they rise to the occasion and serve the citizens of New South Wales to a very high standard.

Mr HOLMES: We would certainly appreciate it if there was not a wage freeze in front of them.

(The witnesses withdrew.)

(Short adjournment)

ANGELA LONERGAN, Cancer patient, before the Committee via teleconference, affirmed and examined

Dr ANTHONY BROWN, Chief Executive Officer, Health Consumers NSW, affirmed and examined

GEORGE HOUSSOS, Board director, Health Consumers NSW, and President, Thalassaemia and Sickle Cell Society of NSW Inc., sworn and examined

CHAIR: For people who may be watching this hearing on the internet, we have two witnesses present in the room and joining us by teleconference is our third witness, the details of whom we will come to in a moment. I should also mention that two members of this Committee are not present, one of whom is definitely is watching the proceedings from Wagga Wagga, the Hon. Wes Fang. I thank Wes for his appearance today. We believe that the Hon. Lou Amato may also be watching. They will text any questions to the Hon. Natasha Maclaren-Jones. They are participating although they are not in the room.

I confirm that the Committee has received submissions from Health Consumers NSW, No. 50 to the inquiry. It has been incorporated and sits as evidence for the inquiry and has been uploaded to the web page of the inquiry. Ms Lonergan's submission is No. 42 and has also been incorporated and is on the inquiries web page and available for people to view. Do you want to make an opening statement?

Dr BROWN: We will share ours with Ms Lonergan.

Mr HOUSSOS: I want to start off by acknowledging the general high standards of health care in New South Wales but we welcome this opportunity to contribute and constructively help play a role in improving the standard of care, particularly in south-western Sydney. As I stated, I am the President of the Thalassaemia and Sickle Cell Society of NSW Inc. Our society has been in existence for about 42 years. We represent lifelong sufferers of thalassaemia and sickle cell and other heamoglobinopathies. I want to touch on some of the treatment path because it is critical to understanding why we are here and where we think the services could be improved. The treatment for people with thalassaemia and sickle cell is complex and mixed. It involves a life-long treatment, regular blood transfusions and chelation to avoid iron overload.

The disease then also has other indirect consequences and requires close management to avoid complications such as support service in endocrine, fertility treatment., constant monitoring, access to MRI services. It also requires support services of counselling and psychological services for both patients and family members. If this mix of treatment is done well people with thalassaemia and sickle cell can live perfectly normal lives. But sadly the standards that we are seeing in south-western Sydney is compromising some of those outcomes for our members. As a non-government organisation and a society that looks across all of New South Wales we are starting to see first-hand the disparity between out treatment centres in the eastern suburbs and the city and those of south-western Sydney.

One of the key reasons why this is happening we think is the Area Health Service is failing to meet the needs of growth but also the demographics. In society we like not to differentiate people but sadly this disease does. People from the Middle East, the African nations and south-east Asia are more prone to suffer from thalassaemia and sickle cell in addition to the traditional Mediterranean areas. As we are seeing a lot of new migrant communities come to south-western Sydney there has been a lag in keeping up with this new demand. That offers a lot of new challenges which are currently not being met. We think there is room for improvement. We would like to see more consistency across New South Wales and we would like to see better support for our patients and our members because compliance is a key indicator or health outcomes.

Dr BROWN: Health Consumers NSW is a peak organisation for patients and their families who access health services in New South Wales. We work closely with health services to ensure that health consumers, people who use those services, have an active role in designing service responses and health policy responses. We have a membership that is made up of organisations such as the Thalassaemia and Sickle Cell Society and other consumer-based groups, as well as individual members which gives us a reach of about 20,000 people who use health services in New South Wales.

We share the concerns expressed by Mr Houssos around the disparity of services in south-east Sydney. We are particularly concerned about what we hear with current service gaps that are happening across a whole range of different services and people with different health conditions. But we are also very concerned that health consumers, patients, family and the community in general in south-western Sydney have not been adequately involved in these planning discussions and planning decisions around what is happening for their health services which is something that we have strongly advocated for in our submission.

CHAIR: Ms Lonergan, can you hear me?

Ms LONERGAN: Yes I can.

CHAIR: Do you want to make an opening statement. I acknowledge and thank you for your submission which sits effectively as a case study, if I can describe it that way, because it is your own experience.

Ms LONERGAN: Yes.

The CHAIR: Assume that Committee members have read your submission so they are across the detail of it so you do not need to go through it in fine detail. You can make some comment and then we will pass over to questions.

Ms LONERGAN: Thank you. I thank you for the opportunity to speak today. Cancer is not something that anyone would choose to have but if you are diagnosed with this terrible disease, it goes without saying that you would want the best treatment and support available. I have a cancer history that stretches back over more than 30 years starting from 1988 when there was only one medical oncologist for the whole of south-west Sydney when cancer patients had to travel outside of the area for treatment. For the past five years I have been receiving treatment at Macarthur Cancer Therapy Centre. What sets this centre apart is the dedication of all staff to providing holistic health and wellbeing support for patients and their families leading them to winning Best Cancer Centre in New South Wales five years in a row. The fact that Macarthur Cancer Therapy Centre does this, whilst receiving significantly less funding per patient than other Local Health Districts is remarkable and an even greater testament to the staff and the Executive of the centre and the hospital, as well as the centre's high level of local community engagement and support.

The Macarthur Cancer Therapy Centre model of care is a great example of how other cancer therapy centres specifically, and any health service more generally, can be structured to fully meet the needs of its community. However, the lack of funding means that the centre is constantly under pressure and the full level of services required cannot be provided for current patients let alone to meet the needs of the projected population growth in the local community. With limited funding the centre must rightly focus first on the physical cancer treatment requirements for the patient. However, this leads to reductions in terms of in other areas. For example, the provision of cancer-specific psychological support for patients is limited to only one psychologist working 15 hours per week for all patients in the centre. Patients can access external private psychologists, however, they are not specifically trained in the cancer field and also charge fees for treatment. The public lymphedema service is overwhelmed with patients and currently only provides monitoring to the majority of their cancer patients. Lymphedema is a chronic disease which requires regular treatment to manage symptoms so many patients are forced to pay for treatment privately.

The centre has also established care coordinator roles where an individual staff member is a central point of contact for the patient and other staff. This relationship helps the patient feel save and supported whilst improving communication channels and minimising confusion for multiple staff working with the patient. However, a number of these roles are reliant on external funding so they are only temporary or they are not guaranteed to continue into the future. Transport is another issue where it is provided by local charities and by Cancer Council NSW. This year many charities have been hit hard by the COVID-19 pandemic. This shows the danger for Macarthur Cancer Therapy Centre relying on community fundraising and volunteering for ongoing initiatives such as transport, and the need for the centre to be able to fund health-related transport and other ongoing initiatives internally. These cancer support services, along with many other allied health areas, as well as survivorship and wellness activities, provide important resources and support for cancer patients as they undergo treatment, helping to reduce stress, lessen side effects and increase the patient's feeling of health and wellbeing.

The current funding level for the Macarthur Cancer Therapy Centre is simply not adequate to meet the full gamut of need of current patients. With the Macarthur community projected to increase substantially, significant increases in funding will be required to meet both current and future service provision to cancer patients in the Macarthur community. Thank you again for the opportunity to speak today and for your time and attention given to the matters that I have raised.

CHAIR: Thank you for your excellent opening statement that covers the area very nicely and sets things up for questioning. For the benefit of myself and perhaps others what is the actual physical location of the Macarthur Cancer Therapy Centre?

Ms LONERGAN: Based as part of Campbelltown Hospital.

CHAIR: If members direct a question to Ms Lonergan will they please identify themselves.

The Hon. WALT SECORD: Ms Lonergan, I am the shadow Treasurer and acting shadow health Minister. Will you share your experience with cancer treatment? In 1988 where did you receive your treatment?

Ms LONERGAN: In 1988 I was diagnosed with Hodgkin's lymphoma. I was only 14 years old—I am giving away my age here. There was no treatment in south-west Sydney apart from surgery. I had my surgery at Liverpool Hospital but I then had radiotherapy at Westmead adults. I do not know if there was not a Westmead children's or they did not have radiotherapy set up there but I went to Westmead adults hospital for radiotherapy.

The Hon. WALT SECORD: You have mentioned that for the past five years your contact has been with Macarthur cancer centre. I am alluding to your experience of cancer treatment near your home versus the impact of having to travel vast distances to get treatment. I would like you to talk about that.

Ms LONERGAN: When I was only a child when we were travelling to Westmead my mother went to work every day but left at lunchtime, came and picked me up because radiotherapy is every day. She had to travel all the way along the Cumberland Highway as it was being constructed so we were in roadworks there and back. On the way back I would be vomiting in a bucket in the car from the treatment. It was traumatic for me but I can just imagine it would have been even worse for my mother dealing with that every day and trying to support her child. Unfortunately, as far as I know, paediatric cancer services are only in the Sydney children's network so its parents of children that need treatment still need to travel out of south-western Sydney to be able to get treatment. We have come some way to provide cancer treatment for our local residents in south-western Sydney but not all the way. I have been really lucky as an adult. I have had treatment for the past five years at Macarthur Cancer Therapy Centre and being close to home, 10 minutes away, also having transport provided by the centre has given that sense of relief, and taken away some of the stress in an already very stressful time.

The Hon. WALT SECORD: Do you have contact or are you looped into a network of other patients who are receiving cancer treatment? What is the experience that you have heard from other patients? Would your views be similar?

Ms LONERGAN: Yes, I have been. I started doing a lot of advocacy around late effects of cancer treatment. I did that on my own for a long time because that is something that affected me personally. Through doing that I was linked into the Cancer Council of New South Wales. It has a whole community called CanAct which is a whole community of volunteers who provide advocacy around cancer services in New South Wales. That has been a wonderful experience. I have been involved in receiving training, going to conferences and so I joined one of its local groups which is called South West Sydney Cancer Advocacy Network and until my health took a turn last year I was actually chair of that network.

The Hon. WALT SECORD: Dr Brown, what is the reach of your organisation into the south-west?

Dr BROWN: Our reach is through our members and through our connection with staff and other colleagues. I don't know off the top of my head how many members—

The CHAIR: You may take that on notice if you wish.

The Hon. WALT SECORD: I guess what I am trying to elicit from you is how tuned into the local community—where is Health Consumers NSW based?

Dr BROWN: Our head office is in the city. We have strong networks and links with the various consumer groups within the various health services, including the South Western Sydney Local Health District, and we have provided consumer representatives to be part of various health services, committees and advisory groups.

The Hon. WALT SECORD: What are your representatives—the people who are active in your organisation in south-west Sydney—telling you about what they feel the adequacy or provision of health care in the region is?

Dr BROWN: What they are telling us sadly reflects the evidence you have already heard. We have heard from people who are accessing cancer services, dialysis, mental health, and maternity services. We are hearing very similar stories around difficulties of access—about limited access—and about some people needing to leave the area to receive adequate treatment. Sadly, those themes are what we are hearing from people across the board. We are also hearing from community members that people are concerned that the growth that is already occurring in the region—that infrastructure and health infrastructure is not keeping up with the growth. We have people who are very involved with the local community and various community and health consumer groups who feel that they have a lot to give and a lot of local knowledge that should be incorporated and involved in health infrastructure planning and they don't feel they have had an adequate chance to have their voices heard.

The Hon. WALT SECORD: Mr Houssos, because of the changing demographics in migrant settlement and things like that, is that why your organisation has an interest in sickle-cell anaemia in south-west Sydney?

Mr HOUSSOS: That is a key reason. This is a lifelong disease, so a lot of people go to Westmead Children's Hospital as kids. When they reach 18, they are meant to transition to adult hospitals and treatment centres. There is a huge reluctance to go to Liverpool because the standard is not as high as the treatment centres at RPA and Prince of Wales. For example, 40 per cent of patients at RPA actually live in south-western Sydney.

The Hon. WALT SECORD: So they drive past Liverpool Hospital?

Mr HOUSSOS: Absolutely. There are others that go to Prince of Wales just because the standard is so low. They are chronically understaffed. They desperately need senior nursing clinicians there. They need a clinical nursing consultant who acts as a coordinator for all the transfusions and booking appointments to get the MRIs, to get all the regular blood tests that they need to do, to get their bone density tests. The CNCs—the clinical nursing consultants—are a conduit between the day-to-day nurses and the specialists, and there is just none there. That service isn't provided. They are falling through the cracks. That service is provided at RPA and Prince of Wales. There is this dread for people—and transitioning from children's to adults' hospitals can bring its own anxieties. Sadly, it is compounded because they don't want to go to Liverpool because they know it is not there. For those who are there, where you get treated depends on whether you are there on a weekday or a weekend. There is not a proper haematologist specialist centre where they can get treated. In some cases on the weekend they are just put in with the general hospital outpatients, and sometimes they can wait significant times before they get their treatment.

You have got to keep in mind that this is something that is a lifelong disease. Retention of experienced nurses and doctors is important because then they understand the patients' needs—the nuances—and they can follow up on the care. I will give you a practical example: cannulation for a patient. There is a huge difference between being cannulated by an experienced nurse and not. Ordinarily, it wouldn't really matter if someone misses a couple of times, but for these people it is a lifelong treatment so it does matter. Their veins can get damaged and it causes other complications. It increases anxiety for these patients. Again, these are practical and real-life examples of why people are avoiding Liverpool Hospital.

The Hon. WALT SECORD: At Liverpool is it the fact that it is under-supported or are the eastern and inner-city hospitals being disproportionately supported?

Mr HOUSSOS: Definitely Liverpool is under-supported. There could be room for improvement in the eastern suburbs and city, but Liverpool is chronically under-supported.

The Hon. WALT SECORD: What size of a population are we talking about? How many people have sickle cell?

Mr HOUSSOS: Again, getting these sorts of statistics is a bit hard but there are roughly 100 patients that are there every month.

The Hon. WALT SECORD: So they would have a network and they would talk and they would know each other and they would say, "Go to RPA, go to—"

Mr HOUSSOS: Yes. Also the nurses and the doctors at Westmead say, "If you want the best for your child, you should go to RPA or Prince of Wales."

The Hon. WALT SECORD: My knowledge of sickle cell from living in North America 30 years ago is that it used to be a disease where you had a shorter life, but now people can actually manage it and live with it throughout their entire life. Is that correct?

Mr HOUSSOS: That is correct.

The Hon. WALT SECORD: So you have a situation where somebody could be driving for the rest of their life from south-west Sydney to the city?

Mr HOUSSOS: That is right. A key part of that longevity is maintaining compliance with all the treatment of complexities. For example, MRIs are a critical part of follow-up tests but in south-western Sydney they have to pay for it. At Prince of Wales, they don't.

The Hon. EMMA HURST: You talked about the lack of psychological support, and in your opening statement you talked about one psychologist for 15 hours is what has been allotted. To give us a bit of an understanding of how undercut that really is, can you explain what that means on the ground and what would be a better situation?

Ms LONERGAN: In 2019, as far as I am aware, there was about 1,400 new admissions to Macarthur Cancer Therapy Clinic. When you have an initial diagnosis of cancer, that would be the best time to get psychological services involved because it is a huge shock getting that diagnosis not only for you but for your

entire family. It is almost like a new normal that you need to try to navigate—this is a world that you are not used to—and then you have all the emotional stress that goes with that. It is never offered at any appointment unless there seems to be a reason for it, whereas I think it should be something that is offered to everybody because everybody feels that stress as they go through that initial diagnosis.

I found in my experience it was not offered to me at all even after I was diagnosed with metastatic cancer, which to me is even more of a reason when you know that you have got a non-curable disease. I had a little bit of a meltdown while I was at the centre. It was the build-up of all this emotion and all this stress over a long period of time, and that is when it was offered to me. It is not because the staff don't care; it is because they know they don't have the available resources to meet the needs that are out there so they can't offer it. Fifteen hours with one staff member who is absolutely run off her feet really doesn't get anywhere near what is needed for the patients there.

The Hon. EMMA HURST: Did you have to wait a long time to be able to see that psychologist when you did reach out?

Ms LONERGAN: Yes, I did. I had to wait a number of weeks. Then my appointments were spaced about four to six weeks apart because the appointments just were not there at that time.

The Hon. EMMA HURST: I wanted to ask you about the transport gaps that you mentioned as well and the fact that the transport is funded by charities. Do you know if that is fully funded by charities and if it has been affected recently by reduced donations?

Ms LONERGAN: I don't think the information has come out yet in terms of whether it has been affected by the pandemic, but I would assume that it has. I know a lot of charities have had their fundraising revenue reduced. However, the funding that comes from the transport is a really great partnership between a local grassroots charity called 24 Hour Fight Against Cancer Macarthur. They have been fundraising for over 10 years just for Macarthur Cancer Therapy Centre, and they have raised in excess of $1 million for that service. They have a partnership where they ask the hospital to give them their wish list of what the cancer therapy centre needs. Apart from funding the transport—they fund a driver for that—they have funded cold caps for patients so that they can stop hair loss during chemotherapy. They have funded equipment for lymphoedema. They have funded massage vouchers for patients to give them the chance to relax and reduce stress. They do a huge range of things that really help to support the work that happens at Macarthur Cancer Therapy Centre.

The Hon. EMMA HURST: What do you propose is the best model going forward to ensure that this transport system continues to run? It sounds like it relies almost entirely on these charities and this fundraising.

Ms LONERGAN: Yes, it does. Health-related transport is a huge issue and it has been a huge issue for many years, not just in cancer therapy but right across the hospital system. There needs to be funding internally for transport. Transport may be seen as an extra, but to me it is part of an essential service of supporting patients to be able to get to treatment safely and to reduce stress on families when there is already a huge amount of stress and cost. Having this free service is really important. Community transport is not something that meets this. There is not hospital-based transport and that is where I think that it really sits.

The Hon. EMMA HURST: Dr Brown and Mr Houssos, south-west Sydney is a very culturally and linguistically diverse community. Do you have any thoughts on how the Government and NSW Health can properly consult and engage with such a broad and diverse community?

Dr BROWN: Firstly by talking to them—I believe that in many cases it is as simple as that. Yes, it is a diverse community but it is also a community that is incredibly resilient. Within the community we find that there are a number of organisations, support groups and local NGOs that have all formed to support people from various backgrounds and ethnicities. Connecting up with those groups is an important and relatively easy first step. Organisations like local government already have strong networks with some of those groups, so bringing local government into the discussions as well, and connecting up with organisations such as ourselves, such as the thalassaemia and sickle cell association and the various other population-specific and disease-specific groups is one way to bring people into the discussion.

If we look at what is happening in particular local areas and particular geographies, there are things like town hall meetings and proactively going out and talking to groups in particular locations. There is a variety of methods and social research that is being employed to get people involved. South Western Sydney Local Health District, and to a lesser extent the primary health network, both have consumer and community engagement infrastructure that within the LHD is quite robust. That is being underutilised in these planning efforts. It is doing great stuff in terms of service delivery and improving service delivery internally, but it could be utilised a bit more.

Mr HOUSSOS: Organisations like ours depend heavily on government funding, and more funding would give us more capacity to do that outreach. I will give you an example. When we started 42 years ago it was all about raising awareness and education amongst the Greek community and the Italian community. We are at the coalface and we have seen that demographic has changed, and now we have to reach out to communities from the African subcontinent and the Middle East, but we are best placed to do that because there are still cultural implications to a disease like thalassaemia and sickle cell. There is still shame in some of these communities. They feel they have got to keep it secret. It affects the family and the status of the family. We have experience in how to circumvent those sorts of issues. While we have been lucky enough to have had good support from the New South Wales Government for 40 years, we are at a point where we do need more, and organisations like us do need more, because the issues are now more complex.

Ms CATE FAEHRMANN: I note that in your very good submission towards the end you say that population growth in south-west Sydney going to be yet another strain on the Government and already-stretched health services. In a relatively wealthy country like Australia, are you shocked or disappointed that you have had treatments reduced and have had to pay for your cancer treatment to get the level of treatment that you needed?

Ms LONERGAN: Overall, I think I have been very lucky. I am not saying that to go against your question. I just want to say that in terms of the overall healthcare system here, I have had a huge amount of things provided to me through the public system. However, I really think that south-west Sydney was not given establishment funds when other parts of Sydney were and it has always been playing catch-up ever since. I think that from my experience of living here for most of my life and raising my family here, there has been a whole lot of things that we have had to fight for and have come a lot later and may be in piecemeal fashion. That means that we have lagged behind other parts of Sydney. Yes, I did find that frustrating.

There have been parts of my cancer treatment that I had to pay for. I had to pay for the chemo co-payments up to 2015 when that was abolished. I was originally having to pay for the price of a script for each of my chemo drugs. That was roughly $100; every time I had chemotherapy I had to pay that out of my own pocket. That was abolished in 2015. There have been things like that that have always been there. I have had to pay for a number of different MRIs, mammograms and other scans that I have had to do privately rather than through the hospital. Yes, there have been areas where I feel like we are not up to scratch or that compared with other parts of Sydney we do not get the same level of service. However, overall I think in terms of having seven surgeries and 10 different rounds of chemo and radiation therapy plus all the other appointments and treatments that I have had, I have been pretty lucky overall.

Ms CATE FAEHRMANN: Thank you. For people who you are no doubt connected with—potentially a community of cancer patients in your area—is it the general sentiment that living in the south-west as a community, you are treated differently or not given as much of a priority? I am just trying to get the sentiment amongst the community.

Ms LONERGAN: I think that probably the key services are there but the extras are not, which is what I referred to in my submission as the allied health services and the other complimentary services that surround that. They are not there where they may be in other areas. I do not have a huge amount of experience of treatment in other areas; it is just from speaking to other people that I get that idea. The main part—the physical treatment—mostly that is there but the extras like allied health is where it falls down.

Ms CATE FAEHRMANN: So would you like to see—sorry, did you have something else to add?

Ms LONERGAN: I just wanted to add as an example of that about lymphoedema. Lymphoedema is a condition that I have in my arm. That has been caused from treatments and surgery to my lymph nodes for cancer treatments. I would just say that lymphoedema is an area that is really grossly underfunded and that is in not just south-west Sydney but also across the board. My experience is in south-west Sydney where our public service is not able to provide treatment. I have spent over the course of three years over $4,000 on private treatment for lymphoedema. That was at a time when I was not working, so it was a really difficult expense for me to have to carry at that time.

Ms CATE FAEHRMANN: So would you like to see the Government ensuring that the already-stretched health services within south-west Sydney are fixed, if you like, or at least get greater investment so that that is right before a lot of the developments go ahead there? This is the south-west growth centre particularly.

Ms LONERGAN: Definitely. There has already been an increase in population and it is going to substantially increase even more. As I was saying before about playing catch-up, I think there needs to be some significant investment in south-western Sydney. A majority of our community that lives in Sydney is on this side, in south-western Sydney, in western Sydney. This is really where I think the funding has been lacking. If there is some significant investment in that area that has a population explosion plus has some poor healthcare outcomes

already for local residents, I think there need to be further investments to be able to not just get it up to standard but also then make it best practice and try to really improve the health of our local community as much as we can.

Ms CATE FAEHRMANN: Thank you. I have one final question to Dr Brown. Your submission urged the Committee to get the views of Health Consumers more for this inquiry. Do you have any suggestions as to the best methods we could do that and why that is so important for the Committee to do?

Dr BROWN: I think it is so important for the Committee to do because what are the health services and who are the health services in south-western Sydney serving? Why do they exist? They exist to serve the people who live there. I really passionately believe that the solutions to many of our problems are found in community and with the people who are actually dealing with those issues. I think proactively working with organisations like ours is one way—with some shared resourcing and additional time, we could assist with some consultations—but also things like—forgive me if this is already happening—hearings in south-west Sydney, giving local people the opportunity to appear before you in town hall-style meetings to hear the issues that are coming up, and surveys and partnerships with local groups and things like that.

I think one of the points that we made in our submission was that well-resourced organisations and policy wonks know about parliamentary inquiries and we want to respond to them, but for people who live in local areas are busy with their own lives, this is not part of their everyday way of doing business. So I guess going out there and connecting directly is something that we would really strongly encourage and talking to people and having hearings in the local area is something that could be one way to achieve that.

The Hon. NATASHA MACLAREN-JONES: Following on that, Dr Brown, you said in your submission that you did not have time to consult with the community groups or the member groups that you engage with in south-western Sydney. How long would that normally take you to do and what is the process you go through?

Dr BROWN: That is like how long is a piece of string. Within a couple of weeks using online methods, we can connect up with our members and supporters who live in the local area and draw together some high-level themes around what is happening as well as identify some case studies. With more time—actually going out there, spending time talking to people and conducting surveys and focus groups over a couple of months—we can get something that is even richer. It is not just time; it is resources. We are a small organisation and we have multiple demands on our time. We would have loved to have done those things but it is a capacity issue. Does that answer your question?

The Hon. NATASHA MACLAREN-JONES: No, that is fine. It just gives me that idea of a couple of weeks or a few months would have been a longer scope. The other thing is that you mentioned before about more engagement with council. I was just wondering if you have a view—we have a number of councillors coming tomorrow—of what more support councils could give organisations like yours in the community basically?

Dr BROWN: For organisations like ours that our State-based, the connection with individual councils is quite limited. We tend to work with the State-based peaks. But locally, through providing forums for local groups, through things like inter-agencies and other mechanisms that councils, through their social and welfare branches, operate, they often are quite well linked in with the local organisations. There is a bit of a gulf, in my experience, on a local level between community and welfare organisations, and health services. I think it is a gulf that is due to resources and busyness and a lot of those sorts of things but councils are often in an excellent position to be the mediator and to bring those local groups together by providing sometimes a physical space but also providing the resources to be able to bring groups together to have those discussions.

The Hon. NATASHA MACLAREN-JONES: In your submission you say that you are the peak body for consumers in New South Wales and that you were not consulted on the developments across south-western Sydney. Can you give an example of other hospital developments in New South Wales that you have been specifically consulted on?

Dr BROWN: Sure. We were brought in and had discussions pretty early on with what is happening with the Randwick redevelopment. We provided advice on how consumer engagement there could be structured, how those mechanisms could be used and how people could be recruited into that process.

The Hon. NATASHA MACLAREN-JONES: So it was not so much on the development but more on the process of consultation.

Dr BROWN: Yes, because talking to me and talking to our staff, we cannot possibly represent and have the knowledge of the full depth of experience of people who use Health Services. I think our expertise is around helping make those connections and helping give consumers the resources and the confidence to find their own voice, tell their own stories and also help services be in a space where they can actually listen to those stories.

I think our expertise is in building those connections. There is a skill involved in creating a consumer engagement infrastructure.

The Hon. NATASHA MACLAREN-JONES: Do you get paid by the Government to do that or is it voluntary?

Dr BROWN: We get paid from the Ministry of Health to provide support and provide some of that capacity-building work with services across New South Wales. That goes only so far and some of our work, if it is quite specific, is done on a fee for service.

The Hon. NATASHA MACLAREN-JONES: The western Sydney development and the redevelopment of Liverpool Hospital are State-significant developments, so obviously it is all public consultation as well is being able to provide feedback, which has occurred at all stages. I am just wondering exactly what your concerns were about the lack of broad consultation, considering they did follow the requirements.

Dr BROWN: Sorry, I am not quite sure I understand the question.

The Hon. NATASHA MACLAREN-JONES: You said in your submission that you felt that you were not consulted and engaged for the south-western Sydney developments. However, everything was made available publicly, so you could have put in a submission on behalf of consumers about concerns and about the development of how things are being done. I was just wondering why you did not do that and what specifically you are concerned about.

Dr BROWN: Part of the reason we cannot—I think our concern really was a lack of consistency in the way that people are brought into these processes and that when we have good things that are developed, there is not the opportunity to share those learnings that happen in one part of the State with another part of the State and that things often start from scratch. Some of the knowledge, particularly the knowledge of the processes that are needed to make these things happen, is lost when we move from one build to another because of the way, I feel, that the local health districts are structured. Sometimes there is a lack of communication between what is happening in one area and what is happening in another. I suppose our concern was more that there are some inefficiencies when learnings are lost from one area and when things start from scratch in another area.

The CHAIR: Thank you very much, Mr Houssos, Dr Brown and Ms Lonergan. It has been very valuable evidence that we have been able to glean from you this afternoon. It sits nicely with the submissions that have been made. I suspect that following the opportunity for members to read *Hansard*, there will be some supplementary questions. If you would be agreeable, we would circulate those questions to you through the secretariat with a 21-day turnaround time if that is convenient. Thank you very much. I appreciate very much you coming in today. Ms Lonergan, thank you for making yourself available. It has been a very important case study that we can reflect on and use as part of our consideration. Thank you very much.

Ms LONERGAN: Thank you.

The CHAIR: That brings our proceedings to a conclusion today.

(The witnesses withdrew.)

The Committee adjourned at 16:55.