REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Cobar Memorial Services Club, Cobar, on Friday 30 April 2021

The Committee met at 09:45.

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Walt Secord

The CHAIR: I commence by welcoming everybody who has come along this morning. My name is Greg Donnelly and I am Chair of Portfolio Committee No. 2, the health committee of the New South Wales Legislative Council, which is undertaking this inquiry before us today. As you know, the inquiry is an inquiry into health outcomes and access to health and hospital services in rural and regional New South Wales. The inquiry specifically is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales.

Before I commence I would like to acknowledge the Wongaibon people, who are traditional custodians of this land and I would also like to pay respects to Elders, past, present and emerging of the Ngiyampaa nation and extend that respect to other Aboriginals present or who may be joining us over the course of the day. Today we are hearing from a number of stakeholders, including local councils, private citizens, Aboriginal groups and health services, health advocates and the local health district. I thank everybody for making the time to give evidence to this inquiry. I mean that very sincerely. I appreciate the submissions. The quality of the submissions has been very good and they have been provided to us. I also appreciate the attendance of people today.

Before I commence I would like to make some brief comments about the procedures for today's hearing. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives—there are some here today and we welcome you for coming along—are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments you make to the media or to others after you have completed your evidence before the inquiry today. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time in which to respond, that is perfectly understandable if there is a particular question that has some detail associated with it and they may take the question on notice. Written answers to questions taken on notice are to be provided back to the inquiry secretariat within 21 days. If witnesses wish to hand up documents, they can do so and they should do that through one of the Committee's staff.

In terms of the audibility of the hearing today, I remind both Committee members and witnesses to speak into the microphones. They should be close enough, but if witnesses need to bring them closer please feel free to do so. There are two sets of microphones: One is for general audibility in the room, and there are also the Hansard microphones. As witnesses would know, *Hansard* is the official record of the Parliament and Hansard staff are here today, doing their very important work of recording the evidence provided to the inquiry. Finally, can everybody please turn their mobile phones to silent for the duration of the hearing. I welcome everyone to the hearing and indicate that there is a broad cross-section of members of the Committee from different political parties as part of this inquiry. The inquiry started its first visit outside of Sydney yesterday in Deniliquin and we had a great day there. Cobar is number two and there will be many more to come. We are looking very forward to hearing from people from Cobar and the district today about the matters they wish to raise with us.

PETER VLATKO, General Manager, Cobar Shire Council, sworn and examined

PETER ABBOTT, Mayor, Cobar Shire Council, sworn and examined

LEONIE BROWN, Manager Corporate Services, Bourke Shire Council, sworn and examined

BARRY HOLLMAN, Mayor, Bourke Shire Council, sworn and examined

The CHAIR: The time is 9.45 a.m. We will get proceedings underway. Would any of you like to make an opening statement?

Mr ABBOTT: We need to take a more risk-based approach to funding and manning levels for health. They seem to be reactive rather than proactive and are based on a set criteria that does not give any consideration to any type of risk assessment based approach. If such an approach was adopted, Cobar sits on the crossroads of two major highways and have five operating mines within 90 kilometres and they would surely qualify for a higher level of service provision as the risk of both major and the likelihood of increased rates of minor injuries would be greater.

Secondly, on a purely financial basis, the cost of continuing to manage health in Cobar in the way it is done currently must be reviewed to ascertain if better outcomes are possible by placing medical professionals permanently in Cobar. The costs we refer to include the cost of flying people out. Data obtained shows that in the two financial years 2017-18 to 2018-19, 174 people were flown out of Cobar at a cost to the Government of just under $1 million. That is one person being flown out every four days. Data showing the reason for these patients being flown out should be gathered and examined to ascertain if having certain medical professionals, for example midwives or fracture clinic, and/or certain equipment, CT scanner or MRI, on the ground in Cobar could provide better outcomes at a lower cost. The cost of having locums flown out and based at the hospital due to no local GPs. Incentives should be examined to attract and retain doctors in rural areas, which may in fact provide a better financial outcome than continuing to pay for locums.

Thirdly, there seems to be no appreciation for distances travelled in rural areas, which includes the perception that Cobar is around about geographically at Narromine. I have no doubt that in the submissions received there will be examples of the many Cobar residents who have been flown or transported to Dubbo for treatment and discharged at all hours of the night and told to find their own accommodation or their own way home. It is reasonable to assume most of these cases are emergencies where the person has no time to pack a bag or grab their wallet and phone so they are left stranded 300 kilometres from home with nothing but the clothes they stand up in. This would certainly be repeated across the many western area towns that feed patients into Dubbo, which is supposedly designed and run as a regional hospital but seems to have no ability to cater for patients other than Dubbo residents.

If Dubbo is truly a regional hospital, then our suggestion would be that the inquiry recommend (a) the employment of a community liaison officer to assist non-Dubbo patients from the region to find accommodation, link with family and friends who can assist, book the transport, direct patients to financial help et cetera; and (b) the building of short-term accommodation specifically to cater for the people transported to Dubbo from remote and regional areas and that this accommodation be provided at no cost to patients. Thank you.

The CHAIR: Thank you very much. On behalf of the Committee I would like to thank the mayors for attending today and your fellow councillors for the outstanding work you do, obviously in local government in your respective jurisdictions but also the advocacy that you do in a number of areas, importantly in recent years on the matters of medicine and health. We were only reflecting yesterday at Deniliquin that once upon a time health and medical matters were not necessarily matters that had to be at the top of the advocacy list for local councils. There are lots of other matters that exercise your time and place demands on you, but increasingly in recent times matters to do with medicine and health have raised themselves up to tier one items that councils are advocating for, particularly councils outside the big metropolitan areas. We sincerely thank the mayors and your fellow councillors for taking up matters raised directly with you by your constituents from the respective wards that are represented by councillors talking about these frontline issues they face. We will move to the next opening statement. Who is going to present that?

Mr HOLLMAN: Through you, Mr Chair—our manager of corporate services, Leonie Brown, put the application in so I think it is only fitting that she does the presentation here today.

Ms BROWN: Bourke Shire Council commends the New South Wales Legislative Council on undertaking its inquiry into health outcomes and access to health services in rural, regional and remote New South Wales. Health service has been and continues to be a matter of increasing concern for the residents of Bourke Shire, a rural and remote New South Wales locality. Bourke Shire is located 780 kilometres west of Sydney and

380 kilometres north-west of Dubbo. Bourke Shire comprises of the township of Bourke and six outlying villages and is considered a gateway into the Far West of New South Wales and into south-west Queensland. The shire has an area of 41,000 square kilometres. To put that into perspective, the area of the shire is two-thirds the size of Tasmania. The western boundary is 200 kilometres from Bourke out at Wanaaring and the northern border stretches to Queensland. The prosperity of the Shire is built around the pastoral, irrigation, tourism and service industries.

Bourke is a regional centre to these outlying areas and the provision of a reasonable medical service is expected to be provided. Bourke has seen a decline in population in the last 20 years and also a decline in medical services. The decline in medical services was highlighted in council's submission, No. 631, to the inquiry. Bourke and the surrounding areas are rich in Indigenous culture and history. It is the traditional country of the Ngemba people. The population of the local government area [LGA] is estimated to be 2,860 people with 31 per cent, or 886, identifying as Aboriginal. Bourke Shire Council's direct operating cost for the provision of health services to the Bourke community is approximately $238,000 per year. Council owns the doctor surgery, allied health facility, dental surgery and housing. The total value of assets owned by the council associated with health is estimated to be $3.45 million. Council provides this level of service to ensure medical facilities are available to the community.

Throughout the 705 submissions, the issue of unmanageable workloads was raised. It is similar across many LGAs if not all. Staff are burning out due to working long hours and not being able to have reasonable breaks. An example just this week at Bourke—the multipurpose centre had only three nursing staff to look after the whole of the hospital due to illness of other staff. This is with a 15-bed residential care unit. Skilled, experienced staff are burning out and leaving. Overseas staff at times need to be upskilled and have significant language barriers that at times make it very difficult for the patients. Not only is there a shortage with nursing staff but hotel services are also of concern. The issues caused from this include infection control within the facility. Doctors are also working long additional hours and, as such, are fatigued. Staff cannot go away for training as there is not enough staff available to fill shifts. At times the health service manager and the nurse unit manager are required to be on the floor. This in turn affects the governance and the roles that they are employed to do.

Bourke has an ageing population. A number of people have high needs, including chronic disease such as kidney and heart disease. They are the most vulnerable and disadvantaged people in New South Wales. Mental health is not supported in Bourke as a rural and remote area. There needs to be urgent review of the replacement of psychologists in rural areas. It is very daunting for a patient with a psychological injury to talk to a video call facility when they have got a mental health issue. Community consultation from the local health district [LHD] is almost non-existent. It was only by sheer luck that council found out that the tender for the medical services was available. The community is entitled to be advised what services will be provided. Last year the community of Bourke was faced with the prospect that, for the majority of the week, emergency patients presenting to the hospital would be seen by tele-doctors.

Whilst this did not eventuate, the original tender process was the thin edge of the wedge and come next tender, whoever is in government, we will no doubt have to again rally against cutbacks. The Far West deserves better and is annoyed at constantly being the poor cousin when it comes to health services. Tell the good people on the North Shore of Sydney when they are having a heart attack that the doctor will assess them via a video call—downgrading after downgrading. Bourke Shire Council would like to see a clinical review of the health system to support rural and remote areas, to support the medical staff that are on the ground and to increase the services that are being provided to our community.

The CHAIR: Ms Brown, that was a clear and concise opening statement that touched on a number of key points that complement very nicely—a quality submission from Bourke council, which no doubt you had much to do with in terms of its preparation.

The Hon. WES FANG: It is really important that we come out here and speak to you and actually get firsthand experiences. I ask a question to both your councils: In your experience how much has your system relied on, say, overseas-trained doctors and nurses? Have you seen that reduced recently due to COVID impacting people being able to come in and out? We heard yesterday, for example, that it has had an impact. Have you seen or felt that in your shires?

Mr HOLLMAN: Look, when you are in a situation where there is a doctor shortage, you take who you get. You get it done no matter—whether it is overseas or in Australia. Our problem is getting doctors—bottom line. I cannot add any more than that. There is a shortage of doctors. This has gone on in the past decade. It has gradually gotten worse and worse. Now in some communities it is "spot the doctor". If COVID has taught any of us anything, it is health is at the head of everything that we do. You cannot play sport, work or have a job. You cannot do anything without health. It is just so important that these doctors are available 24/7. We believe—look,

I am emotional about it—it is our right to have medical service 24/7 in our town. To answer your question, I do not care who the doctors are. If they are qualified, we will accept them into our town and make them more than welcome.

The Hon. WES FANG: The question around doctors and doctor training—we have seen a lot of focus recently around looking at training more medical staff in rural and regional communities, hoping that they will actually fall in love with the community and stay there. We know some local medical schools are opening across New South Wales. Have you been engaged at all by those medical schools themselves to look at how we can actually attract those people that are training through them into remote and rural places like Cobar and Bourke?

Mr VLATKO: I can make a comment in terms of NSW Rural Doctors Network, for example. But they require a contribution from council to support that. I think it is $3000 per student or whatever the case may be. But it goes back to the principle that we believe—which does not hurt us but we are very much committed to—that to attract any doctor to Cobar, we have to compete with attracting that doctor to Bourke or Narromine. Therefore, we have to make sure that we have got an opportunity to put more on the table, irrespective of where they come from. For example, the outback division that runs our medical centre are forever talking to the mines and the council to see what else we can put on the table to attract the next doctor irrespective of where they are from. That becomes a bit of an issue for us because one of the issues that we have also got is we are trying to ensure that those doctors, when they do come here, also want to work at the hospital. So, yes, from that point of view we would love to be engaged with those types of activities, but we still think at the end of the day that there has to be some sort of incentive to encourage a doctor or a health practitioner to want to come out here and be a part of the community rather than just fly in and fly out.

The Hon. WES FANG: Yes. I think that is what the program is trying to do: train them in our regions so that they actually fall in love with the area and stay. When we talk about rural generalists and what we are looking to do around that area to provide rural and remote communities that broader range of skills with doctors—have you had any engagement with that at all? Do you find that there are certain skills that you need in your communities that are not available that maybe you would be looking to see have more provision in your multipurpose services [MPSs] and/or health facilities?

Mr VLATKO: I will let Ms Brown talk about that because she is more familiar with the health side of it. But from everybody in this room I can guarantee you that it is a great place to live out in the bush.

The Hon. WES FANG: Absolutely.

Mr VLATKO: Alright? So we are very proud that people want to come and live in Cobar or Bourke or anywhere out here. Because once they get out here there is a bit of fresh air and lovely weather.

Ms BROWN: It is difficult to attract doctors to these areas. I agree with that. But the other thing that we are having a lot of problems with, to answer your question, is other services. Mental health is a real issue. We need to be doing something about that. Chronic diseases that we have in Bourke and no doubt in other remote areas like ours—we need to be able to provide that service as well. We have two nurses who are trained in dialysis for kidney disease. One of those is leaving and the other one is still there at the moment. What happens when she leaves? We do not have a dialysis nurse who can actually perform what is required. We are lacking in so many areas in regards to health. One example that was provided to me recently was the criteria in regards to allied health service. If you have not got a chronic disease, for example, you would see the podiatrist that comes to Bourke every six weeks. If you have not got a chronic disease, you have to travel to Dubbo. Those services are all lacking. But the main thing is that the nursing staff and doctors are just burning out because we are not providing incentives to get people to come to our communities such as what the teachers and the police do. I really think the Government has to look at that.

The Hon. WES FANG: We know that provision of medical services is not just doctors. We have to include nurses in there because they are extremely important, as are all the other allied health all the way—you mentioned podiatry. There is dentistry, speech pathology and all those things. How have you found those services over time in your shires as well? Obviously Bourke has spoken about the investment they have made to attract doctors—housing, surgeries and the like. But what about the other services that communities need? How have you gone with attracting those?

Mr HOLLMAN: Well, we have no oncology, no palliative care units, no midwifery there anymore. People have to go down to Dubbo to have a baby now. Our Aboriginal people class it is as not being on their land. They hate that part of it there. And because they have to be down there two or three weeks in advance, they cannot afford to do that down there. They go down—so what happens at home now is they take the action where they go down the day before they are due to have the baby. Simple things like that should be available to communities that have nearly 3,000 people.

Ms BROWN: The decline in service there is over the last 20 years, as I noted in my submission. We could have babies in Bourke 20 years ago. We cannot do that now. It is not okay—the Aboriginal ladies especially would like to give birth on country. It is a very important thing. We do not have a midwifery service so that midwifery service is looked after out of Dubbo. They come in and care for the women and babies on a regular basis. Is that good enough? I say it is not. Something needs to be done with those sorts of services so that we have that available for our community 24/7. We do not expect too much. We just expect a reasonable health service for our communities.

Mr VLATKO: One of the things that is interesting from our point of view—being in Cobar for the last five years, I have noticed that some of these services are dependent on when the budget is allocated for support to manage areas like the outback. And if the money is not allocated, then they take it away. What normally happens is you have to justify that you have got the problem before you can get the funds, whereas what we are saying clearly out in the bush here is we would like to actually be precautionary rather than reactive. A lot of these services—especially for children just to be able to understand, or those that look at their hearing—should be automatic because that then can generate a lot of other opportunities.

But it does not happen unless you have got the numbers et cetera. The budget is not provided to that health fund. That issue has happened for us dramatically over the last—since I have been here for five years. In terms of what we provide to attract, as I said before, we always as a council—the outback division comes to council always saying clearly, "If we are trying to attract this person, what can we do?" Because normally they would expect to come here and not pay rent. Therefore, for example, in Cobar we have built, with grant funds and council support, an extension to our medical facilities so that it can allow for consultants to turn up and hopefully not pay.

Mr ABBOTT: One doctor I spoke with some time back regretted being out here because he could not ply his trade. They seem to think that they lose the ability to set limbs. About the only thing they can or are allowed to do is to stitch.

The Hon. WALT SECORD: I want to jump straight to something Ms Brown mentioned in her opening statement. Why is local government providing a doctor's surgery and dental surgery when it is clearly a State Government responsibility? Your ratepayers are paying for services that the State Government should be providing. What steps did you take to decide to do this? What forced you to do this?

Ms BROWN: We were forced to do it to make sure that we provided a high standard of facility to attract doctors and health professionals to our community. It was important that we were able to do that. With the changes, those were made well over 20 years ago. Council invested in that infrastructure so that we could attract doctors to our community and provide a high level of facility.

Mr ABBOTT: Can I just add that the State Government are expert cost-shifters.

Mr VLATKO: The other thing I would like to say is that communities out here, especially Cobar but Bourke and all that sort of stuff—I do not think the council ever sits back and says, "Well, who should pay?" We just have to do it because our communities are important to us. Therefore, I think that has been a tradition in the past. I do recall a long time ago when I was here in Cobar that the council actually had to provide the dentist surgery, the car and the house and guarantee an income that they never had to pay because—but that is the sort of stuff to attract that person to come to a town like Cobar. Therefore, there is no question about it. Sometimes we do not like it but we get on with it because it is important for our communities to have the services that they need.

The Hon. WALT SECORD: Ms Brown, in your opening statement you made reference to maternity services in Bourke Shire. With situations like that, do you have cases of mums giving birth on the highway or on the way to hospital? Do you have situations like that?

Ms BROWN: We have had situations where mums have presented to hospital and have given birth at the hospital, where there is not an obstetrician or a midwife. There is a videoconferencing facility. There is one example of a young lass presenting to hospital and then arriving at the airport to be transferred on the flying doctor service but delivering the baby at the airport.

The Hon. WALT SECORD: At the airport?

Ms BROWN: Yes.

The Hon. WALT SECORD: Which airport was this?

Ms BROWN: Bourke.

The Hon. WALT SECORD: So she gave birth at Bourke airport?

Ms BROWN: Yes.

The Hon. WALT SECORD: Who assisted her? What medical assistance did she receive?

Ms BROWN: The ambulance and the nursing staff that were with her at the time.

The Hon. WALT SECORD: At the airport?

Mr HOLLMAN: Yes.

Ms BROWN: Then she was brought back to Bourke and then transferred back to Dubbo with the air ambulance. Everything was fine but there is—I could not say that anyone was born on a highway, no.

The Hon. WALT SECORD: In the evidence you talk about the cost of—I think it is Cobar Shire—flying patients to Dubbo and it is $1 million for 174 patients. How do you feel about the local health districts' managing of—it actually makes sense. That $1 million could have been better invested in the local community here rather than spent there. Mr Hollman, you are nodding in agreement. Do you want to make a comment?

Mr HOLLMAN: No, I am agreeing with you there. Of course it would have been better off spent here. But that is just another thing that we face.

The Hon. WALT SECORD: What is your relationship to, or how do you find dealing with, the State Government and the local health district? Do they listen to your views? What happens in that engagement?

Mr HOLLMAN: I think I can answer that by telling you what we have available at our hospital now. We have a $15 million hospital that was built six or seven years ago and they took everything out of it.

The Hon. WALT SECORD: Took everything out of it?

Mr HOLLMAN: Yes. I got told we have no oncology and no palliative care. We have no baby facilities there now. It is just a basic hospital. It was changed from a hospital to a medical centre.

Ms BROWN: Multipurpose centre.

Mr HOLLMAN: Multipurpose centre.

The Hon. WALT SECORD: In Sydney there is something called "ghost wards", where you have empty parts of a hospital. Do you have situations like that at your hospital, where there is an empty facility?

Ms BROWN: Our medical ward is certainly empty, but the facility is very busy in the aged-care unit.

Mr HOLLMAN: Yes.

Ms BROWN: But I guess they are ghost wards to a certain degree. I did not do my homework on how much it costs us to fly people out but we would have an air ambulance visit nearly every day.

Mr HOLLMAN: Yes, we would.

Ms BROWN: There are people flying out nearly every day and we just do not have the service. We do not have the skilled staff or the facility that can complete the minor operations. If you go in with a dislocated thumb, you are more than likely to be flown to Dubbo to get that sorted.

The Hon. WALT SECORD: For a thumb?

Mr HOLLMAN: Yes.

Ms BROWN: There is very limited ability to undertake minor operations. The one that was in my submission was a guy that came from Wanaaring to have a mulga stake removed from his foot. We could not remove that mulga stake. He did not get flown to Dubbo because he was not such an urgent case but then he went to Dubbo, had the mulga stake removed and then turned around and went back to Wanaaring. It was a 14-hour ordeal for that young boy to be driven from Wanaaring to Bourke, then on to Dubbo, then to come back again. That is the sort of minor operations that 20 years ago we would have been undertaking in Bourke and he would not have had to go through that ordeal.

Ms CATE FAEHRMANN: Thank you for appearing today. I want to understand the purpose and the reason for the changes 20 years ago that you have referred to, Ms Brown, in the very good submission that you wrote. Will you talk us through what changes have occurred demographically in the region in the past 20 years?

Ms BROWN: The demographic change, I guess, is our decline in agriculture.

Mr HOLLMAN: That is the huge one.

Ms BROWN: That is about it. Back in the late nineties we had 3,500 people. We now have about 2,800 people, so there has been a significant decline in that industry and that is where our loss of population has come from. We have less skilled labour now, with people moving away from the community. That causes not only impacts with health—we have had a decline in health—but also education. You do not get the quality of teachers when you do not have the number of kids at the school. That is the demographic change that we have seen. But the service that we provided in the hospital 20 years ago was—we delivered babies, we did tonsillectomies, we did appendectomies and whatever came through the door. We attracted doctors and skilled nurses because it was exciting. You would get more interesting cases coming through the door of Bourke or Cobar hospitals than what you would probably get in the city, where you were just sitting in a ward. The doctors and nurses would come out because you did not know what was going to come each day, whether it was off a farm or you were delivering a baby. So there are significant changes. No doubt everybody needs to have change and they have put changes in but they do not always work, so we need to review that.

Ms CATE FAEHRMANN: Can I check with Cobar as well? Have there been changes in terms of the demographic in Cobar? Have the mines—

Mr VLATKO: Yes. If you want to go for a tourist drive you can actually see that back in the early days of Cobar we had 44,000 people here. We do not have that now. We are a mining town, as well as agriculture, and we have less than 5,000 people now.

Ms CATE FAEHRMANN: So the past 20 years—probably the same?

Mr VLATKO: Yes. The decline is so much that when the mines change their roster, we therefore go into this business now where our unemployment is very low. If the mines are looking for people then they will have to fly in or drive in. That creates a significant problem for us as a community, because they are not living here and their families are not here. That creates, as you just said, a reduction in our demographics. But at the same time, elderly people are still coming back to live here because this is their home and this is where they were born. So we have that mixture and we are very proud of that mixture. I also say clearly that back in those days we had a hospital as well. We do not have a hospital now. It was demolished and we actually have a multipurpose centre. One of the things that the mayor said here quite clearly in terms of risk factor is—originally when we argued with the State about what type of medical facilities they are building, I had no doubt they are building it based on the risk factor and their interpretation of what they can afford. Therefore if you have a fracture or something then yes, I understand you have to fly to Dubbo. We do have great facilities and we are very grateful for the new facilities, but it is not a hospital in terms of the old definition of what used to be here.

Mr HOLLMAN: No.

Mr VLATKO: But at the moment what the staff provide there, and I can vouch for this because I have been there myself, in terms of coming in and making the decisions is brilliant—except that I was treated by a locum from Sydney.

Ms CATE FAEHRMANN: What are your views of the multipurpose facilities as compared to the hospital that you had before? We have heard a lot of submissions about those changes and we have had some Government representatives really talk up the kind of flash multipurpose facilities. What level of care—what does it mean in terms of reduced services as a result? What are you missing out on?

Mr VLATKO: The comment that we can raise, and it is subject to individuals, is that I do not think what you have in terms of the nurses that are in there is the problem. I can only recall that when we did debate about whether our facility should have a theatre or whether it should have babies being born there, it always came back to this technicality of insurance or technicality that a doctor has to have so many babies born each year—otherwise why would they come out here?—et cetera.

Ms CATE FAEHRMANN: When you say you had the debate, what format? What forum? Is this through public consultation with the LHD?

Mr VLATKO: Yes, we were fortunate enough that we provided the Government with a piece of land next to our nursing home. Mind you, I would sell Scott for a dollar. Based on that, they did help us immensely with the village itself by providing some additional beds. But when we did that exercise, we argued on behalf of the community because of what the mayor said before: We have a mining town here. We have significant roads and significant opportunity for accidents. Why can we not have a medical facility that can cater for a little bit more than just flying them to Dubbo? We argued for that but of course, as I said, it is probably about dollars and the risk factor. It was considered that it would be better to build what they did build.

Ms CATE FAEHRMANN: But you have had it before, in terms of the risk factor. Is that correct?

Mr VLATKO: Before, when we had the hospital, yes. The policies of the Government started changing so that it was always difficult to attract a doctor up here.

Ms CATE FAEHRMANN: And potentially the level of money that they wanted to put into a community like this changed as well, in terms of the desire and the amount of money that they wanted to contribute. That changed.

Mr VLATKO: It would have, but I am grateful that they at least built a brand new facility. As to whether they would have spent a little bit more money and made it into a hospital—but that is not what they are calling it now.

Ms CATE FAEHRMANN: Ms Brown, your submission suggests that a number of health facilities within the Far West are also suffering a decline in medical services. That may be due to budget cuts and also the centralisation of services to larger centres. We have also heard about a decline in nursing staff, where the Government basically set a policy a while ago not to fill positions when they became vacant. That sounds like budget cuts to me. Does it sound like that to you?

Ms BROWN: Oh, definitely. There are budget cuts and that is making a whole difference—also the time taken to fill positions. When positions are becoming available, it is taking a long time. By the time the interviews and everything have taken place, the people that have been selected may have taken positions elsewhere rather than in the remote areas. There are certainly budget cuts. One thing I would like to say is we have spent $241 million on a new hospital in Dubbo, which is fantastic. We spent $15 million back in the early 2000s for the Bourke District Hospital. Bricks and mortar do not save lives. It is the operating cost of running those facilities and making sure that there is nursing staff available to save lives that is so important, and that is where the cuts have been. Recently we have met with the Minister and he was very accommodating. We heard about what we are building, but it will always come down to—a hundred years ago we were having babies in bower sheds. We are probably better off going back to that.

Mr HOLLMAN: Cate, can I just add something? I said it earlier: We seem to lose the consultation thing now. When something happens to our hospital, we are told when it is done. I will give you a good example; I will not keep you long. Just recently we had a new medical service that took over. Ochre Health took over from Rural and Remote Medical Services and we were told that we were having telehealth and all that. My comment to the guy that ran it was, "We weren't consulted about any of this here." He said, "We did not have to. It is not our clauses either." How will we ever have a proper service when we are not consulted? That was the end of things. They did not have to come back to us to tell us what they were giving our town; they were telling us what we needed. We just fall behind. I am sure if we could have been consulted that some of the things at the hospital we would never have let go. But we were just told, not consulted.

Ms CATE FAEHRMANN: We heard yesterday about the centralisation of health services.

Mr HOLLMAN: Yes.

Ms CATE FAEHRMANN: The decision to centralise it and take it away from the local health boards has really taken power away from communities being able to have their say about what they need. Is that a common experience?

Ms BROWN: Definitely.

Mr HOLLMAN: Yes, the old health boards were great. The ones now have no authority. What can they do? They just have a meeting; they cannot make recommendations. Well, they can, but it just goes in one ear and out the other. But the old boards ran the hospitals and our hospital was great when we had a proper board, which had an input into what their health was. That is another thing we have lost.

The Hon. WALT SECORD: Can I ask a quick question in relation to Cobar District Hospital? We read in the national media about distressing situations at Cobar District Hospital and Dubbo Base Hospital—no amputations, no blood supply, no maternity or surgical services, nurses running from patient to patient, support staff and cleaning staff having to help with patients. What is actually happening at Cobar District Hospital and how does the community feel about the hospital, Mr Mayor, as the community leader?

Mr ABBOTT: That is a hard one, actually. There are certainly groups of people who are not at all happy with the situation, but I would personally prefer not to get into it.

The Hon. WALT SECORD: Do you just want services restored and fixed?

Mr VLATKO: Just to help the mayor there, I think one of the difficulties that we have up there is that it depends on who was treated. I do not want to go into the personal stuff because I can relate to my personal stuff and I would definitely not complain about the level of service that I had—but remembering that the doctor who

treated me was a locum from Sydney. But the reality for us is that it is an important part of the foundation of our community. We have different views within our council itself but the council is saying quite clearly, "Just get it right."

Mr HOLLMAN: Yes.

Mr VLATKO: Do not look at the money; look at what you are trying to produce up there and support our community so that we do not have issues.

The Hon. WALT SECORD: Mr Hollman, our paths have crossed over many years. I have seen you as a local government leader. Yesterday we had doctors give evidence in Deniliquin, where they were told this is the price that country people pay because they live in the country.

Mr HOLLMAN: How do you want me to answer that? That is BS.

The Hon. WALT SECORD: How do you feel about that?

Mr HOLLMAN: I feel disgusted. That is terrible.

The Hon. WES FANG: That is not what happened, Walt.

The Hon. WALT SECORD: Yes, it was. They talked about a lack of support—

The Hon. WES FANG: We are trying to be collaborative here.

The CHAIR: Gentlemen, we are almost at the end and we have been doing pretty well up to now. I will give Wes the call to round it off.

The Hon. WES FANG: We are all genuinely listening to see what we can do.

Mr HOLLMAN: Yes.

The Hon. WES FANG: There was actually something that you touched on a little bit earlier, Mayor Abbott, about people deskilling as they come into smaller areas. I am fortunate that my ex-wife was a paediatrician in a rural setting. She went from doing tertiary-level intubation of newborns and premature babies to a regional or rural setting where she barely did it. She said that she would feel like she was deskilling when that came up. When you have a declining population, you just do not have the number of cases to continue the skills that you would normally have. We heard evidence about that yesterday. Has the LHD spoken to you about how issues around keeping doctors' proficiency and currency as populations decrease may affect what is provided within your communities? Have you been given a chance to actually have some input into that?

Mr ABBOTT: No, we have not. I am sorry, I have lost my train of thought.

The Hon. WES FANG: That is okay.

Mr HOLLMAN: The decrease in populations can also be affected when your medical service is not good. On numerous occasion when we get people applying for positions in Bourke, their first or second question is always, "What is your medical service like?" That is where it goes.

The Hon. WES FANG: Yes, it is chicken and egg.

Mr HOLLMAN: That can have an effect on your population declining.

The Hon. WES FANG: I understand. It is just one of those things about people deskilling. Because they do fewer operations, they do not retain the skills. You need to do so many operations. I wonder if you have been given the opportunity to actually have some input around what services are provided in your shires?

Ms BROWN: A few years ago we were. When they decided that the maternity unit was going to close, there was a number of meetings held in Bourke in regards to that.

Mr HOLLMAN: Yes.

Ms BROWN: We did have a GP-obstetrician who left Bourke after they decided to close the maternity unit because he then could no longer do deliveries. But I will add that he went to a remote area in Western Australia and delivered babies. You can go to a remote area in Western Australia and they can still deliver babies. They cannot deliver babies in Bourke. It is the same with midwifery. Midwives train to deliver babies so they do not want to come out there. For us to attract a midwife to come out, to be there before the baby is born and to be there after the baby is born—they are not actually utilising the skills they are trained for. That is a real issue.

The Hon. WES FANG: That issue came up yesterday when we were talking about how, when there is an incident that happens, the Government is expected to respond. That response might mean there are ongoing

effects from that and that is the balance that we are trying to find. Your evidence today has been really helpful in helping us try to find that balance.

The CHAIR: Thank you very much once again for coming today. I appreciate the leadership that the mayors give for their respective communities. They both have wonderful leadership histories. When you think of what Australia is as a country so much of what you think of is regional, rural and remote—and the people who live and work and have families who for generations and generations have been part of those communities and who continue to do so. Whilst those populations ebb and flow and change over time, there are a whole lot of very good reasons why people want to live and raise families and spend their lives outside big metropolitan cities.

Mr HOLLMAN: Hear, hear.

The CHAIR: We do feel a weight of obligation in this inquiry to speak to the shires and the councils to get firsthand information about what your constituents are raising with you. They are not things that are manufactured, that just pop out of the air. People are raising them directly with you. For the senior officers in the councils, the general managers and the corporate service managers, the support you give the mayors to articulate and present that as you have done today is extremely important as well. Thank you all very much for coming along. There was a lot of good evidence and we will be taking that into account in our deliberations.

(The witnesses withdrew.)

ALLY PEARSON, private citizen, affirmed and examined

GEOFFREY LANGFORD, private citizen, sworn and examined

PEN McLACHLAN, private citizen, affirmed and examined

The CHAIR: I welcome our next set of witnesses. Thank you for making yourself available today. You have a lot of things on your plate and you have carved out some time to appear before us today, so thank you for that. We consider the evidence from individuals as very valuable and important evidence to the inquiry. It gives us firsthand insights into matters that we otherwise may not be informed of. Would any of you like to make an opening statement?

Miss PEARSON: Good morning. I would like to preface my testimony by saying that I wrote my submission not only as a review of local services but in support of Cobar health professionals. I have received nothing but professional and caring support over my time as a resident and I am glad of my invitation to speak here today. My testimony is based on my experiences with what, in my opinion, are basic services. I understand the need to travel for specialist care in some circumstances but where is the line with these circumstances? I am not here to discuss an obscure illness or disease where specialist care is only available in a handful of places nationwide. While all care in regional areas needs to be reviewed, the areas I will focus on today are midwifery, maternity and obstetrics and emergency care.

To focus specifically on maternity, we are talking about something that women have done since the beginning of time. While I am not trying to bring too much emotion into my testimony, it is still baffling to me that we must be moved 300 kilometres to do something that our bodies are built to do. I understand there are risks involved with birth and my submission highlights some of these. I gave birth in the midst of the pandemic lockdowns and while it was an isolating experience, the difference in normal times for regional people would not have been overly different. I still would have had to have been hours from my home, bundled in a car with a new baby and a sore body just to do the most natural thing in the world.

Our councillors have spoken on demographic changes and the attraction of doctors and workers to our towns. I would like to further support these statements by saying, how do you attract people to live in a place where there are very little basic services? Our demographics are changing for a variety of reasons but I can assure you, anyone with a family will definitely factor in health care into a decision on where to live. I can assure you that as a local, every time I hear that air ambulance, my heart skips a beat hoping that person gets the help that they need quickly. I thank you for your time and I hope that I can provide you with the information to help not only Cobar but the surrounding towns.

The CHAIR: Thank you, Ms Pearson, that is an excellent opening statement. It sets up the questions very nicely. Mr Langford?

Mr LANGFORD: I am a resident of Cobar Shire and I live on a grazing property out of town. I am a general legal practitioner in Cobar and I have been conducting my practice here since 1984. My roots are in Cobar. My parents spent their lives here and died here and I have spent most of my life here. I am a single person; I live alone. I wish to continue to live here for the rest of my days. To put Cobar District Hospital into some context, I tender two Cobar publications. One is from 1959 describing a 36-bed hospital and another is a tear sheet of *The Cobar Age* of 19 September 1968 describing the opening of the new hospital. I had the honour of being a patient in the old hospital, the new hospital and the new multipurpose one as well. On 25 September 2019 I became painfully aware of the absence of blood availability for transfusion at Cobar hospital. I had collapsed after bleeding from my penis. There was a swift response by Cobar ambulance and a swift admission into ICU at Cobar hospital, as well as excellent attention and treatment by the nurses and the visiting doctor. I thank them all. That evening I was transferred to Orange hospital by helicopter.

Whilst in Cobar ICU, I discovered that I needed a blood transfusion. My blood pressure was 70 over 50. I then discovered that the blood had to come 300 kilometres from Dubbo by police highway patrol. That upset me. I knew of blood transfusions here many years ago, and I have set them out in my submission. My local member asked a question in Parliament after I wrote to him. I consider the Minister's response dismissive and inadequate. That is why I have made my submission to this inquiry. My second submission is about rural addressing at Cobar. The new system is well meaning but ludicrous. Worse is that it is misleading and it needs revision. For example, if there is an accident at the gun club, which is situated about two kilometres behind me now, the 000 operator will ask for the address—17 Kidman Way, Cobar. If it is required at the rugby union club, which is about a kilometre away from where we are now in that direction behind you, the address is 36297 Kidman Way, Cobar. The address of the miner's camp which is situated that way about two kilometres is 12747 Barrier Highway, Cobar. It is ludicrous.

My third submission is a transfer to a distant hospital. Regrettably, I have heard of sad reports of Dubbo hospital. I have had an unsatisfactory experience there in 2016. I believe the staff there were overworked to the extreme. On a happy note I am able to say that my fourth submission is about the former cardiovascular program which has been replaced by an excellent cardiopulmonary program that is operating now in Cobar. I myself have had the benefits of that and so have other people. It is a great asset to our local hospital. I applaud the resumption of that service in Cobar. I ask the honourable members of the inquiry to give kind consideration to my submissions. I believe that the Minister has to hear rural and remote people and allow them to make a decision. The Minister should not leave decisions to a distant and centralised bureaucracy. Local health councils are a wonderful idea, but they should be detached from the local health bureaucracy and they should act independently of it. The Minister and Western NSW Local Health District have to answer the concerns and questions raised by local residents here in this inquiry and elsewhere.

The CHAIR: Thank you, Mr Langford. That is a good opening statement and provides some very valuable information and historical context as well in terms of what health and medical services have been available hitherto in Cobar. Ms McLachlan—

Pen McLACHLAN: I am actually just Pen. No Ms, Miss or anything like that. This morning I travelled from Condobolin, which is 3½ hours away from here. I am here to represent the nurses not just of my community but of all smaller rural communities. I have worked for NSW Health for 24 years. Twenty-two of those have been at Condobolin hospital. I have seen some changes: some for the good and others, as those from Cobar said, basically removing services from our town. We need a doctor on site at our facility that is there in our emergency department. We have a very busy little emergency department. We have two, soon to be three, mines in our area. We are a very big agricultural centre. We form part of the food bowl that feeds Australia. Our current visiting medical officer [VMO] who visits is on call from eight to five Monday to Friday and also works off site at a medical practice. He is leaving in mid-May.

There is no availability of basic services. If anybody requires suturing or removal of foreign bodies from eyes, they are then required to go to Forbes or Parkes which is at least another 200 kilometre round trip for those people. That also puts extra pressure on Parkes and Forbes emergency departments. The nursing staff are struggling. We are constantly understaffed and we are not just nurses. We are management, admin, security, cleaners, transport bookers. You name it, we do it. Also, like Cobar, we are unable to recruit suitably qualified nurses. Trust me, I could sit here all day and give you horror story after horror story but I will just give you a recent one. Recently, the cook from the hospital was forced to sit with a patient in a car park outside our facility who had had a stroke. This was because the two nurses who were on duty were too busy in the emergency department [ED] and in the ward. I think at that point we had nine inpatients.

The CHAIR: Are we talking about in 2021?

Pen McLACHLAN: Yes, we are. We are talking about two weeks ago. There was no ambulance in town to provide backup assistance. That is what the ambulance normally do for us. The patient was forced to wait in the car for 15 to 20 minutes until the fire brigade could attend to provide assistance. This is a fire brigade that is run by retained firefighters, I think they are called. They are not actually full time. The paramedics are also struggling. Their numbers are too low. They do between two to five transfers per week out of Condobolin with a minimum six-hour return trip, leaving our town with no cover and the nurses without emergency backup. Because of that, patients are not getting to specialist care within a reasonable time frame. Those are just three points that I have chosen for today, but trust me, I could sit here all day and speak about what is going on with health.

The CHAIR: Thank you very much. That too is a very enlightening opening statement. We will move to questions now.

Ms CATE FAEHRMANN: Thank you so much for appearing before the Committee today and having the courage to tell your stories in such a public way. It is so important that we do hear them. Pen, the fire brigade was called. Was there a fire? Was the person trapped in the car?

Pen McLACHLAN: No. Because the person had had a cerebrovascular accident and had some weakness they were not able to get out of the car themselves. The nursing staff are not supposed to leave the hospital to give assistance to help people out of vehicles. But even if we were able to, they could not that day due to the fact that they were snowed under. They just did not have the capacity to leave patients unattended in the hospital.

Ms CATE FAEHRMANN: I have the New South Wales Government's submission to this inquiry in front of me, which I think is supposed to represent all of the local health districts [LHDs] across the State for the purposes of this inquiry. I just wanted to read out a small paragraph on page 4 of this submission and get your views on it:

> All LHDs are supported by NSW Health Pillars and other Health Support Organisations within NSW Health, and patient care is provided as part of an effective integrated network of clinical services across the State. All these elements work together to deliver seamless, high quality care for New South Wales residents regardless of location.

I would just like to get your views on that statement. Firstly, true or false, Miss Pearson?

Pen McLACHLAN: False. Sorry, I thought you were addressing me.

Miss PEARSON: Pardon, it was true or false?

Ms CATE FAEHRMANN: True or false?

Miss PEARSON: False.

Mr LANGFORD: Not true.

Pen McLACHLAN: False.

Ms CATE FAEHRMANN: In terms of your experience, Ms Pearson, I have another sentence for you in terms of midwives and the maternity services that the New South Wales Government delivers. The submission says:

> Birthing services across NSW are planned and provided according to local needs, birth numbers, and availability of staff. Birthing services are 'networked' to enable consultation, referral, and transfer of women who develop complications during pregnancy. This ensures pregnant women receive the right care, in the right place, at the right time, as close to home as possible.

What do you think of that statement by the New South Wales Government?

Miss PEARSON: That was a lot of information, but the thing I took out of it mostly was that the word "network" kept getting used. How big is this network? That is the question we have got to ask. Yes, we have access to it, but our network is 300-plus kilometres away from us. What deems that we should not have one closer that can service all of these smaller towns, somewhere in the middle? In the right place at the right time—what deems a right place? To me the right place to give birth is my home. We had somebody state that Aboriginal women would prefer to give birth on their lands. That is their right place. My right place is not Dubbo, my right place is not Orange; it is here.

Ms CATE FAEHRMANN: Why have services been reduced in this area? In fact, it is not just here. We are hearing about the lack of midwives, the lack of maternity beds—maternity wards being closed down and always centralised to somewhere else and it ultimately results in less beds. Women are still giving birth in this area. Do you think that is putting them at risk?

Miss PEARSON: It is not just here. It is Australia wide. We know that women are having less children than they once were, it is quite obvious, but we are still doing it. It is 100 per cent the most natural thing in the world. There was actually a news article—I believe it was Prime or WIN news, I am unsure of which, that held a special segment on how many babies were born at Dubbo hospital this year. One nurse or hospital staff member went through and made special hangings to put throughout the hospital with the child's date of birth and the name. It was a record number of births that year for Dubbo. They are coming from our areas. They are not just from Dubbo. We are still having babies and we need the services.

Ms CATE FAEHRMANN: There are some services in Dubbo. Mr Langford, you said you were not happy with the services in Dubbo. Is that correct?

Mr LANGFORD: That is correct, yes.

Ms CATE FAEHRMANN: Would you like to expand on that? What were the reasons behind that?

Mr LANGFORD: Well, I and another gentleman went down by air ambulance from Cobar and we were picked up at the airport by the local Dubbo ambulance who took us to the hospital, where we were in a corridor with another Cobar person. Both of these gentlemen have recently died—I am the only survivor, but not of the hospital system. We were there and a lady came up and said to me, "Hello, I'm Vanessa. I'm going to treat you. I'm your treating doctor today." I have not seen her since, and that was July 2016. The three of us were in the corridor for a lengthy period of time. Then we were put into a ward and we stayed there—with the thing going pump, pump, pump on my arm and the other two near me. After two days I was a bit fed up, I was still dressed much the same as I am dressed right now, so I told them that I wanted to go. I had no contact, my family did not know where I was because I had gone in there unexpectedly, and then I saw a doctor who tried to talk me out of leaving. I told him that I would just go straight home and make an appointment to see my cardiologist in Sydney. I left. I caught a taxi to the Dubbo railway station and a bus back to Cobar. When I got back to Cobar, I rang my cardiologist in Sydney and at 9.30 two days later he treated me.

Ms CATE FAEHRMANN: We are hearing, for example your situation Mr Langford, there is no blood available in Cobar but there used to be. People will still need blood in Cobar. With not as many nurses, with no maternity services, do you feel that you are basically being abandoned by the Government? It is quite extraordinary that people are expected to come to places and work in places as remote as Cobar and Bourke but—you have got thousands of people still living in Cobar and Bourke, so to not have the health services, how do you feel the Government is treating you? I just want you to be as open as possible about this.

Mr LANGFORD: It is inadequate treatment. The Minister refers to blood not being able to be kept at every hospital, but it will be kept at nearby hospitals. Well, with respect, he is not thinking of Cobar-Bourke 160 kilometres, Cobar-Dubbo 300 kilometres. He is thinking of Fairlight to Manly. He is not thinking of the distances out here. I think the reason is, regrettably, that the decline in services comes from the very top, through a centralised bureaucracy, through people who are not experiencing what life is in the bush. That is why I think that we should go back to what we used to have. Mr Hollman made reference to the hospital boards which ran the hospitals, which is referred to in that correspondence that I gave you. But I think we are living and working in a dangerous situation here.

I recount a number of motor vehicle accidents just on my road. We have had deaths in mines here. We had a doctor here who went down the mine to treat people; it is not going to happen. There is a disaster or many disasters coming and the hospital here will not be able to cope because it is not given the power to do so. As Pen said, the nurses are not allowed to go outside to help someone from a car. I had that situation happen. A friend of mine, whom I picked up at Cobar airport, had come in by Angel Flight. He had taken a turn on the Angel Flight and I took him to the hospital. I was the one who was obliged to move him from my car to the wheelchair. But that is not the nurses' fault. That is not the nurses' fault at all. That is the rule that has come from on high—a distant bureaucracy that does not have the feel or local knowledge. It is a disaster coming.

The Hon. WALT SECORD: Thank you for sharing what is very personal information. I know that you are doing it because you want to improve the system. Pen, you work at Condobolin District Hospital?

Pen McLACHLAN: That is correct, yes.

The Hon. WALT SECORD: Yesterday we heard evidence that a tea lady was asked to assist with babies and you tell us about—was it three weeks ago?

Pen McLACHLAN: Yes, two or three weeks ago. I am not exactly sure of the date.

The Hon. WALT SECORD: Two or three weeks ago that a cook in the hospital assisted with a stroke patient in the car park. This is a ludicrous question, but did the cook have medical training?

Pen McLACHLAN: She, like everybody else that is employed in NSW Health, has basic life support skills, yes.

The Hon. WALT SECORD: First aid?

Pen McLACHLAN: Yes.

The Hon. WALT SECORD: Is this a rare occurrence?

Pen McLACHLAN: Sadly, no. I mean, if we get busy—which is often, very often—they end up answering phones, they end up letting people into the facility and they sit people up for breakfast or their meals. You know, they are put of—I mean, we are very privileged in the fact we have got a tight little team, but our team is just taking hit after hit, and we are exhausted. We are done.

The Hon. WALT SECORD: So the cook is part of your team?

Pen McLACHLAN: Yes. So are the cleaners. Everybody is. We are a tight little unit, but this tight little unit is slowly falling apart.

The Hon. WALT SECORD: You are actually using military terms, like you are banding together a defence—

Pen McLACHLAN: Yes, well, we are. We are.

The Hon. WALT SECORD: —to fight something.

Pen McLACHLAN: Yes.

The Hon. WALT SECORD: What about the doctors? Where are the doctors?

Pen McLACHLAN: Our doctor—we actually had the privilege of having a doctor over Easter, who is a highly qualified man who actually works in South Australia. He also works for medical administration. It was

very interesting getting his perspective on Condobolin, because he comes out twice a year to keep his clinical skills up. He actually said in a town the size of Condobolin in Queensland, you would have two doctors—one for ED, one for the ward—and they would be based at your hospital.

The Hon. WALT SECORD: I want to take you back to something you said: "We had the privilege at Easter."

Pen McLACHLAN: Yes, we did.

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

Pen McLACHLAN: Because he was there onsite. Again, our ED is a very busy little ED department and he was there to do suturing, relocations. We had a child who would normally have had to have gone to Orange for rehydration; he was able to cannulate and give fluids. The kid went home in three-quarters of an hour. I worked three afternoons over Easter and I am pretty sure that every afternoon by having that doctor onsite we saved three transfers out of that facility every afternoon. So that is nine transfers over three days.

The Hon. WALT SECORD: So what do you do otherwise? Do you have long stretches where you do not have a doctor there?

Pen McLACHLAN: We do have a VMO but, as I said, he also works at a medical centre and he is only on call from eight to five. We use the virtual rural generalist service for triages 4 and 5, which are your lower, less important cases, and then for your emergencies we use vCare.

The Hon. WALT SECORD: What is vCare?

Pen McLACHLAN: vCare is our virtual care. That is over a camera.

The Hon. WALT SECORD: That is a camera.

Pen McLACHLAN: Yes. You are looking at nurses who—and this doctor that we had at Easter, he said, "You are being expected to work at the level of a JMO without the training."

The Hon. WALT SECORD: What is a JMO?

Pen McLACHLAN: Junior medical officer.

The Hon. WALT SECORD: You are a nurse and you are expected to act like a doctor.

Pen McLACHLAN: We are being expected to perform tasks. We had one terrible situation—I am not sure how long ago it was—the lady unfortunately ended up passing away, but she had come in, she was having a bleed, she was vomiting blood. We were asked by vCare, or the nurses on duty, sorry, were asked to put in a nasogastric [NG]tube to try and stop the vomiting. The one nurse could not do it; she tried three times. The patient was becoming distressed. They had another nurse came in, she also attempted to do it and the vCare doctor said, "Where are your expert nurses?" That was insulting to the two nurses that were there doing their darnedest to get this NG tube into this woman's gut, and she just went, "Stop. I've had enough", and when they got that woman to Orange they had to take her to the theatre to put the NG tube down because none of their "expert" nurses or doctors could do it either.

The Hon. WALT SECORD: I want to take you back to something you said earlier. You have a VMO 8.00 to 5.00 p.m.

Pen McLACHLAN: Monday to Friday.

The Hon. WALT SECORD: So you have a doctor 8.00 a.m. to 5.00 p.m. Monday to Friday.

Pen McLACHLAN: And he works at a medical centre as well.

The Hon. WALT SECORD: What happens outside of office hours? So what happens on a Friday night or a Saturday?

Pen McLACHLAN: We also in Condobolin have two very big bike races, like moto enduro bike races each year and we also have a big motorcycle club that races flat track and stuff. We sometimes get doctors for those big weekends but otherwise we are relying on that virtual rural generalist service and vCare and the two nurses that are there.

The Hon. WALT SECORD: So two nurses in a hospital on a weekend with a camera.

Pen McLACHLAN: Yep, that is it.

The Hon. WALT SECORD: So are you called upon to do things that you have never expected to do?

Pen McLACHLAN: I guess working rurally you know that potentially you are going to have to do a bit—I mean, it is exciting, it is great; that is why we love doing what we are doing.

The Hon. WALT SECORD: I can tell.

Pen McLACHLAN: But there is no support, there is no backup, there is no "Congratulations, you've done a great job." I do not know how you change it.

The Hon. WALT SECORD: We are a parliamentary committee and we make recommendations to the Parliament and to the Minister. If I tossed a magic wand to you and I said, "What do you want at Condobolin Hospital? What do you need?"—practical; do not just say "More money" because of course you need more money. They can build things, but you need staff in those facilities.

Pen McLACHLAN: Yes, absolutely.

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

Pen McLACHLAN: You have to provide your nurses. Years ago a friend of mine, she came from up in the Northern Territory down to Forbes to work; they gave her a $5,000 bonus and they moved her. They gave her a $5,000 cash bonus and moved her to Forbes. There is no incentive for nurses to come out here, and, as I think one of the Bourke or Cobar people said, the overseas trained nurses they are great but the language barrier—and they are not hitting the ground running, they are not First Line Emergency Care Course [FLECC] credentialed, so they have not got that First Line Emergency Care Course under their belts.

The Hon. WALT SECORD: Pen, how long have you been at Condobolin and how long have you been a nurse?

Pen McLACHLAN: I have been nursing in Condobolin for 22 years.

The Hon. WALT SECORD: And how long have you been a nurse? Don't give away your age.

The CHAIR: You can if you want.

Pen McLACHLAN: Not long.

The CHAIR: We are all ageing gracefully.

The Hon. WALT SECORD: Twenty-two years.

Pen McLACHLAN: In an acute setting. Twenty-two years in the acute setting is what I mean.

The Hon. WALT SECORD: Okay, so to do this job, with the pressure, it is not just a job to you, is it; you feel a responsibility?

Pen McLACHLAN: No, we love our community. That is why we do what we do, because we want to provide for our rural community. We love our town.

The Hon. WALT SECORD: Thank you.

The CHAIR: The Hon. Wes Fang.

The Hon. WES FANG: Thank you very much for coming in and sharing all your stories today. It has been very powerful and thank you so much. Pen, I wanted to follow on a little bit from what the Hon. Walt Secord was asking you. I just wanted to ask you about what the Hon. Walt Secord was asking you just before I took over with regard to nurses working in your areas. Is there a mix of registered nurses [RNs] and enrolled nurses [ENs]?

Pen McLACHLAN: Yes, I am an endorsed enrolled nurse with advanced skills so I cannulate, I take blood, I do everything, I guess, bar use the S8—I do not have access to the S8 medications. But there are only two ENs left now—we are both very experienced ENs—and the rest are registered nurses.

The Hon. WES FANG: So if there was to be a vacancy in your group, how do they go about recruiting in Condobolin to get some more people or—

Pen McLACHLAN: Sadly, they take whoever applies, because the last person we have put on she was the only one applied for the job.

The Hon. WES FANG: There was only one applicant?

Pen McLACHLAN: Yes. As far as I am aware, yes.

The Hon. WES FANG: Do you find that people are moving to Condobolin to work there or are they people that are living in the area who are filling the gaps?

Pen McLACHLAN: We are actually lucky because this last lady that was put on full-time, she has moved to Condobolin, her and her husband, and the new sergeant of police that is coming out, his wife is a registered nurse and she is going to be picking up three days a week, and that is just what does not happen anymore. Partners and farmers do not go away and marry nurses and bring them back to the community like they used to do. Country life has changed. The way country values used to be—it is not the values, that is not the right word, but the way things used to happen has just changed so dramatically.

The Hon. WES FANG: And that is one of the things that we are looking at in this inquiry. As I said earlier, it is not just about attracting doctors; it is about attracting all those—in the provision of midwives, for example.

Pen McLACHLAN: Absolutely, yes.

The Hon. WES FANG: And blood collectors. We need not only doctors but we need nurses, both enrolled and registered, and allied health staff.

Pen McLACHLAN: Absolutely. Our occupational therapist [OT], who has been pregnant, our health service manager has not advertised her job. Emily finished on Friday. This was not a surprise; Emily did not just pop up and go, "Oh my gosh, I'm nine months' pregnant, I've got to go on leave." For some reason, they have been sitting on their hands and refusing to advertise for the job. Our OT, she eliminates pressure—she provides us with education on pressure area care, on falls, on all that sort of stuff that are supposedly such an important part of Western NSW health, but then we are not given the people to help us to try and eliminate those things from happening. I do not know how you fix it but it has got to start somewhere and it has got to start soon.

The Hon. WES FANG: The last question—I know we are out of time and thank you for the indulgence: We have heard a lot about telehealth and the negatives around it, but given that your facility seems to have quite a lot of access to the use of it, I am curious as to whether there have been any good outcomes from telehealth. For example, I come from Wagga and we have there one of the telestroke services where they can go to a stroke specialist using the telehealth system. The outcomes have been pretty good. Have you had any experience around that sort of stuff?

Pen McLACHLAN: For sure. You cannot say that it does not have its place, and we certainly have had some really good outcomes. We shipped out two cerebrovascular accidents [CVAs] that ended up, I think, at St Vincent's or one of the big stroke hospitals in Sydney and the outcome was really good because we acted within the time frame and followed the steps to get them where they needed to be. It is not all bad but, jeez, when it is bad it is bloody terrible.

The Hon. WES FANG: We need to find where that line is because there are good stories. I am glad you told me about the telehealth stroke, because that service has seen a real marked increase in the quality of life for those patients, like the two that you just identified. But it is where that line is, for us, so thank you for that. Ms Pearson, I wanted to say thank you for your story. Once you got back to Cobar after you had given birth, how were the wraparound services that were provided to you with visits at home, advice and the like? Has that still continued here?

Miss PEARSON: Yes, absolutely. We have a wonderful baby community health nurse. She does home visits, regular visits, inoculations and all sorts of things with the children, and that is absolutely flawless.

The Hon. WES FANG: Okay. I just wanted to make sure that—

Miss PEARSON: She is wonderful.

The CHAIR: Pen, with respect to your extensive work as a professional nurse, I am interested in your comments about reflections on end-of-life care in a place like you have been working for a period of time, and perhaps other places as well. Thinking particularly about the very end stage, the last days or hours of life, and the palliation and palliative care you were able to give when we do not actually have doctors available to make those judgements about the type of specific pharmaceuticals to use to relieve pain, distress and what have you—

Pen McLACHLAN: Yes, and it also depends on the doctors. Doctors have such differing views on medication and pain relief. Some will come up with a great regime to make sure things are peaceful and calm. Others are just—you do not know what has happened in the past, but they are very reluctant to give morphine and pain-relieving drugs. That makes it very hard for us, who have then got to go and deal with the families. There is no across-the-board regime for that sort of thing. But then, every death is different; not all pains are easily relieved and you just have to take it on each individual basis. Again, it is back to nursing staff numbers. We used to give great palliative care in Condo, but now we are just too busy. We do not have that time to spend with the family. Recently—just one more horror story—we were flat out in ED and the ward. A gentleman came in from the local

nursing home. He was very agitated. He had a not-for-resuscitation order and that was all fine. He had been incontinent of faeces—

The CHAIR: Sorry, just so I know, he came through ED via an ambulance?

Pen McLACHLAN: Yes. We were not able to give him the time. His daughter and granddaughter were cleaning up his faecal incontinence. We then managed to call another nurse, who came in out of the goodness of her heart and took this gentleman to the shower, where he proceeded to die on the bathroom floor. We had to call the fire brigade to help get him off the floor. But the fact that we were not able to give that time to that family and let them just—

The CHAIR: Yes. The man was dying.

Pen McLACHLAN: Yes. The daughter came and said goodbye to her father on the bathroom floor. Again, where do we start to fix it and how do we start to fix it? Because it is a bloody big problem.

The CHAIR: On that note—and it is a very sad note, that specific case study you have given—I thank you all very much for coming along. You have given very detailed evidence, and very heartfelt in the way it has been delivered from your different perspectives. On behalf of the Committee, thank you very much. I can assure you that this evidence, rich as it is in detail and specifics, will be taken into account when we are developing our report and recommendations. Thank you all very much.

Pen McLACHLAN: Thank you for the opportunity. It is very much appreciated to have a voice.

(The witnesses withdrew.)

SCOTT McLACHLAN, Chief Executive, Western NSW Local Health District, sworn and examined

BRENDAN CUTMORE, Executive Director, Aboriginal Health and Wellbeing, Western NSW Local Health District, sworn and examined

The CHAIR: We welcome our next set of witnesses, who will take us through to the lunch break. Gentlemen, thank you very much for coming along today. Before we move into questioning, I make this clear to the witnesses: We had on the scheduled appearance of witnesses in this session Ms Rena Clements, the Chief Executive Officer of Cobar Local Aboriginal Land Council. For reasons that are not clear, she has not been able to make it. There may be a delay or something which has caught her up so that she is not able to make it this time. I am sure if she does and is able to make it later today, we will do our darnedest to fit her in. The plan was to have her present. That is the best explanation we can give. I hope she is okay, and I hope we hear from her before the day is out.

That being the case, that leaves us with yourselves, gentlemen, which is fine and good, because it will provide time to give particular focus to the organisation's point of view. Of course, you are here for and on behalf of NSW Health under the umbrella of its submission to the inquiry—that is, the Government's submission—which is submission No. 630. All members have that and are well aware of its content. I invite an opening statement from one or both of you, whichever you prefer—thank you, Mr McLachlan—and then will move to questioning from members. Is that agreeable to you?

Mr McLACHLAN: Absolutely.

The CHAIR: That will take us through until 12.15 p.m. or thereabouts, which will enable you to address the questions of Committee members.

Mr McLACHLAN: Thank you, Mr Chair, and thank you for the opportunity to participate in this hearing. I would also like to acknowledge that we have the privilege today of meeting on Ngiyampaa country. I would like to pay my deep respects to the Elders who have passed, those of today and those emerging in the future. I also offer respect to all of the 30,000 Aboriginal people right across the nine Aboriginal nations in western New South Wales and to all Aboriginal people who are here with us today. I feel incredibly privileged to work in rural health. I know that my colleagues, both clinical and non-clinical, feel the same. We approach every day with a determination to improve the health and wellbeing of our communities. And they are our communities. We live and work here by choice because we love the lifestyle, the people, the culture and the spirit of western New South Wales. Every day we provide services to our families, to our friends and to our colleagues. It is a responsibility that I know all of our 8,000 staff take incredibly seriously.

We care for a growing but vulnerable population of over 280,000 people spread across this beautiful country of over a quarter of a million square kilometres. The majority of people live outside of the growing regional cities of Orange, Bathurst and Dubbo in rural and remote communities. We have a network of over 38 hospitals and multipurpose services in western New South Wales with 60 community health services that make it possible to provide care as close to home as possible. Aboriginal people make up over 13 per cent of our population, some living in remote, discrete communities. We appreciate the history that has created inequity, poorer health outcomes and barriers to accessing health care. Making a difference and seeing meaningful gains in the community are critical priorities for us. We cannot do this in isolation. Working in partnership with Aboriginal communities and organisations is absolutely essential, and I am grateful for the partnerships we have with the Aboriginal medical services, and the Murdi Paaki and Three Rivers assemblies in the region.

Our health services have come some way in creating a more inviting and safe environment for Aboriginal people to access care and support, but we know there is much more to be done. The challenges of attracting and maintaining a health workforce cannot be underestimated, and it is important to understand how those challenges have shaped many of the district's services. There have been significant changes that have taken rural health districts into new territory, like support services for people with complex care needs in the absence of other providers. The development of multipurpose services to create a health centre with emergency, acute, aged care and primary care services over the last 20 years has been positive in expanding services available to communities. While residential care is not the traditional responsibility of State health systems, through our 27 multipurpose services we are now the largest provider of residential aged care in the region with over 400 aged residents calling our facilities home.

The number of GPs in small towns is diminishing, and we are being called on more and more to step in to provide what was typically provided by small private practices. Rural generalists, quite rightly, want a work-life balance, time with their family, reasonable working hours, relief from on-call responsibilities, holidays and professional development time. GPs who are capable of and willing to work in rural hospitals are difficult to find,

resulting in challenges sustaining 24/7 cover for our hospitals. When GP visiting medical officers [VMOs] who see our patients in our hospitals are unavailable, one alternative is for a locum doctor to provide services to the hospital. Locums can be incredibly difficult to source, even with generous remuneration arrangements in place. We have developed some innovative solutions to support patient care. Our Virtual Rural Generalist Service provides the bedside team 24/7 access to a team of Australian-trained doctors with rural generalist skills. These clinicians assist local staff daily in making a diagnosis or guiding treatment. They are definitely a supplement, not a substitution for face-to-face care, which is the case for over 90 per cent of patients in small rural hospitals.

Our partnerships with the NSW Rural Doctors Network and the Primary Health Network are absolutely crucial to guide the future of rural health in looking to projects to seek to create more sustainable general practice in town. These include projects like the 4Ts over Tottenham, Tullamore, Trundle and Trangie, and the Canola Fields initiative in Canowindra, where the Commonwealth has funded and stepped up to help us to support growing general practice in those towns. We have many rural hospitals delivering life-sustaining care such as chemotherapy and renal dialysis to ensure patients can get care closer to home, and that includes here in Cobar. The Western Cancer Centre in Dubbo, which is currently under construction and will be finished soon, will offer sophisticated services far closer to home for people living in the northern part of our region. In responding to the unique environment we live and work in, we have no choice but to explore new ways of providing care. The people I represent today show up to respond to our unique situation to provide the best care they can to patients every day.

We know we do not get it right for everyone all of the time, and some experiences have not been what any of us would have wished. To those people and to this Committee, I want to say that I am sorry. Regardless of how or where it happens, a poor outcome or experience is regrettable. We take the responsibility of providing good care seriously, and we are determined to continue to improve. The vast majority of people who come into our care leave having a positive experience and a good clinical outcome. What is very clear is that the solutions of the past may not be the solutions for the future. We need to be positive, realistic and ambitious to design new approaches that may not be familiar but are safe, effective and sustainable. I look forward to this inquiry supporting and contributing to this goal.

The Hon. WALT SECORD: Thank you, Mr McLachlan.

The CHAIR: Yes. That is what I normally do.

The Hon. WALT SECORD: Oh sorry, Chair.

The CHAIR: He thinks he wants to be a chair, but he has to get a promotion. Of course, we all thank you, including the Hon. Walt Secord, for that opening statement. It was very clear and, indeed, heartfelt. We understand precisely the meaning of the words you incorporated in that statement in terms of other matters that may have happened. So we appreciate it. The Hon. Walt Secord will start the questions.

The Hon. WALT SECORD: Mr McLachlan, in your opening statement—I want to make sure I have this correct—you referred to 38 hospitals and how many multipurpose services [MPSs]? Was it 27?

Mr McLACHLAN: Twenty-seven.

The Hon. WALT SECORD: So 38 hospitals, 27 MPSs—

Mr McLACHLAN: That includes the 27 MPSs.

The Hon. WALT SECORD: So 38 hospitals and MPSs.

Mr McLACHLAN: And MPSs—that is right.

The Hon. WALT SECORD: You were here earlier for the evidence that Condobolin District Hospital has a Visiting Medical Officer 8.00 a.m. to 5.00 p.m. Monday to Friday. Of the 38 hospitals and MPSs, how many of those are without a doctor?

Mr McLACHLAN: Thank you, Mr Secord. The vast majority of our hospitals have Visiting Medical Officers who do visit the hospital. It varies from town to town. We are absolutely committed to continuing to recruit in doctors who can visit the hospital, work in general practice and primary care in the rural town. We would love to see all of our hospitals covered 24/7 by a local doctor. Where that is not possible, we do provide virtual services to back up and support the local clinical care staff.

The Hon. WALT SECORD: You said you would love to provide physical doctors. Can I ask you again? How many of the 38 hospitals in the local health district are without a doctor on the weekends?

Mr McLACHLAN: I would have to take the question on notice to give you an exact figure.

The Hon. WALT SECORD: You do not know the answer to that?

The Hon. WES FANG: Point of order—

Mr McLACHLAN: I know there are five hospitals—

The CHAIR: Members will settle down.

The Hon. WALT SECORD: Wes, I am going to press this point. This is a very important—

The Hon. WES FANG: At least allow the witness to finish.

The CHAIR: Gentlemen, we have been doing very well today, thus far. I am keen for that to continue. If you have a concern, you know the procedure, which is to take a point of order. It is not to cut across a member. The member asked the question and may continue to press the question appropriately.

The Hon. WALT SECORD: Wes, before I speak, I have to warn you that I am going to press the point but I will do it respectfully.

The Hon. WES FANG: I did take a point of order, Chair. The point of order was to allow the witness to finish his answer before the next question was asked.

The CHAIR: We know how this rolls.

The Hon. WALT SECORD: Wes, I will press this point.

The CHAIR: You do not have to explain yourself.

The Hon. WALT SECORD: Mr McLachlan, 38 MPSs and hospitals in your local health district—you must know which hospitals are without a doctor on a weekend. How many of the hospitals under your jurisdiction—under your responsibility—do not have a doctor on duty on the weekends?

Mr McLACHLAN: Mr Secord, we absolutely do know from day to day and week to week whether a hospital has got cover or not. It does vary from weekend to weekend depending on whether a doctor is taking some leave from town or has other commitments. We do have a lot of things in place to ensure that our doctors are able to get leave and are supported out of hours, to make sure that they get good sleep, time with their families and time away. Over half of our facilities will have cover right throughout the week and the weekend. To answer for the most recent weekend, I might have to take the question on notice for the exact detail.

The Hon. WALT SECORD: I would like to know, last weekend—if you are taking this on notice—how many of the 38 hospitals and MPSs did not have a doctor physically in the hospital?

The CHAIR: Take that on notice.

The Hon. WALT SECORD: You said there are 8,000 staff that work for the local health district. How many of those staff are bureaucrats?

Mr McLACHLAN: Mr Secord, all of our staff are incredibly committed to the region. The staff that work in corporate and support services are less than 2 per cent of our staff.

The Hon. WALT SECORD: I will flip it, then. Of the 8,000 staff, how many staff are nurses and doctors?

Mr McLACHLAN: I can tell you a couple of figures that will help with that. We have over 2,500 nurses, over 700 doctors and a range of other corporate support staff.

The Hon. WALT SECORD: That is good, thank you. We heard evidence earlier today that at Condobolin District Hospital a cook with basic first aid sat with a stroke patient in the car park. Were you aware of that?

Mr McLACHLAN: I believe the patient was not able to get out of the car and did need some serious assistance. Our nurses' roles are providing clinical care inside the facility. I know that the request to have the fire brigade come and support with that was crucial to get the patient into the care in the hospital.

The Hon. WALT SECORD: Why is a cook with first aid sitting with a stroke patient at Condobolin hospital?

The CHAIR: In the car park.

Mr McLACHLAN: Mr Secord, it is certainly not something we would do on a regular occasion. It is something that I would like to see us be able to improve but that experience for the patient I am sure was incredibly troubling. We certainly take the responsibility to make sure that patients are safe in all of our facilities. In this

case, I know that the fire brigade and people responded as quickly as possible to help with that. We certainly would not put a non-clinical staff member in the role of having to provide clinical care if it was not appropriate.

The Hon. WALT SECORD: The nurse described the situation that the cook was part of her medical team. Do you think that is acceptable?

The Hon. WES FANG: Point of order: That is a recharacterisation. The Hon. Walt Secord himself said that the camaraderie that happens between colleagues of all levels is particularly—

The CHAIR: In terms of ruling—

The Hon. WES FANG: She never said "medical team".

Ms CATE FAEHRMANN: It is not a point of order.

The CHAIR: I will be patient, but listen. The two gentlemen here have been present throughout the course of the morning. They have heard the evidence. I am satisfied that the way in which Mr Secord put the question does not editorialise at all the statement made by the evidence from the witness earlier this morning before this panel. And I think Mr McLachlan is more than capable of answering that question.

The Hon. WES FANG: The objection was characterising it as a medical team and that is my concern.

The Hon. WALT SECORD: Chari, I am mindful of the time and I want to ask more questions.

The CHAIR: Sure.

The Hon. WALT SECORD: Mr McLachlan, in your opening statement you apologised to the community. I am sure that is an apology that you believe. What steps are you taking to have doctors in hospitals and to have nursing staff properly supported such that they are not relying on cooks? It was devastating to hear of the lack of palliative care such that a daughter said goodbye to her father on a bathroom floor. What steps are you taking other than issuing an apology? What practical steps are you and the Government taking to improve health? I understand that health outcomes in this local health district for First Nation and white population are the worst in New South Wales. How do you respond to that?

Mr McLACHLAN: Mr Secord, the first part of the question was around intent and commitment to increasing the workforce in the region. We are going to a lot of lengths to ensure that we can recruit in new and additional clinicians for every hospital right across the region, as I said. I would love to see doctors available 24/7 in our hospitals and to have enough nursing staff to cover all of our rosters. We have got extensive incentives and support programs that include providing accommodation for staff when they come into town, relocation incentives and other supports to ensure that people can get home to their families and get good time off and time away from the workplace. We provide a lot of education and support to ensure that particularly nurses can practise at the top of their scope. It was great to hear Pen McLachlan talking about an enrolled nurse's role being able to manage medications and a whole range of other clinical conditions. That is part of extensive training and development programs that we are committed to delivering for all of our staff. That will continue into the future.

We do work at a time of incredible difficulty in recruiting in. We will keep doing everything we can to find ways to attract people into country towns. Our relationships with local councils, with the Primary Health Network and with the Rural Doctors Network are also crucial to making sure that we can coordinate the attempts to make sure that, when someone is interested in coming to a town, we can provide all the attraction and support for them to network socially in the community and to find encouraging and safe practice in rural communities. All of the supports that we provide through our virtual services are all intended to support local clinicians providing the best care they can in their community.

The Hon. WES FANG: Chair, obviously the focus with the original set of witnesses was on Indigenous health, but we seem to have changed focus.

The Hon. WALT SECORD: No, I asked about First Nation and—

The Hon. WES FANG: I was just wondering whether we should invite Dr Nott up, seeing as we are following this line of questioning.

The CHAIR: No, we do know that members have inquiries representing their parties. Broad latitude is given in terms of the questions—

The Hon. WES FANG: I understand that.

The CHAIR: —and those questions sometimes invite subsequent questions which might go beyond certain points but that is fine. There is wide latitude here, as I have given the Government members as well.

The Hon. WES FANG: I was just wondering whether he might be able to provide some more insight.

The CHAIR: There will be further opportunity this afternoon.

The Hon. LOU AMATO: I would like to hear a bit more about the challenge and difficulties facing Indigenous communities in relation to accessing health. Also, we heard earlier during the hearing about Indigenous women not being able to give birth on their land and the cultural significance of that. Could you perhaps walk the Committee through your insights into it all, please?

Mr CUTMORE: Thank you for the question. If I could also start, since this is my first chance to talk, by acknowledging that we are meeting on Ngiyampaa country and passing my respect on to any Aboriginal people from country in this room. If I could pick up a part of the question from Mr Secord's question in relation to the advancements of workforce, first of all, one of the opportunities that we have had across this region, and certainly have had a lot of success in in recent times, is the growth of our Aboriginal workforce and equally the growth of our professional Aboriginal workforce across a number of professional clinical areas. That part answers a little bit of the question, I think, Mr Amato, in relation to the types of supports that we are able to provide to our Aboriginal communities across this region.

We have increased our Aboriginal nursing workforce. We have increased our frontline Aboriginal health workers in positions across our region, ensuring we have better opportunities to support Aboriginal families and patients with their care coordination. Equally—this relates to the maternity component of the question—we have just recently recruited an Aboriginal health worker as part of our maternity team in Dubbo hospital to ensure, as mothers of Aboriginal babies enter the facility, that they have a direct connection point with an Aboriginal health worker to offer any cultural support to the mother of the Aboriginal baby plus the baby themselves that we are expecting and, equally, the other broader family that are there to support the birth. As a part of that process as well—because, obviously, when it comes to my people we need to take into very strong consideration all of the social determinants of health as well.

Part of the issues that we face across a region like ours, which is very similar to where I am from in Tamworth, New South Wales, is the social determinants and ensuring that Aboriginal people have good connection points to all the additional supports that are required when we travel off country or if we are receiving health care are available as well. Those things include access, where required, to support for accommodation, access to support for things like transport et cetera. We do that through a number of either State- or Commonwealth-funded initiatives. Probably the key part that I would say, just in relation to the question about some of the challenges that I think our communities face across this region, is that for a long time Aboriginal people right across this country have not had a chance to shape the decision-making in relation to what the services would look like.

Across our region what we do is that we have real partnerships with Aboriginal communities through the local decision-making process that Mr McLachlan has mentioned. We empower the voice of Aboriginal people to actually co-design and shape services that we deliver and to ensure that we have community voices to understand how we provide those services in a better way and we are not doing what I would say Aboriginal communities feel has happened, and that is that we have told them what the best services for them are that are available. I will probably leave it at that and you can ask me any questions.

The Hon. WES FANG: We have been discussing how we can go to more remote places to talk to people about the health access that they have. But can you speak to what the local health district is doing to work with Indigenous communities in those remote areas and across the local health district [LHD] in general?

Mr CUTMORE: Yes, sure. If I can give a couple of examples—I noticed that earlier on in the session this morning we spoke about COVID. If I can use a part of what I believe our successful community partnerships have driven is, for example, the community action plan process that we undertook with Goodooga. It is a discrete small community up in the very north of the State where we, in partnership with community leaders, developed a community action plan that allowed community to drive all of the needs that the community needed in relation to how to keep COVID out of the community but equally, though, how to, where possible, ensure that all the other additional support services came into the community and minimised the risk of the community needing to travel out. That is an example.

The Hon. WES FANG: Mr McLachlan, do you have any further insights?

Mr McLACHLAN: We have an extensive network of Aboriginal health workers right across our region, including over 20 in our north-west rural and remote towns that are community members and passionate clinicians and Aboriginal health workers that help patients that come into all of our services. That is a critical role to helping Aboriginal people to feel comfortable and safe in hospitals. We know the history of hospitals right across Australia incites real fear in the Aboriginal community and that is something that we are desperately trying to improve and

overcome. The support that we provide to all of our staff, providing cultural education and knowledge of both the local community and across our region, is something that we all need to do as health workers to make sure that there is good clinical care provided. But a culturally safe environment is absolutely crucial. Mr Cutmore was talking about the growth in our workforce. We have grown to over 5.7 per cent of our workforce is now Aboriginal—an increase of over 80 staff in the last 12 months. It is something that we are committed to growing to 9.4 per cent over the next three years. The growth of our Aboriginal workforce right across our community is going to be key to improving relationships.

The Hon. WES FANG: If I have the numbers right it was 8,000, did you say, is your total workforce? So there has been a 1 per cent increase in the last 12 months.

Mr McLACHLAN: Yes, last 12 months.

The Hon. WES FANG: It has increased 1 per cent. Regarding cultural support, not only for mothers delivering babies but also parents in general, are you able to provide some guidance on what cultural supports are available to provide staff and parents with the ability to gain that trust within NSW Health that is so important for us to provide that health care to communities who may historically have had trouble trusting us?

Mr CUTMORE: Thank you for the question. I will step into the first part. All of our services are available to Aboriginal people across our footprint. Mr McLachlan mentioned ensuring that we deliver cultural training and support to all staff across our local health district. Equally, though, when it comes to services like our maternity services, we have an amazing team of Aboriginal staff supported by clinicians across our region as part of our Aboriginal maternal infant health service. At the heart of ensuring really sound cultural support is ensuring that there is a connection point available for Aboriginal people to access—for Aboriginal communities to access Aboriginal staff. In communities like ours, I suppose the trust component comes down to that we obviously employ people from right across our region here and, like my family, we have all grown up knowing each other's families. So as much as it is about building trust and relationships between the facilities, it is equally about the natural trust between historical family ties and who we know as Aboriginal people as part of services.

In addition, what we have done across our region is to have a look at the models of our services and to ensure that the other additional supports—and I have mentioned the social determinants component—are a part of the strong consideration of the way that we deliver services so that we do not just see that it is about just the healthcare service itself. It is equally about understanding that to take a lot of stress and pressure away from families, or the patient themselves, we need to ensure that all of our staff understand that what is important when engaging with Aboriginal patients is to engage with the whole family and, equally, to understand the roles of the family in that process. We do this through some simple ways. We provide tools to our staff beyond cultural training to ensure that they understand some of the soft ways to communicate properly with Aboriginal people and, equally, we take a bit of the pressure off Aboriginal families by doing some of that coordination of the accommodation and transport stuff.

The Hon. WES FANG: My colleague from The Greens, Ms Cate Faehrmann, has a strong interest in Indigenous health.

The CHAIR: Thank you, but the Chair normally does that. I appreciate your generosity.

The Hon. WES FANG: I want to acknowledge the Ms Cate Faehrmann's interest.

The CHAIR: Thank you for the acknowledgement.

Ms CATE FAEHRMANN: I will go straight to questions without commentary. Mr Cutmore, thank you for appearing. I am part of another inquiry that is looking into registered nurses in aged care. Just the other day we had an interesting witness who spoke about the need for specific aged-care services for Aboriginal people that are designed by Aboriginal people. There was reference to potentially one in two Aboriginal people over 60 knowing or having a very strong involvement in terms of the Stolen Generations. Being stolen themselves and going into an aged-care service is incredibly distressing for them and traumatic. Are there services within this LHD that are designed and will cater for Aboriginal people, particularly in terms of aged care?

Mr CUTMORE: The answer is that all of our services are available to Aboriginal aged-care residents—

Ms CATE FAEHRMANN: Yes, I heard you say that. This is services specifically designed and run by Aboriginal people for Aboriginal people.

Mr CUTMORE: The answer to that question is no.

Ms CATE FAEHRMANN: Have you heard of that request and that issue?

Mr CUTMORE: No, not directly to me. I have seen parts of the concept. I am just trying to think of whether or not I have seen this concept run successfully in Queensland or if it is another part of New South Wales.

Ms CATE FAEHRMANN: South Australia is one.

Mr CUTMORE: Okay, so South Australia. I think the concept—if I can answer this part of the question—is a wonderful concept.

Ms CATE FAEHRMANN: My questions are not meant to be an attack on you and your position personally, it is just the provision of health services. Did you say 13 per cent of people in this are Aboriginal? What consultation do you do in this LHD with Aboriginal people to determine what type of health services they want?

Mr CUTMORE: I take pride in my own work and the work of the pool of Aboriginal leaders that work with me on the work we do with the local decision-making group—if I can reference a piece of that work in answering the question. The local decision-making process has empowered the voice of identified or recognised appointed—probably appointed is the right word—Aboriginal leaders to work with the State Government to negotiate priority areas for each of their individual communities. As a part of the work that we did through Health, we agreed—and if I could use the Three Rivers Regional Assembly process as an example—that what we did not want to do was place all responsibility on just the appointed lead of the regional assembly.

We offered to go out in partnership with the regional assembly lead, each of the individual community leads and Department of Aboriginal Affairs, and we developed local health action plans in open consultations with Aboriginal communities right across the southern footprint of our Western NSW Local Health District. As you can imagine, some of those local health action plans are quite lengthy and they are all around the types of things that community people have described they would like to see changed. We will be going through the same process for the Murdi Paaki Regional Assembly. Cobar and the surrounding communities are a part of that. That process is due to commence, I would say, within sight of the June-July window.

Ms CATE FAEHRMANN: Looking at different submissions to this inquiry, one is from the Aboriginal Health and Medical Research Council of New South Wales. The main point that they make is really around kind of formal service level agreements between Aboriginal service providers and the LHD but they do reference, for example, that a high number of Aboriginal people feel unsafe within the hospital system, and that is reflected through the number of Aboriginal patients who discharge against medical advice because they just want to get out of there. That is reflected as well in the evidence I referenced earlier in terms of Aboriginal people not wanting to go into aged care. What is the LHD doing about what I think is a clearly identified need for more Aboriginal services right across New South Wales but particularly in this area being designed by and run by Aboriginal people for Aboriginal people? You probably need more funding for that but is there enough, and is there a greater need in this area for that?

Mr CUTMORE: Yes, we do need more—yes, funding would be great. But what I can say though is that in a region like ours there are a whole number of non-government services that we partner with. For us our primary partners in health—and they are certainly supported by the Aboriginal Health and Medical Research Council—are the Aboriginal medical services right across our region. Of the 10 that I partner with right across all of west New South Wales and touching into the far west region—we have got any number of localised programs and services that we would partner on. In terms of the processes around ensuring that there is community voice in shaping those things, we ensure that we link in our Aboriginal medical services where possible into those local decision-making conversations and include our partners in any of the community forums that we have. Equally, I should say on the record that is always reciprocated as well.

Our Aboriginal medical services will, as good partners in the healthcare services that we deliver across the region, equally offer us to come in as well and partner on their programs and services and equally when they are going to consult with the community. In terms of opportunities for people to contribute all of the time to shaping services, I cannot comment for all the services that are delivered right across the region but certainly the ones that I am responsible for in the local health district we, through the process I described before, make sure that the voice of Aboriginal people forms a big part of that.

Ms CATE FAEHRMANN: Is there a formal service level agreement between the Aboriginal medical services between them—

Mr CUTMORE: Yes, there is. We have an overarching partnership commitment with the Bila Muuji Aboriginal Health Incorporated Services, a consortium of Aboriginal medical services. We also have a number of individual Aboriginal partnership agreements with individual AMSs. Outside of that—as you can imagine in a region like ours—we have a number of other partnership agreements between the AMS themselves and, for example, Dubbo hospital or any of the other services that are delivered.

Ms CATE FAEHRMANN: Recognising that you are an Aboriginal man—Gamilaroi, did you say?

Mr CUTMORE: Yes, Gamilaroi.

Ms CATE FAEHRMANN: Hopefully you can answer this question anyway, but what does it mean for an Aboriginal woman to be able to give birth on her country?

The Hon. LOU AMATO: I asked about that.

Ms CATE FAEHRMANN: Yes, I know. What does it mean?

Mr CUTMORE: I think we have heard today—I think it is important.

Ms CATE FAEHRMANN: Have you asked or lobbied people within the LHD or spoken to government about the fact that Aboriginal women are having to move off country because of losses in maternity beds and what that means for them? Do they come to you for this? Is this being spoken about within government? Is there anything being done to address it?

Mr CUTMORE: The focus of myself and my team is to put in place the supports that are required to ensure that mothers of Aboriginal babies—whether an Aboriginal mother or a non-Aboriginal mother—are supported to deliver in the safest place possible and to put the right cultural support around that process.

Mr McLACHLAN: We really do recognise the difficulty for Aboriginal mums being off country and birthing. Over the last three or four years, for example, in Bourke we have attempted to recruit in local midwives connected with the Aboriginal Maternal Infant Health Service that Mr Cutmore was talking about a minute ago that help coordinate the antenatal and postnatal care—so pre- and post-birth for pregnant mums. We have recruited in an Aboriginal health worker in Dubbo and the midwife to support that transition and care in Dubbo. We have stepped up to provide a lot more transport and accommodation assistance when mums need to travel down to Dubbo for two to three weeks prior to birth to make sure they have a safe birth. We now spend over $5.4 million in Isolated Patients Travel and Accommodation Assistance Scheme [IPTAAS] support. A lot of that is dedicated to the transport and accommodation for Aboriginal and pregnant mums across the northern part of our region.

Importantly, one of the things that we have heard from community is that when mums and babies come back to the community with a sense of being disconnected because they have birthed off country it is incredibly important, so we provide transport assistance for Aboriginal pregnant mums to come back to Bourke to stay in the Bourke hospital. While they are there in that time the community comes in to help welcome the baby back onto country. There is a ceremony that is conducted that the community helps to provide—a smoking ceremony and a welcoming back onto country—and that has been incredibly soothing for a lot of the mums and families who have had the birth off country. But we try to take all of those steps to make sure that first of all the baby and mum are safe in the delivery and, where possible, we help to connect back to the cultural community.

The Hon. WALT SECORD: Mr McLachlan, you heard evidence earlier today and there was also some media coverage about no blood at Cobar hospital. Is there now blood at Cobar hospital?

Mr McLACHLAN: Mr Secord, we do not carry blood at Cobar hospital. We do carry it at Bourke hospital. If I can put a bit of context around the management of blood—

The Hon. WALT SECORD: So you do not carry blood at Cobar hospital.

Mr McLACHLAN: No, we do not, and the reason for that is blood products have a very short life span or shelf life. They need to be turned over and used very regularly. We do not want to waste blood that is in short supply. We need to, from the time we receive a bag of blood, have it turned over or used within eight days or located at a site that will use the blood. Over the last 10 years there has been a 70 percent decrease in the use of blood and a lot because of the clinical knowledge around the appropriate use of blood—the clinical conditions that are absolutely necessary—but also the clinical conditions that do not require, or we should not use blood, when there has been a bad outcome for patients in some of those conditions.

What we do have in place is transport, and very quick transport, available through our retrieval services to get blood to Cobar and to all of our other health services. We know that the Royal Flying Doctor Service [RFDS] and other retrieval services have that available. We will continue to make sure that those response times are as quick as possible.

The Hon. WALT SECORD: So, of the 30 hospitals and MPSs in your local health district, how many of them are in the same situation as Cobar?

Mr McLACHLAN: We have blood stored at nine of our 38 health services.

The Hon. WALT SECORD: So, nine of the 38 have blood—and nine of the 38. Can you provide the name of those nine on notice to us, please?

Mr McLACHLAN: Yes.

The CHAIR: One more question. I am conscious of the time. Please proceed.

The Hon. WALT SECORD: I will actually end my questioning on Aboriginal health. We know that dental can affect your overall health and wellbeing. What steps are you taking to improve dental care within the Aboriginal community in your local health district? Maybe Mr Cutmore would like to answer that?

Mr McLACHLAN: Thank you for the question. We have an extensive network of dental services right across our 38 hospitals and health services, plus some dedicated funding and workforce around the care of Aboriginal people, both kids that need good prevention and early treatment and adults through that team. We have a fantastic service: We contract the Royal Flying Doctor Service that flies a dental team out to Cobar, Bourke, Brewarrina, Walgett, Lightning Ridge and other centres on a very regular basis. That is an extensive network of services. We also provide a lot of support to the Aboriginal Medical Services that Mr Cutmore was talking about. We both share staff and dental staff into the Aboriginal Medical Services. Most of the Aboriginal Medical Services have dental chairs and an extensive program particularly focused on young kids, making sure that they can stay free of dental caries and other conditions.

The Hon. WALT SECORD: Thank you.

The CHAIR: A Government member?

The Hon. LOU AMATO: Thank you. This question is directed to either of you gentlemen. I want to hear a bit more about palliative care in relation to Aboriginal communities. Earlier on one of our witnesses was saying that one doctor would give good quality pain relief and another would not. I would like to hear how it is all happening in the Aboriginal community?

Mr McLACHLAN: I might start with that question and hand over to Mr Cutmore. We have got an extensive network of both our facilities that have end of life and palliative care beds in the vast majority of our facilities. Those contributed to by our community they see this as a safe and good place to come and pass their end of days. In our community-based services, all of our community nurses have the skills and ability to provide support to people at end of life. We have a network of palliative care specialists right across the region. At the moment we are recruiting two new dedicated palliative care specialists, one in Dubbo and one in Orange, that will provide specialist support across the region. In recent years we have increased our nursing and allied health staff in those teams as well. For this part of the region, Lourdes Hospital, which is a service that we fund in Dubbo, also provides specialist palliative care nurses that do outreach into these communities.

The critical importance around Aboriginal patients at end of life is the connection with family and an appreciation of the extent that we need to go to to support not just the patient or person at the end of life but the whole family. There are a lot of experiences that we have that have helped us to understand that and make sure that things are in place to support it. One example I could give you is an experience with an Aboriginal person who was in their last days of life at very short notice in Nyngan hospital. They came from Brewarrina and the concern that was very evident was that they were not with their family and community at the end of their life. Now, we were able to use our extensive network of videoconference and telehealth devices to connect all of the family from Brewarrina to the bedside of that patient while the staff members helped that person through the end of their hours. But that connection to community and family was just incredible to see for our staff and the family. Those are the extents that we go to to make sure the cultural considerations and needs of Aboriginal patients are absolutely paramount for us.

The Hon. LOU AMATO: You have anything to add, Mr Cutmore?

Mr CUTMORE: I would only just add to, Minister Amato, that obviously, like for all communities, the time before for us is a sorry business. As Aboriginal people there is obviously a deeply sad stage and this is where having access to the 59 Aboriginal health workers that we have got across our local health district and a growing number of Aboriginal staff in other roles being available to help families through that process, and not just that part of the process but equally beyond when a person has passed into some of the coordination of the things that need to take place after. I will not go into detail, but it is all the stuff that is remarkable work that they do in really tough circumstances, but what I can say that in the event families request assistance and support and we have our Aboriginal staff available, they step into support.

The CHAIR: Sorry for interrupting, but I think that the Hon. Lou Amato, in his question, was also giving some reflection on the issue of the very end stage of death. We are talking about the days and hours, particularly around pain relief and stress relief. People can be subject to all sorts of terrible pain in the hours before

death and of course stress. That requires, obviously, a palliative care specialist that has been referred to but also GPs where appropriate and of course nursing staff who have not just the skills but also the legal rights to administer pain relief. That is very sophisticated, the delivery of that, to ensure that there is not pain and distress. How much of that is being delivered to the Indigenous here in the district to ensure that they are not suffering at that very end stage? I do appreciate the cultural matters about the leading up to death and the post-death period, but we do not want people dying in situations of excruciating pain and distress.

Mr McLACHLAN: I am happy to take that question. This is so incredibly important to people at the end of life but also their families. We have a network across the region of a 24/7 service that is available for all of our staff and community to access. They can provide specialist palliative care advice and medication support for both the GPs, our community nurses and other carers that are in the home as well as in our multipurpose services and hospitals right across the region. We connected to, if we needed to, our Vcare service that was mentioned earlier. That is a 24/7 service of both specialist nurses and specialist doctors who have the ability to give medication, instruction and support to all of our clinicians that if we needed to change a medication regime at end of life—

The CHAIR: Which is commonplace.

Mr McLACHLAN: —to make sure that the person is not suffering or in pain that that can absolutely be done.

Ms CATE FAEHRMANN: I have a question about telehealth and Aboriginal people's experiences with it. I am sure there are additional barriers to that. Could you tell the Committee what feedback you have had from Aboriginal people using telehealth services?

Mr CUTMORE: I suppose I will speak to a bit of my history working in health. Like any change, any population needs to see something work before they can accept credibility et cetera in it or have confidence in it. One of the things, Minister, that I can share with you—and we would need to collect some data on this and reflect back—what we have experienced, if I use the previous pandemic that we have been through, is a dispelling of the myth that all Aboriginal people would not like to access telehealth services or virtual services. For our Aboriginal medical services and certainly for a lot of the services that we have delivered, we have seen a significant increase in Aboriginal people using telehealth.

Our AMSs, so our key strategic partners, across our region have adopted, for a lot of the different services that they deliver, different modes of telehealth through some of the services that they deliver too. As you can imagine, through the pandemic communities were fairly restricted to movement and equally we did not want all populations travelling around all over the place. Being able to use that technology and seeing that Aboriginal people were prepared to come in and use that modality, I think has been a real positive learning from the COVID process—not that I would call COVID positive in anyway, Minister, at all.

Ms CATE FAEHRMANN: No, I understand.

The CHAIR: Thank you both very much coming along today and thank you for your good and important work you do on behalf of all the people in your district. We do not underestimate the challenges. It is a big piece of earth you cover, so to speak. There is much going on at any point in time. We do understand the challenges but we are all about looking at ways and means of trying to raise all the boats, so to speak, with the tide and to try and ensure how we can shrink that gap, that difference between the people who fortunately live in the large metropolitan locations and do have that ready access and how we can deliver as far as we can of service and care to people outside those centres. Thank you very much.

(The witnesses withdrew.)

(Luncheon adjournment)

JENNY TYACK, Chair, Condobolin Doctor Crisis Working Party, sworn and examined

ANNIE RYAN, Deputy Chair, Condobolin Doctor Crisis Working Party, sworn and examined

The CHAIR: I welcome our next two witnesses. I invite you to make an opening statement.

Ms TYACK: Thank you for the opportunity to speak to you concerning the doctor crisis in Condobolin. The working party for the doctor crisis in Condobolin met with 36 community members on very short notice to voice their concerns to the electoral offices of Roy Butler on 15 April 2021. Here we heard some heartbreaking, frightening and distressing stories. From that meeting we have chosen to highlight some of the major issues that are occurring within our Condobolin community and our health service. Firstly, the current staffing level at the hospital is two nurses per shift. Staff are required to attend often very complex emergency drug and alcohol, mental health and trauma cases. This often leaves inpatients unattended for days at a time due to the lack of staff. In addition, we have evidence that patients are being discharged late in the day and some as late as 11.30 p.m. without discharge summaries, medication or prescriptions. The majority of these patients are elderly, live alone and are expected to rely on friends to collect them.

Secondly, telehealth has allegedly been a contributing factor to a number of misdiagnosis. The nursing staff on shift are required to provide diagnostic examination beyond their scope of practice which is leading to decreasing confidence in addressing complex presentations, especially as there is no doctor on site. We have had three experienced nurses leave the Condobolin hospital since January 2021 due to a lack of medical support. Thirdly, we have patients travelling up to 130 kilometres to Condobolin hospital from more remote locations and due to the lack of services, patients are then redirected to drive themselves up to another 200 kilometres to other hospitals in order to get appropriate medical support. This high rate of redirection and transfers has a flow-on effect to other hospitals, putting pressure on their services.

Fourthly, the high number of patient redirections and transfers and the lack of presentations to Condobolin Health Service contributes to a false picture of the statistics, leading to a decrease in services and in turn a lowering of staff numbers. The high number of patient transfers and redirections also contributes to a lack of communication with our local GPs and pharmacy services upon patient discharge. Patients are often left confused as to what medications they need or need to cease or to remain on. Communication is terrible and potentially life threatening. Fifthly, patients in Condobolin are choosing not to pursue treatment for cancer and chronic diseases due to the lack of access and dissatisfaction with local services.

Sixthly, community health staff across Western NSW Local Health District are mandated to take two weeks annual leave over the Christmas and New Year period, leaving patients such as palliative care patients without appropriate levels of nursing or support. This past Christmas period, there was absolutely no doctor in the town of Condobolin for two whole weeks. We have a letter to read as part of our submission that describes the experience of a palliative care patient as a result of this decision. Finally, a doctor working at our hospital from another State indicated that doctors wages in other States of Australia are as much as one-third higher than ours. Is this correct? If so, is this a contributing factor to the inability to attract and retain doctors? As a community, we are devastated by the continual lack of response to our pleas for better service. Our rural communities are suffering and experiencing Third World care in a First World country.

Ms RYAN: I do have a letter to support that. Would you like me to read that after? The sixth point.

The CHAIR: How long is that? Is it a particularly long one?

Ms RYAN: About an hour. No. It is a page and a half. I do think it is probably worth hearing because it pertains to the palliative care.

The CHAIR: It complements that so it sets it up. Let's proceed that way then.

Ms RYAN: In relation to the sixth point, which is about the palliative care, I will read this directly from the written letter.

The CHAIR: Just to be clear, is this a piece of correspondence you are directing to someone or is this part of a statement you would like to make?

Ms RYAN: This is a letter given to our doctor crisis working party. Is that appropriate to read that to you? No names are included.

The CHAIR: As long as the correspondence or where it is directed would not object to you reading it.

Ms RYAN: No, we have her permission completely.

The CHAIR: As long as people are de-identified, that is fine.

Ms RYAN: I will start:

I live in Condobolin, NSW. I am the pastor of a local church and a proud constituent of the Barwon Electorate for the past 12 years.

I am writing to you with grave concerns regarding the lack of accessible, quality medical care provided by doctors in our community. My family and I experienced this first-hand in the months and days leading to my father's death in my home on 7 January 2021 as a result of stage 4 metastatic cancer of the larynx that had spread to his liver.

My father relocated to Condobolin to live with me in August 2020. Shortly after I was contacted by his oncologist on the South Coast and informed that my father had been diagnosed with liver cancer. At the time of his diagnosis there was only one doctor with his books open and able to support my Dad through his cancer journey, practicing out of the Aboriginal Medical Centre.

In the months leading up to my father's death at home (his wishes and mine), this doctor made several significant errors that impacted heavily on my Dad's treatment options and ultimate wellbeing. These included the following:

- Refusing to refer my Dad to a local oncologist to organise a liver biopsy as per the two written requests of the oncologist my father had previously seen on the south coast.
- Upon my pressing, telling me that if I wanted to short-cut the process of getting my father to a specialist that I should drive him 220km to Orange Base Hospital and take him to the emergency department.
- When pressed further, finally relenting and writing a referral to an oncologist but failing to mention his liver cancer diagnosis and sending it to Western Care Cancer Lodge in Orange rather than the Oncology Department at Orange Base Hospital. This forced me to see a visiting locum in yet another appointment and asking the Clinic nurse to support me in finally getting a referral to the oncology department in Orange.
- Being so aggressive in his manner towards me and my father, that Dad refused to attend his clinic anymore. In the end, I organised enduring guardianship so that I could attend the surgery myself to get scripts filled and discuss any medical concerns I had.
- Completing the ambulance plan incorrectly which complicated and delayed the process of Dad getting a syringe driver to consistently administer medications when he was in the last 2 weeks of his life. This error also meant that when Dad required breakthrough medication, I was unable to be trained to do this (which normally would have happened) and I was required to call an ambulance any time this was needed.

I would like to note that the 2-3-week delay in getting a referral meant that by the time my father saw an oncologist, he was too frail to undergo the treatment options that they expected would be available to him and that would have given my father more time with his family.

The other concern I would like to discuss with you is the lack of consistent, accessible service by medical professionals, particularly from 18 December 2020 to 7 January 2021 which was the period my Dad declined rapidly and eventually died. During this period there were literally no doctors in our community who could support my Dad. The regional palliative care team and the local district nurses, who would normally have supported me on a daily basis, were also all on leave for the period of time my father declined and passed away.

Initially, the only avenue of support I had available in that 2-week period, was a palliative care hotline which I rang numerous times. The nurses that took these calls relied upon my verbal, untrained description of what was happening to make decisions and direct my administration of Oral Morphine. To say this was frightening is an absolute understatement. I was also able to access the support of Hammond Care Assistant Nurses on 5 occasions in a 2-week period to help with Dad's basic hygiene needs and our local paramedics' multiple times per day and who were incredible but having to assist me in a situation they were not trained to do. Other than this support, I was solely responsible for my Dad's care for the 2 weeks leading to his death. As a single woman, with my family living 8 hours away, this was incredibly distressing.

Whilst I do not have any issue with hardworking, passionate medical professionals such as the District Nurses and Palliative care nurses having much needed time off; I am writing to you in the hopes that my story could help affect change for Condobolin and other communities like ours. Our communities deserve equitable access to caring, professional doctors. From my perspective, it is also appalling that Western NSW Health would leave Condobolin, West Wyalong, Lake Cargelligo and I'm sure other towns like ours, without appropriate medical support for such a long time.

And it goes on say to she would be very happy to speak.

The CHAIR: Thank you very much and thank you for the de-identification of the example, leaving us with the details of what happened but not the individuals involved.

The Hon. WES FANG: Thank you very much for appearing today and for sharing the stories that you have brought. It is very important that we hear from you and hear stories from the community. The health provision is so important to us. Ms Tyack, I was making some notes as you made your opening statement. You spoke about misdiagnoses from telehealth. Can you expand on that a little bit? Do you have some firsthand knowledge and perhaps what made it happen?

Ms RYAN: I actually can expand on that.

Ms TYACK: Do you mind if Ms Ryan—

The Hon. WES FANG: Yes, that is all right.

Ms RYAN: This actually was a submission by one of our locals:

"I recently had a bad experience with telehealth at Condobolin emergency. Long story short they miss diagnosed my illness," the submission begins.

"The Telehealth doctor told me I had gastro when I actually had appendicitis. I believe the nurse thought it was a serious stomach issue however was over ruled by the tele health doctor.

"Unhappy with this diagnosis I travelled to Forbes hospital (100km away) where a doctor assessed me in person than admitted me and commenced treatment for an infection.

"Further testing found it was to be appendicitis. My appendix were then removed 5 days later.

"This potentially fatal mistake I believe could have been averted if there was a doctor in person at Condobolin emergency department.

"The nurses in Condobolin are exceptional and did a great job. IT WAS TELEHEALTH THAT LET THE HOSPITAL DOWN.

"I cannot work out how you can have an emergency department without a doctor onsite."

The Hon. WES FANG: The issue was appendicitis?

Ms RYAN: Yes.

The Hon. WES FANG: We heard Pen McLachlan today about what sorts of limitations there are around the telehealth system. Was there only one story that you had of a misdiagnosis?

Ms RYAN: Here, yes, but we are collating stories. I do not have anything as yet.

Ms TYACK: What actually happened was, we had two days there where I actually put it on Facebook to say that there was going to be a meeting with Roy Butler's team—two days before the meeting was held. We said to the lady down at the building, "Look, there could be three people, there could be four people or no-one might turn up." Well, three times they had to shift it to different rooms because people kept coming in, on two days' notice.

Ms RYAN: There are a lot more stories.

Ms TYACK: We had 36 and we have had phone calls since then.

The Hon. WES FANG: Part of the other evidence we have heard from Condobolin today around telehealth was that the system has actually provided some real benefits for those specialties that you would not necessarily get even in a metropolitan hospital setting, like stroke—

Ms TYACK: Yes.

Ms RYAN: Can I take the answer to that, though? I am sorry, Wes, I do not believe that a video screen replaces a doctor in emergency. I get completely—

The Hon. WES FANG: That is not the question I was going to ask.

Ms RYAN: Sorry.

The Hon. WALT SECORD: That was the question you asked.

The CHAIR: Order!

The Hon. WES FANG: Walt, I have been very respectful. I think we have been very collaborative on this.

The Hon. WALT SECORD: Okay. I am sorry, Wes.

The Hon. LOU AMATO: Can we carry on, please?

The Hon. WES FANG: We have heard some stories where telehealth has actually made a difference. We know that with stroke it is that immediacy of being able to provide the treatment. Were you given any stories where telehealth has actually provided a good outcome for patients in those areas?

Ms RYAN: Wes, we are only looking at the negative at this point, I can tell you.

Ms TYACK: And we are not nurses. We are only community members of Condobolin.

Ms RYAN: We are just hearing people's voices.

Ms TYACK: The community are telling us their stories and, if I can say, even though I am not a nurse or a doctor—

The Hon. WES FANG: Neither am I.

Ms TYACK: —you saying about a stroke victim with the telehealth, there is a difference between the stroke victim that has a machine that they can put on them to a doctor feeling and pressing on your stomach—

The Hon. WES FANG: I could not agree more.

Ms TYACK: —and saying, "You have got an obstruction", the feel. That is my personal opinion.

The Hon. WES FANG: I agree. I guess what I am trying to tease out here is that there has been a lot of focus on telehealth. There is a focus on the negative stories, but we know for a number of specialties—that is, a stroke or, for example, you are not going to have a vascular surgeon in every town. We heard from oncologists and renal physicians that being able to have access through telehealth to a vascular surgeon has been really beneficial. For dialysis patients who have a clogged line or something like that, to have a vascular surgeon providing extra advice on how to actually retain access to that line was beneficial. So, I am just wondering, in your inquiries have you actually tried to look at what is working in telehealth?

Ms RYAN: Can I answer that, Wes?

The Hon. WES FANG: Yes.

Ms RYAN: I think I have got the question. I think what you are referring to is telehealth is a wonderful thing when we are talking specialists. That type of stuff is not going to be done in our emergency department [ED] anyway. What we need is doctors on the front line to actually diagnose that to see whether they need to be going to those specialists and whatnot. We do not have that. We have the most basic things. We have got a doctor on telehealth for the most basic things. We are not talking specialist. Obviously they will always be referred onto. This is basic care and it is being done through a video? I am sorry.

The Hon. WES FANG: I am just trying to find out, because we do know that there are good stories out there but they are just not seeing the light of day. I want to make sure that we have some balance.

Ms RYAN: Yes, absolutely.

The Hon. WES FANG: The last thing I wanted to touch on was, in your opening statement you talked about a doctor's wages being a third higher in another State?

Ms TYACK: Yes.

The Hon. WES FANG: Can you just expand on that a little bit for me, please?

Ms TYACK: I am only saying what has been told by a doctor—

Ms RYAN: Who works in South Australia.

Ms TYACK: Yes, that New South Wales doctors and nurses are paid less than the other States. I am only expressing what has been told to me. I do not know.

Ms RYAN: And we would like to know if that is the case.

Ms TYACK: That is why we are asking.

The Hon. WES FANG: The testimony we have heard is, depending on how they are contracted—you know, they might be contracted as a visiting medical officer [VMO] or they might be contracted as a staff specialist. But I think staff specialist wages are generally the same across, pretty much, the country.

Ms RYAN: Yes, and we do not know.

The Hon. WES FANG: But VMO wages are generally done by Medicare through the Federal Government or the health funds, in which case I do not think being in one State or another really makes any difference at all.

Ms RYAN: Okay.

Ms TYACK: Yes, good.

The Hon. WES FANG: I was just trying to establish what it was so I could actually do some more digging, because I cannot see how a doctor in South Australia can be paid a third more than what they are—

Ms TYACK: Well, it is a VMO doctor.

The Hon. WES FANG: Well, a VMO would likely be paid through Medicare, which would be Federal—

Ms RYAN: So our area health does not have anything to do with that?

The Hon. WES FANG: They would contract the VMO, but likely they would bill through either—again, there are different models, is my understanding. But I am just trying to establish what it was, because when you say it is a third higher I am trying to work out how that is actually the case.

Ms TYACK: Same, we are too.

Ms RYAN: How that point came up is, we were wondering is that one of our issues as to why we cannot retain or get doctors. It is a question that we want to ask.

The Hon. WES FANG: Yes, and whether they are a locum. Because, again, they could be a locum here but working, you know—I was trying to establish whether you knew any more, so that I could go back and do some research.

Ms TYACK: Good, yes, because that would be—

Ms RYAN: That would be great.

The Hon. LOU AMATO: Thank you both for taking the time to be here today. Ms Ryan, in your opening statement you were talking about a lady who was talking about palliative care for her father. Can you tell me from your understanding and the information that comes back to you how do you think that pain management, particularly in people's final days, has been administered? Do people need to be suffering?

Ms RYAN: Can I jump over that?

The Hon. LOU AMATO: That is really important.

Ms RYAN: Yes, I agree, it is very important. But what I think is a really important part of this story is that this girl was left to look after her father in those end stages of life. For that period we had no community health because they are mandated to take their holidays in that period and we had no doctor in the town for two weeks.

The Hon. LOU AMATO: Sorry to interrupt you. So was she administering pain relief to her father herself?

Ms TYACK: Yes.

Ms RYAN: She was having to. She would call the ambulance and they were helping her with it. But it is an horrendous story and it has just happened. So completing the ambulance plan—wait there, where are we? So she was—I can actually give you guys a copy of this. Yes, she was having to administer that pain medication herself.

The Hon. LOU AMATO: Is more or less what is happening out there in the community now that family members are having to administer pain relief to their loved ones?

Ms RYAN: Well, this is one story of it. I mean, you only had to listen to Pen McLachlan to know that we are so short staffed there that somebody can die on the floor in the bathroom because we are that short staffed. I mean, people at the end stage of life—there are people there that have lived their whole lives in their community. There can be three and four generations in that community. It is not good enough care.

The Hon. WALT SECORD: Ms Ryan and Ms Tyack, you mentioned there was a period at Christmas for two weeks where there was no doctor. What did people in the community do if you had a sharp pain in the abdomen or a chest pain?

Ms RYAN: You go and talk to a video—and they cannot touch you, that doctor on the telehealth—or you drive to Forbes, or you drive to Orange. People are frightened and they have lost their confidence. Again, it gives us false numbers of presentations to ED—less services, less staff. So people are frightened in our community. You have no idea how frightened people are.

The Hon. WALT SECORD: Because you have assumed these community roles are people coming to you and sharing their anxiety with you?

Ms TYACK: Oh yes.

Ms RYAN: We have only just had that meeting on 15 April. We have just had so many people contacting us and emailing us, and obviously very short notice for this. We could give you and we will be collating their stories.

The Hon. WALT SECORD: Are you guys getting support? It must be quite distressing to hear what—

Ms TYACK: It is. It is very distressing. And I think a lot of this—in the country, mental health is there anyway because, not that we are isolated but—

Ms RYAN: We live through droughts and—

Ms TYACK: Yes, we live through a lot of things and we are strong people; we are very strong and passionate people. And in the country I think things like this—going to a hospital where you know you are not going to see a doctor, and I know that the doctors on the screen are professionals, they are good, it is not the same thing as talking to somebody and having somebody there that is passionate and says to you, "Do you know what? You're going to be okay." The doctors on the screen are just saying, "Oh well, I think it is blah, blah, blah." They are so direct.

The Hon. LOU AMATO: That is the human element side.

Ms RYAN: Yes.

Ms TYACK: We have lost that human element.

Ms RYAN: Yes, it is lost, and we need that.

The Hon. WES FANG: Country people need that.

Ms TYACK: We all do.

The Hon. WALT SECORD: Ms Ryan and Ms Tyack, what do you do when someone in the community comes forward and says they are not going to pursue cancer treatment?

Ms RYAN: I actually have—

The Hon. WALT SECORD: What do you do when that occurs?

Ms RYAN: —I can never say this word: anecdotally, we have a lovely young man in our community—and I can tell his story without a name—and he is maybe in his late forties, early fifties, and he is suffering from renal failure, so he needs dialysis. He is also legally blind and he lives with an ageing mother who is his carer. He has refused to have treatment because we do not have a dialysis chair in our hospital, we do not have trained dialysis nurses—however, we used to, but we have patients driving to Forbes three times a week and to Dubbo three times a week to have their dialysis done. I think it might have been 20 years ago we had a dialysis chair, we had people being dialysised. We are so much worse off than we were.

Ms TYACK: And we have got quite a few.

The Hon. WALT SECORD: So what do you tell this young gentleman when he says he is not going to get treatment?

Ms RYAN: What do you tell him? The reason that Jenny and I took this on was those 36 people that came to that really short-notice meeting was because they are older, we have got an ageing population and they are scared. Look, we are both busy, we have families, we work, but we have ageing parents, we have younger children. People are frightened in our communities and those older people do not have a voice and we are trying to be that voice for them. But what do we tell that boy that he has decided not to have treatment because of how poor our system is in our town?

The Hon. WALT SECORD: You used a word "redirections".

Ms RYAN: Yes.

The Hon. WALT SECORD: What are you talking about?

Ms TYACK: If I presented myself to the Condobolin hospital and say I had something in my eye, they would then redirect me from Condobolin hospital another 100 kilometres to Forbes or Parkes, but more than likely I would have to travel 200 kilometres to Orange to have that removed from my eye.

Ms TYACK: They do not like to do hospital-to-hospital transfers from where we are.

Ms RYAN: No, because it is expensive.

Ms TYACK: Because, that costs money.

The Hon. WALT SECORD: So you go to Condobolin hospital and they say, "We can't do anything about this, there is no doctor on duty"—

Ms RYAN: You would be better off to drive—they will tell us: "You are better off to drive to Orange." They tell us, nursing staff tell us. But they cannot do it.

Ms TYACK: Sometimes the ambulance are not there.

The Hon. WALT SECORD: Does Condobolin District Hospital admit patients?

Ms RYAN: Yes, but you have got to really push it.

The Hon. WALT SECORD: It might sound like a crazy question but—

Ms RYAN: It is actually not a crazy question. They do, but they do not like to keep them in there and they like to get you out as quick as they can because they are so short-staffed. We are not here to punish the nurses, because they are so under the pump, but, no, they do not want you in hospital and they do not want to keep people in hospital. Sorry, I am getting very passionate. You had better pull me up, Wes.

The Hon. WES FANG: I understand your passion, I really do.

The Hon. WALT SECORD: You go ahead, Wes. Do you want a clarification?

The Hon. WES FANG: You said they do not want to keep—

Ms RYAN: The powers that be perhaps.

The Hon. WES FANG: No, no, again I am really trying to establish—

Ms CATE FAEHRMANN: Is that just a quick clarification?

Ms RYAN: I can do a quick clarification, Wes, I think.

The Hon. WALT SECORD: Okay, you clarify what you—

Ms RYAN: Can you tell me if I am answering probably what you are about to ask?

The Hon. WES FANG: I can sense the mood of my colleagues.

The Hon. WALT SECORD: Ms Ryan, answer the question however you like.

The CHAIR: The Hon. Cate Faehrmann has some important questions to ask. We do not want to cut you off, but—

Ms RYAN: No, go for it.

The CHAIR: We know how this works. The best thing is to ask a specific question which elucidates an answer, as opposed to having a little bit of a chat. Chats are good but this material is very valuable evidence. So Cate Faehrmann.

Ms CATE FAEHRMANN: Thank you both for appearing today and for the work you do in advocating for your community. I just wanted to get your views on telehealth and the ability for telehealth services to take more time off nurses, for example, who have to be there with the patient. There is a doctor there and normally the doctor would be able to see the patient and the nurse gets on with their duties in other parts of the hospital. Now we have this system, which we are hearing lots of good things about but when it is replacing, as everybody has said, that is the issue. So in your view, in your experience, it is taking a lot more time of nurses, is it not?

Ms TYACK: Definitely.

Ms RYAN: We have got two nursing staff on shift. It is taking the care away from the inpatients. The way our hospital is set up is there is the middle, then you have got the ED. So if you have got somebody in the ED in telehealth, you have taken that nurse completely away from the floor. That is dangerous.

Ms CATE FAEHRMANN: Over the past 20 years we have heard a lot about closing down hospitals and cuts to staffing and what have you. Do you sense that there could be a risk that Condobolin hospital is going to close?

Ms TYACK: Definitely.

Ms RYAN: Very much a risk. I would say it is actually probably on the cards.

Ms CATE FAEHRMANN: Have you heard that?

Ms RYAN: There is always talk and that is not factual, but there is always talk around the town because people are frightened. But, yes, we have heard that. But I cannot state that factually.

The Hon. WES FANG: It is really important—

Ms CATE FAEHRMANN: I have still got questions on this issue, Wes. I am still going.

The Hon. WES FANG: It is really important. We need to actually—

The CHAIR: Wes, if you want to do some tidy-up work that is a separate issue.

The Hon. WES FANG: You cannot just say that and then just—

The CHAIR: We know that it is not for people to put words into the mouths of people who answer. Please proceed.

Ms CATE FAEHRMANN: Thank you. So the cutting back of services to Condobolin hospital you have had in, say, the last 10 or 20 years, and there are reduced services that you are able to deliver to people there. Is that correct?

Ms RYAN: It is correct, and could I add to that I have had a registered nursing sister, who is an amazingly experienced woman who has 47 years of training, who has left and she wrote me a letter. Could I quickly—it would be very quick.

Ms CATE FAEHRMANN: Yes.

Ms RYAN: It does pertain to—

Ms TYACK: Your question.

Ms RYAN: —what we had and what we have lost:

> I have been nursing for 47 years. I first worked at Condo Hospital in 1976. It had theatre, maternity, children's ward, two physios, three wardsmen, gardeners/handyman duties, a laundry, x-ray, paymaster, CEO Matron, meals on wheels, receptionist. It also had visiting surgeons for ENT, general surgery, minor and major operations and procedures. Had a dedicated theatre staff for operations conducted by visiting medicos and our GPs. It had at least three Doctors with visiting rights at the hospital and the "on call" was shared.
>
> Most importantly we had our own Board of Directors. I believe the hospitals fate was sealed when the Government/Dept of Health disbanded local Boards. We lost our voice. We lost our representatives we lost any chance of ever being able to fight for our health rights. They say we have a health council. It is a complete waste of everybody's time and commitment. They have no power or any rights to protest decision or alter outcomes. They are not allowed to express their opinions. They have to parrot the drivel sent out by Big Brother. I know this, I have served on both the hospital board and the health council.
>
> Further to this whoever came up with the idea of two staff members on each shift is delusional and has obviously never had to work in that situation. The nurses are but rabbits in the headlights. To think that two people can manage the inpatients the admissions/ discharges the phone inquiries and visitors the basic nursing care, that in some cases is mandated that two must attend while dealing with whatever walks into the ED dept or is brought in by distressed or abusive family members or active trauma or cardiac or snakebite or mental health crisis or drug abuse cases.
>
> Every shift has a proven potential to have these scenarios and your Government or health department pretends that two staff can manage. In an active emergency there is not even a spare pair of hands to ring for help. The virtual doctor scenario works for minor advice or simple script provision.
>
> "The virtual doctor should never be deemed adequate for an emergency presentation. The nurses should never be expected to carry that burden nor assumed to have the skills from a few hours of online learning that a Doctor has from a minimum of seven years of training.
>
> "The nurses silence is deafening … we have always been told that we are "not allowed" to make public comment at risk of dismissal or disciplinary action or breach of whatever they come up with to make sure they are not challenged. You wonder why you can't get staff to work out here and why would a GP walk into this."

That is not me.

Ms CATE FAEHRMANN: Thank you. That was very useful. What is the bare minimum? Have you done work as a working party? What is the bare minimum of health services that Condobolin needs?

Ms RYAN: I would say, if you gave me that magic wand that you were going to give Pen McLachlan, that we need two VMOs at all times. We need a day VMO and a night VMO. You cannot expect one doctor to do 24 hours. We need a minimum of three GPs downtown and we have to up our nursing staff.

Ms TYACK: And a doctor that works during the night.

Ms RYAN: We cannot do less than that. We have a population of roughly 3,500 for that shire. It is impossible.

Ms CATE FAEHRMANN: Does the lack of health services in a town like Condobolin impact people staying in the region and coming to the region?

Ms RYAN: Yes.

Ms TYACK: Definitely.

Ms RYAN: I actually know people who have left because of our poor health services.

Ms TYACK: Yes.

Ms CATE FAEHRMANN: If there is what seems to be a gradual winding back of the health services provided to Condobolin, that seems to imply that it is having an impact on the town itself—

Ms RYAN: It is.

Ms CATE FAEHRMANN: —and the viability of the town itself, in the long term.

Ms RYAN: Absolutely.

Ms TYACK: Definitely.

Ms RYAN: Rural towns are struggling as it is. We do not need any more reasons for people to leave a town, but health services have a massive impact on people leaving.

Ms TYACK: Massive, yes.

Ms CATE FAEHRMANN: How does it make you feel knowing that the town you live in cannot attract good doctors to stay and work in your hospital?

Ms TYACK: Angry.

Ms RYAN: Can I add to that? I just wonder whose responsibility it is to actually attract those doctors. Who is not fulfilling their role? That is our question. Someone is not doing their job, because it should not be up to Ms Tyack and I to be doing this. We should not have to be doing this. Someone is not fulfilling their job description, because they should be the ones getting our doctors and our nursing staff levels up.

Ms CATE FAEHRMANN: Do you think the advertising for doctors in regional areas is sufficient?

Ms RYAN: I do not see it, I must say.

Ms TYACK: I do not either.

Ms RYAN: Because neither of us are in health fields—

Ms CATE FAEHRMANN: You are not looking for jobs elsewhere.

Ms RYAN: No, we are not looking for that, but I certainly think we could obviously be making it more appealing than it is.

Ms CATE FAEHRMANN: Just one last question in relation to your opening statement, or one of the personal stories that you referred to earlier: I think you said that a patient had their appendix removed five days later, after that telehealth—

Ms RYAN: Was misdiagnosed.

Ms CATE FAEHRMANN: Is there a reason why it was five days later?

Ms TYACK: I would think it would be because they are so busy in Orange with the same thing. They are specialists, doctors—

Ms CATE FAEHRMANN: I live in Sydney but I grew up in a small country town, so I am aware of both. If I was in Sydney and I had appendicitis and I needed to get it removed, I would probably get it removed pretty quickly.

The Hon. WES FANG: They may have treated the appendicitis before they had to remove it.

Ms TYACK: This is a personal thing for me. Two and a half years ago I had really bad pains in my stomach. I went up to the hospital in the morning and there was actually a doctor there. He said, "Look, you've got a urine infection." I said, "Okay, great," so he gave me an antibiotic for that. He said, "Go home and come back in five days if you're not better." The next day I was not any better. I went back and he said, "Jen, do you think you might be constipated?" I said, "No, Doctor, I'm not constipated." He said, "Look, go back home and see how you go. If you're no better, come back." The next morning I went back and I said to him, "Look, I am so sorry. I cannot handle this pain." It was excruciating. He then said to me, "But what happens if I send you to Orange by ambulance?" It is all about money. "If I send you to Orange hospital by ambulance and it's only constipation that you've got, and they give you something and it fixes you, I'm going to have egg on my face."

I said, "Really? Where is the egg going to be if it's something serious?" I felt it was, because it was my body that it was happening to. They sent me by ambulance to Orange and I was in emergency for four days,

unbeknownst to me. I had no idea because at that stage the pain had gotten that bad that I had blacked out. They were giving me pain medication. I had four days of my life removed. Then they decided after four days in Orange, where the specialists and the good doctors are, that they would do a CT scan. They found a mass inside my stomach and told my husband and children that I have bowel cancer. They took me to surgery. Whilst in surgery, they busted an abscess the size of a softball in my pelvis, so then I had sepsis. I was in hospital for 16 days. My husband and my children thought I was dying and I felt like I was dying. That was two and a half years ago. This is the sort of thing that is happening in the country.

Ms CATE FAEHRMANN: Thank you for sharing that story. In other words, for serious issues, doctors are reluctant to send people to another hospital. They are almost sending them home—

Ms TYACK: Because of the money. Because it is expensive to get an ambulance to take you. My daughter had a similar thing. They had to get an air ambulance to her to have a baby. It is not fair. We deal with enough in the country. We go through emotional things in the country.

Ms RYAN: We do. Pertaining to that—

Ms TYACK: I am sorry.

Ms CATE FAEHRMANN: No, no, no.

The CHAIR: There is no need to apologise.

Ms RYAN: It is important to hear it. Pertaining to that, when you said about why that was five days with his appendicitis—from what I can gather, it was misdiagnosed as gastro in Condo. And then, it was so badly infected that I assume that they had to get the infection down to take the appendix. I could go a lot further into that if I need to.

The Hon. WES FANG: Thank you. Your stories have been very powerful, but I just wanted to clarify on some of the points that you have raised. You talked about talk of the Condobolin hospital being sold.

Ms RYAN: Closed, not sold.

The Hon. WES FANG: Sorry. When you talked about Orange you said that is where the good doctors are—

Ms RYAN: Well, they actually have doctors.

The Hon. WES FANG: What I fear is that in this, those people who are working in the smaller locations—when you say Orange has the good doctors, all our medical staff across the State are doing the best that they can. I just do not want to see characterisations of doctors in larger centres as "the good doctors" and those—

Ms TYACK: Sorry, that is how we feel.

The Hon. WES FANG: No, no. I appreciate that is what you said. I am just saying that, having spoken to those doctors in the smaller areas, they are working as hard as they can, as well. I think if we characterise the Orange doctors as "good doctors", we really need to be careful about that.

Ms RYAN: I may need to interject there, Mr Fang. I am sorry. At no point have we meant to infer that those doctors—

The Hon. WES FANG: That is what I—

Ms RYAN: No, but I would like to clarify this.

The CHAIR: Can I just say, I do not think there was any interpretation by myself—

The Hon. WES FANG: I am just letting them clarify that, so that it is—

The CHAIR: With the greatest respect, it is not your role to make witnesses clarify their position, Mr Fang.

Ms RYAN: Yes. I am sorry, Mr Fang—

The Hon. WES FANG: I am going to take a point of order on that, Chair.

The CHAIR: You can, if you like. Take your time.

The Hon. WES FANG: Apologies. This is just a Committee thing. Chair, I am just ensuring that the witness's testimony is not misconstrued. I am asking for clarification because I interpreted it that way. That is all that has happened.

Ms TYACK: I am sorry you did.

Ms RYAN: I would like to take a point on that, though, Wes. What we are saying, and we are certainly not doubting any doctors, but as a community we have lost our faith in our medical services. That certainly was not a slight on any doctors. It just would be really lovely if we had some. Thanks.

The Hon. WES FANG: I appreciate that, but I think—

The CHAIR: I think the point has been made. We do not want to dig bigger holes.

Ms RYAN: Yes.

The CHAIR: We are running into the potential of digging a bigger hole than has been dug, so I think that matters. I did not think it needed to be clarified, but that has now been done.

The Hon. WALT SECORD: I do not have another question. I just want to say thank you, Ms Ryan and Ms Tyack, for your evidence today. It is quite clear that you did not set out to take on these two leadership roles.

Ms TYACK: We did not.

The Hon. WALT SECORD: It was thrust upon you. It is reassuring to see that you guys have taken this up and that you are doing what you do. I do not have a question. I just want to say thank you.

Ms RYAN: Thank you.

Ms TYACK: Thank you very much. That really means a lot.

The CHAIR: That is a positive note to end on and a proper acknowledgement of the most valuable work that you are doing as two individuals who have, dare I say, stepped up to the plate. You were probably drawn in, pulled in, dragooned—I do not know how it happened—

Ms RYAN: Our husbands are not happy with us, I can tell you.

The CHAIR: Obviously, you are sacrificing time that otherwise you would be spending with your families, on recreational activities or whatever to deal with something that is clearly a very live issue in your community, which is animated by very real matters that have occurred. This is not a fictitious event; these are matters that have been raised, and you are prosecuting the discussion around them and around how they can be better addressed. For that, we thank you very much.

Ms TYACK: Thank you very much.

Ms RYAN: Thank you for letting us have our voice.

Ms TYACK: We appreciate the time.

(The witnesses withdrew.)

SCOTT McLACHLAN, Chief Executive, Western NSW Local Health District, on former oath

SHANNON NOTT, Rural Health Director of Medical Services, Western NSW Local Health District, sworn and examined

The CHAIR: I welcome our next witnesses, who will take us through to the end of what has been a very good day here in Cobar. I welcome back Mr McLachlan, who provided us with some valuable evidence this morning in his role as the Chief Executive of the Western NSW Local Health District. Joining him this afternoon is Dr Nott, the Rural Health Director of Medical Services for Western NSW Local Health District. As you are aware, the New South Wales Government, through NSW Health, has provided a detailed submission to the inquiry. That stands as submission No. 630. You would be familiar with that. Obviously, Committee members have had the chance to study it. Would you like to make an opening statement this afternoon to get the ball rolling? Once that is done, is it agreeable that we then move to questions from members?

Dr NOTT: Absolutely.

The CHAIR: We will move to the opening statement. Will you provide that, Dr Nott?

Dr NOTT: Yes, I will. First of all, I would like to thank the Committee for allowing us to speak today. I also want to acknowledge the witnesses who presented their own stories today, particularly the citizens of multiple communities. I think it is really important that the local health district [LHD], as all of us on this Committee, understand and hear from community members. I also want to acknowledge that today we meet on Ngiyampaa country, and I want to pay my respects to Elders past, present and future.

As I said before, my name is Dr Shannon Nott. I am the Rural Health Director of Medical Services for Western NSW Local Health District. My role encompasses working alongside our skilled, dedicated and loyal staff across 35 rural and remote communities across western New South Wales. First and foremost, though, I am a fifth-generation person from this country. I grew up in Dunedoo. My father is a farmer of multiple generations of farmers. I understand some of the hardships that have been discussed today, some of the challenges that have been discussed today. I, myself, and my family have lived through drought, flood and fire. We have also understood and experienced the tyranny of distance that many people have described today.

Whilst much of today has been focused on rural and remote health workforce, one of the outcomes of this Committee and this inquiry is understanding the outcomes for rural and remote people. It is not denied that the outcomes for rural and remote people across western New South Wales, across rural and remote New South Wales, across rural and remote Australia and, indeed, the world, are under par, compared to their metropolitan counterparts. I do not think anyone is denying that. I think, though, for us to be able to be real about addressing some of these disparities, we need to understand the social determinants of health—the factors that contribute to overall wellbeing of people living in rural and remote communities. To do this, we need to be able to not only address the health workforce challenges that we face but also address some of the socio-economic disadvantage in our rural and remote communities through driving jobs; getting people into education and providing access to education; making fresh fruit and vegetables cheaper in our rural and remote communities; and also improving housing quality for people who are socio-economically disadvantaged.

In saying that, though, I do not for a moment say that we should not be focusing and continuing to focus on the challenge of rural and remote workforce. Rural and remote communities have for a long time been innovators in this field. The Royal Flying Doctor Service, an organisation that I work for clinically as a primary care provider and retrieval doctor, has been born out of the challenges of distance. That organisation itself, in the early 1900s, was the first organisation in Australia to adopt telehealth, with the Reverend John Flynn and his engineer Alfred Traeger developing the pedal radio to be able to send Morse code messages to rural and remote communities where they did not have doctors or nurses. Those innovations have continued today and continue in this local health district.

Here in Cobar we have been able to develop remote chemotherapy so that cancer patients, where it is appropriate, can access their chemotherapy locally. Within six months this has saved 15,000 kilometres of patient travel. At nearby town Coonabarabran, it has been 68,000 kilometres. Here in Cobar we have met the needs of some of our community members with complex health needs by providing intravenous immunoglobulin, a blood-based product, to be able to support their healthcare needs and avoid them having to travel.

We also have acknowledged that, while primary care is the responsibility of the Commonwealth, where that has failed we also have to step up. We also have been working alongside multiple organisations, including the Rural Doctors Network and primary health care network, not too far from here, in terms of being able to sustain primary care services in the communities of Trangie, Trundle, Tottenham and Tullamore. The reality is, without that collaboration across State and Federal divides, across local government and across primary care

networks and LHDs, none of those communities would have a doctor today. I acknowledge that all of our communities, as do I, want to have rural and remote doctors, rural generalists—doctors that work originally in primary care but also can support the hospital in their towns—and we will continue to endeavour to put all our efforts into recruiting and retaining those doctors in our communities.

The CHAIR: Thank you very much. We appreciate that very detailed and considered opening statement.

The Hon. WALT SECORD: Dr Nott, were you here for this morning's evidence?

Dr NOTT: Yes, I was.

The Hon. WALT SECORD: You would be aware that your local health district has the worst health outcomes in New South Wales for First Nation people and non-First Nation people.

Dr NOTT: I believe that there is another LHD that actually is technically the worst.

The Hon. WALT SECORD: So you are the second worst.

Dr NOTT: We are. Those outcomes are not something that we are proud of. However, we are continuing to work alongside our local communities to look to improve those. As I said before, health workforce is one of the components of those but also we need to address some of the socio-economic disadvantage in this community.

The Hon. WALT SECORD: What is the evidence that you are working alongside communities? What I heard in your opening statement was a bit of a lecture to the community saying that—

The Hon. WES FANG: Point of order—

The CHAIR: I am required to deal with the point of order. A point of order has been taken.

The Hon. WES FANG: The editorialisation by the Hon. Walt Secord in this instance is unhelpful when Dr Nott has clearly come here and is prepared to provide frank and full answers. I do not believe that is helpful. I think he should retract it as well.

The CHAIR: I have to rule on this. I do not think it needs to be retracted but can I invite the honourable member to be considered in the wording used.

The Hon. WALT SECORD: I was going to make a point and then I was going to ask the question. You made your opening remark and you made a number of statements, which included saying that we would like to see fresh fruit cheaper. That is very fine, that is very well and that is very noble.

The Hon. WES FANG: Again, that is editorialisation.

The Hon. WALT SECORD: What is the local health district and the Government doing to have dialogue with the community? Condobolin was two weeks without a doctor. Shouldn't that be a priority? What steps are you taking?

Dr NOTT: First of all, it is a priority every day for our teams to be able to try to get doctors on the ground. For the community of Condobolin, I am in regular contact with the primary care provider there locally, Brenshaw medical. To your point around what are we doing, the doctor there that provides visiting medical officer [VMO] services would not have been able to sign up originally if it was not for the district working with him around ensuring that there was appropriate fatigue management for his care. There were a number of statements earlier today saying that he is only available eight to five. His contract includes emergency after-hours services for when he is needed and when there is a doctor's pair of hands required in that community. There were references already today also that doctors cannot work 24/7 and part of recruitment and retention in our region is working alongside doctors, and alongside our virtual services as well, to support doctors in communities where they may be one of two or one of one, and be able to support them so that they can have longevity in our communities.

The Hon. WALT SECORD: What are the processes and steps in place when you hear that a man had to have his toe amputated at Cobar hospital, that a family member had to say goodbye to a patient on a bathroom floor and that patients are regularly redirected? What does the local health district do when these matters are brought to its attention?

Dr NOTT: First of all, we take all of these matters very seriously. It is really important and we value feedback from community members, loved ones and patients. When we do have incidents, where there is opportunity to improve, we go through a rigorous process, which includes our clinical governance team providing an independent review of cases. That means relevant experts in the field that is applicable to the patient's care are able to review cases and be able to provide advice around systems improvements that we can put in place.

The Hon. WALT SECORD: Mr McLachlan, is there anything that you would like to clarify or expand or report on that you referred to this morning? Did you in fact seek advice during the period about the number of hospitals that were without a doctor?

Dr NOTT: I can answer that question. Mr McLachlan spoke earlier this morning saying that, on any one weekend, there may be fluctuations in regards to doctor availability and, again, priority across the district is to be able to get doctors in our communities on the ground supporting our nursing staff and supporting local rural generalists. Where we cannot do that we do try to get locums into communities. This coming weekend there are nine communities across our region where there is no local doctor available despite all attempts by our district to try to get people there.

The Hon. WALT SECORD: So, this weekend there are nine hospitals in western New South Wales where there is not a doctor on duty.

Dr NOTT: That is correct. An important part of that question as well should be how many communities, without the local health district providing flexible employment options, locums or working with individual practices, would not have a doctor at all? And that count goes to 26.

The Hon. WALT SECORD: Explain that again.

The CHAIR: Say that again.

The Hon. WALT SECORD: I am sorry, I could not follow that.

The Hon. WES FANG: I understood it.

Dr NOTT: There were some comments made earlier today as well, saying that it should be the State Government's responsibility to provide general practice services or to provide community primary care services.

The Hon. WALT SECORD: No, my position is that doctors should be in hospitals.

Dr NOTT: And I agree. In our communities we should have rural generalists that are based in primary care that also service their hospital.

The Hon. WALT SECORD: What is the 26 communities figure?

Dr NOTT: In regard to my opening statement, where there have been communities where general practice—which is the responsibility of the Commonwealth—has failed, we work with local providers. That is through a range of things. Some of those include us working directly with GP practices—whether they are privates, whether they are single doctor owned practices, or whether they are larger corporate practices—around how can we pay doctors and how do we put awards in place and systems in place that support them there. Part of that is money but the other part—and really important part—is appreciating work-life balance is incredibly important for doctors. In some of these small communities, where we only have one or two, that means providing after-hours support for lower acuity cases through our virtual care services.

The Hon. WALT SECORD: What happens this weekend with those nine hospitals that do not have a doctor on duty? Will there be a sign outside? How will patients know that there are nine hospitals that do not have a doctor on duty this weekend?

Dr NOTT: When patients present they would undergo care as they would when a doctor is working as a VMO in the community, recognising that these communities do not have doctors, so under the old model—

The Hon. WALT SECORD: That is a quarter of the hospitals under your jurisdiction.

The Hon. WES FANG: Point of order: I was listening intently to Dr Nott's answer. He was halfway through the answer to the question the Hon. Walt Secord asked when the Hon. Walt Secord interrupted him. He must be allowed to continue his answers. He is providing very thorough, very honest answers and the interruptions from the Hon. Walt Secord are not helpful.

The CHAIR: Question and answer—that is how we follow.

The Hon. WALT SECORD: Just to refresh your memory: How will patients know that nine of the 38 hospitals in this region will not have a doctor on duty this weekend? Is it like a lottery—"I hope there is a doctor there"?

Dr NOTT: First of all, we should recognise that 90 per cent of the care provided in our small rural and remote communities is provided by face-to-face doctors and nurses in the community. When there is not a doctor and when we have exhausted all avenues to get a doctor into these communities, when patients turn up to the facility they are triaged as they would with nursing staff and they are assessed as they would with nursing staff

regardless of whether a doctor was there face to face in the community or whether they are under virtual. Those nurses would explain to the patients that there is a doctor working virtually today and they will see them via videoconference.

Ms CATE FAEHRMANN: Thank you both for appearing. During this inquiry—and this is only our third day; we have a lot more to go—we have already received hundreds of submissions from people expressing their dissatisfaction with the services that they have received and, in fact, the lack of services in their area. You were here this morning and heard about the hospital services declining in the past 20 years. Recognising that these crises are occurring and that people are having to travel hundreds of kilometres to get treated—everything that we have heard today—is there within the LHD any work being done to re-establish some services or to put new services in? We have heard about the centralisation and the cutting back, but things are getting worse and people's health needs are getting more acute, as we are hearing, and more complicated. Is work being done behind the scenes to fix it and bring back some of the services that we have lost?

Mr McLACHLAN: Absolutely, there is. That is every waking hour for us. I can talk at a couple of levels. First of all, the intention to provide patient care in local hospitals is absolute. In trying to maintain face-to-face medical workforce, as Dr Nott said, over 90 per cent of patients do receive face-to-face care in our 35 rural hospitals. In terms of our intention to grow and enhance services, first of all, our outreach services have over 150 specialist medical staff, nursing and allied health staff that come out to rural and remote communities. In Cobar that means about 15 visiting services that come into Cobar. In Bourke that is about 17 services. In Condobolin—I can give you a list of the visiting services that now come into Condobolin.

Ms CATE FAEHRMANN: Could you provide those on notice?

Mr McLACHLAN: I am very happy to. It is an extensive list and some of the concerns and things that are being taken away are actually being reversed by the additional services that we are intending to bring out to rural and remote communities. That is enhanced by a lot of the specialist telehealth and virtual care services. Our specialist paediatricians, obstetricians, intensivists, orthopaedic surgeons that are following up on patients post a fracture—there is a big long list of services that we now have that we did not have three years ago that are saving patients, in the last 12 months, over 1.2 million kilometres in travel right across our region that they previously would have had to travel for. The intent is both to enhance our face-to-face services with GPs and nursing staff on the ground in rural hospitals, our specialist outreach services to take specialists to patients to save them having to travel and where we can have virtual services to save patients travelling as well. Those are all having a significant impact in the lives of people, but we do recognise that there are still gaps in those services and those are the focus areas for all of our service planning, our health needs assessment and our prioritisation of services into the future.

Ms CATE FAEHRMANN: When we are hearing from witnesses and from submissions about cuts to nursing ratios and nursing staff in hospitals, is there any work being done within the LHDs—I understand this is a government decision; that is why I am asking—to reinstate those positions now that there is so much evidence about the impact of those cuts on patient care being received?

Mr McLACHLAN: We absolutely look at the number of patients and care needs of all of our patients and all of our services on a regular basis. We do adjust our nursing staffing levels. I can give you an example. Just recently we have increased the number of registered nurses at Nyngan as a result of the change in patient numbers that are coming to that service. We do this on a weekly and monthly basis where all of our managers have the ability to call in additional staff if there are increases to patient numbers coming into, particularly, our small rural hospitals. Our staff on shift have the ability to call in additional staff if there are things going on. If there is an emergency situation then that is absolutely available to them. We continue to look at the care needs of both our elderly residents in the aged care part of our multi-services. The acute beds and the emergency department beds—that is a regular stocktake that we do.

Ms CATE FAEHRMANN: There have been a number of submissions that refer to and witnesses today referring to the fact that when patients are told that they need to go to another hospital or if they are transferred to another hospital, they will not be counted into the needs of the community in terms of the local hospital and how many people access those services. Is that what happens?

Mr McLACHLAN: No. We do look at the needs of every community—

Ms CATE FAEHRMANN: How do you do that?

Mr McLACHLAN: —and the people from that community that need to access care both locally and across the region, across the State and interstate. It is a regular process that we go through to look at the health of the population, the access needs of every facility and the needs to try and support those services. We have a measure called a self-sufficiency measure.

Ms CATE FAEHRMANN: Can I be very specific? It is a very specific question. This is important for the work of the Committee. The way in which that data is tallied—if you have, say, 20 people in a fortnight from Condobolin going to Orange to access that hospital and emergency services, for example, is that factored into the Condobolin health requirements? Or is it "This many people accessed Orange Hospital. Isn't it great that we have a big hospital in Orange, because all these people are accessing it?" Which is it? I am seeing lots of nods behind me.

Mr McLACHLAN: Yes, it is taken into the Condobolin requirements. Any patients that need to leave Condobolin for more specialist care—we look at the population of Condobolin and all of our towns on a regular basis. The measure called "self-sufficiency" means the proportion of patients that can be cared for in the local hospital as a proportion of the total population. It is something that we do look at on a regular basis.

Ms CATE FAEHRMANN: What does it take within the LHD—let me see how to frame this question—to get services back? How many people does it take to get an emergency department with a doctor working in it? Who makes that decision? Is there data behind that?

Mr McLACHLAN: We would look at a number of things—both the population demand at a local level and the workforce needed to grow the service with the skills to meet that population demand. One example I can give you is the outreach or virtual chemotherapy services which we established in Coonabarabran over two years ago. It was a New South Wales first. This was a step that we took to set up a new service to take a specialist team from Dubbo to Coonabarabran and support the local staff, skill up the local staff and set up a whole heap of systems to support them delivering safe care and chemotherapy to local patients. As Dr Nott mentioned, there is over 25,000 kilometres that have been saved through that new service. That required us having a certain number of patients that needed that care. We could not have done it for one or two patients. We need to maintain the skills of all of our staff in doing the complex tasks and having the skills on a regular basis.

The Hon. WES FANG: The first thing I want to do is clarify some things that have been raised previously. The one I want to clarify most is around the closure of Condobolin hospital. Is there any plan at all by the local health district to do that? Can you elucidate on that?

Mr McLACHLAN: There is absolutely no plan to close Condobolin hospital or any of our hospitals.

The Hon. WES FANG: Okay. Dr Nott?

Dr NOTT: I have got nothing else to add to what Scott McLachlan said.

The Hon. WES FANG: Can you explain how comments like that might actually reduce the community's confidence in health care in the area?

Mr McLACHLAN: We absolutely understand the concern of rural communities. Things have changed over the last 15 and 20 years and that does create fear and concern for the communities. We have done a lot of things to try and return services to country towns that have changed over recent years. Some of that is in face-to-face services and some of it is in virtual services. I said before things are going to continue to change, probably at a greater rate of knots into the future. We know that does create concern and fear in communities. The thing I will absolutely confirm is there is no intention to close facilities. We will be doing everything we can to recruit face-to-face doctors, nurses and other staff into our smaller country towns. We know how crucial that is. Where we cannot do that, we will do everything in our power to be able to provide both virtual and other supports to make sure that patients can receive care.

The Hon. WES FANG: We heard yesterday in Deniliquin that a rumour had started that resulted in the council printing an advocacy document that said that the hospital does not see patients under 16, which was completely false. They had to actually modify the whole document because—

The CHAIR: Hang on. I am going to pull you up.

The Hon. WALT SECORD: That is not true.

The Hon. WES FANG: What is not true? Tell me.

The CHAIR: It is not a case of telling you. I think the witnesses are entitled to know specifically what it was. It was a document and contained within it was a reference to a particular point which was subsequently found to be inaccurate and which the council then struck out by putting a line through it. So that document was not just around that single point. It was to cover a number of points, and it was an advocacy document—

The Hon. WES FANG: I called it an advocacy document.

The CHAIR: Correct, yes. It was to do with matters medical and health. There was one point in it that proved to be inaccurate and they moved—

The Hon. WES FANG: It was a pretty big point.

The CHAIR: Listen, hang on. I have not finished.

The Hon. WES FANG: Okay, go ahead.

The CHAIR: The witnesses are entitled to answer questions based on—

The Hon. WES FANG: As I was explaining it to them.

The CHAIR: No, not as you explain it, with the greatest respect.

The Hon. WES FANG: You can run interference, Greg, if you want, but I am going to put the question.

The CHAIR: We can do this a couple of ways.

The Hon. WES FANG: Continue by all means.

The CHAIR: I intend to do so. Let us get this very clear. Will the secretariat please get me the document from yesterday if we have got it?

The Hon. WES FANG: I have got it. It is in my bag.

The CHAIR: You raised it.

The Hon. WES FANG: This is it. This is the document.

The CHAIR: Wes, you know how this rolls. You do not do this. Through the secretariat—

The Hon. WES FANG: You are burning up my time. Thanks, Chair.

The CHAIR: With the greatest respect—

The Hon. WES FANG: It is a very simple question.

The CHAIR: No, it was not, because you fundamentally misled the witnesses.

The Hon. WES FANG: How? Explain to me how I did that, please, Chair.

The CHAIR: Mr McLachlan, you may or not—

The Hon. WES FANG: Point of order: How did I misrepresent the situation?

The CHAIR: Mr McLachlan, you probably have not seen the document. You will see on page 2 a strikeout. They put a line through a particular—

The Hon. WES FANG: Section 2, Deniliquin Hospital—you will see a line through the bottom of the rationale.

The CHAIR: Yes. That is the inaccuracy contained within the document on that particular point, and that point only, that the council then needed to deal with.

The Hon. WES FANG: Can I now continue my questioning?

The CHAIR: Please do not interrupt me.

The Hon. WES FANG: You are interrupting them.

The CHAIR: You can be as rude as you like—

The Hon. WES FANG: I am not being rude. You are burning up my time.

The CHAIR: You are talking over me. I consider it quite rude, but it is not going to distract me from making the point so they are very clear about what we are dealing—

The Hon. WES FANG: I was clear on the point.

The CHAIR: You can keep interrupting but it will not stop me from providing the witnesses with the detail they need to know.

The Hon. WES FANG: No, you are deliberately burning up my time.

The CHAIR: We will continue this for as long as you like, mate. That is the document being referred to. That is the point that needed to be clarified by the council. It was struck out as soon as the error was discovered and we had some discussion about that with the councillors yesterday.

The Hon. WES FANG: You can see the document in front of you. What started as a rumour was printed on a council document that said the hospital would not see patients under the age of 16 years, which then led the community to not send any sick children to the hospital. Can you see that potential rumours around health care end up becoming issues where communities lose faith in their healthcare provider? Information that is provided within not only the community but within the media and all sections of the LHD need to be accurate. Can you provide your thoughts on that?

The CHAIR: But before you proceed I want to make this point very clear: The evidence yesterday was not that it started to lead to community members and families not sending their children to hospital. It had the potential to do that—

The Hon. WES FANG: I asked them that.

The CHAIR: —but immediately having discovered that in fact what was in the document was inaccurate, the council took immediate steps and had it corrected. That is what happened yesterday. So with that knowledge of what happened—that is the explanation. Obviously you can respond to any question, but that is the factual position.

Mr McLACHLAN: I would be first to admit that we can improve our communication and engagement with all the people across country towns in the region. We know how crucial and important health services are to a community. There is no question that we want to maintain the confidence of the town that they can come and access services at their local hospital when they are crook—when they do need extra care and support, if they have got mental health issues or other chronic conditions. The lengths that we will go to improve that—I would love to commit that we will step into further communication and engagement with our communities to help appreciate what services are available. I think there are some concerns about things that may have stopped but they are actually existing and any changes into the future that might happen for them.

The Hon. WES FANG: And the LHD correcting misinformation that is out there in the community is really important?

Mr McLACHLAN: Absolutely.

The Hon. WES FANG: Dr Nott, can you speak to the difficulties in recruiting doctors to areas where this sort of misinformation swirls. Do you find that it is harder to bring people in when there is misinformation floating around? Are there concerns around the provision of health care?

Dr NOTT: First of all, I think it is difficult to recruit doctors and a skilled workforce in rural and remote regions. That is not a new thing and it is not unique to western New South Wales, New South Wales or even Australia. In regard to being able to get doctors into the community, for those that have not met a community before, one of the natural things in this day and age is to google the town. Certainly, positive news stories about communities are important in terms of being able to actively recruit and retain people in rural and remote communities. In saying that though, we highly respect the communities' right to be able to express concerns throughout whatever mechanism that is regarding the health care provided in rural and remote towns.

The Hon. WES FANG: Can I just ask about—we have heard a lot about telehealth the provision of experts in care, but we have heard both sides in this inquiry. Can you provide us with some thoughts around how virtual care has provided some good outcomes for people particularly in remote rural communities that you have in your LHD?

Dr NOTT: I think there are good news stories regarding telehealth every day. I also want to preface that by saying that I completely acknowledge the community's desire to have rural generalists in all of their towns, and that is absolutely a commitment to try and continue to do. However, telehealth has had for a long period of time significant benefits in being able to increase access to specialised health care, being able to reduce patient time in terms of travel, days off work, being able to provide patients with choice in regards to the way that they access their health care. Telehealth in our region—Mr McLachlan talked about the remote chemotherapy service. I was at the Sydney Children's Hospitals Network meeting in Sydney talking about paediatrics and how we can support some of our complex paediatric patients across the region that would normally have to travel for subspecialty advice to Sydney. During COVID across the state of New South Wales, they have saved 56 million kilometres for patients, just paediatric patients and their families.

When you look at the CSIRO tele-homecare trials, that is for the most vulnerable populations across our regions. These are trials where we could utilise advances in technology to help manage and support community members who have complex and chronic conditions. Those programs showed an increase in terms of patients' satisfaction, increased ability for patients to be able to self-care for chronic disease, decreased reliance on emergency department presentations and a greater satisfaction for patients in terms of being able to be treated at

home. Telehealth is not new. It is not just for rural and remote communities. This is happening across metropolitan regions. In fact, a program which we have been running out of here in Cobar where we have had clinical pharmacists support our patients around their medication management, their education working alongside doctors in terms of being able to improve their medication management has actually been accepted into Sydney where our region is able to support Royal Prince Alfred, one of the big quaternary centres in terms of the pharmacists' advice.

The Hon. WES FANG: Do I have more time?

The CHAIR: I think the Hon. Lou Amato has some questions.

The Hon. LOU AMATO: Dr Nott, in your opening statement you said some things that might not be spoken about but I think in a way is relevant to what is happening, particularly in recruitment of medical professionals. We spoke about education and we spoke about even businesses to be put on notice that in the past were regional and when businesses shut down, there are fewer and fewer opportunities. Could that be part of the reason why it is also more difficult to entice nurses and doctors and specialists dealing with young children to come into these areas? How maybe can we overcome this?

Dr NOTT: I think that there are multiple factors in regards to why people do not choose a rural and remote health career. One of the ways that we should be able to look to overcome it is to reflect on what the evidence is in regards to being able to get rural health clinicians—and I purposely do not use the term "doctors". This includes our allied health, our nurses and our doctors in rural and remote communities. So, consistently across the evidence, there are three main things: one is getting rural background students from communities into health degrees. We are certainly doing that in partnership with multiple universities that have been referenced earlier today in regards to end to end training at the University of Sydney, which is starting next year and the Murray-Darling medical school out of Orange, which started this year and had overwhelming applications. The other component is that I know some local councils themselves have provided scholarships to students to be able to go to university and supporting their own to be able to grown their own, so to speak.

The other component is providing support for the whole family unit, recognising that young families, it is not just a doctor, that come to the community. They bring their wife and their children. Many rural and remote communities take significant pride in the fact that they do welcome with open arms a family and certainly there are ways that we can improve and look at those factors moving forward. And the final component is actually giving people positive experiences in rural and remote settings. That starts at high school and through childhood but also through university, so even those people that go to university in metropolitan settings, giving them opportunities to come to remote environments and many rural clinical schools, university departments of rural health do that.

That continues through to the junior years where doctors, nurses, and allied health professionals need to get access to not just our regional towns but also our smaller rural remote settings. That is being done through the Rural Junior Doctors Training Innovation Fund where junior doctors are able to come and work alongside GPs in the community and experience what it is like. It is done through our new graduate programs where nurses, fresh out of the university, are able to work in many of our rural and remote environments. The final component around experience that we need to recognise is that there is a changing attitude around the workforce and that is just not the medical workforce. Work-life balance is incredibly important for younger generations of people entering the health workforce.

The Hon. LOU AMATO: Yes.

Dr NOTT: We need to recognise that there have to be ways that we address, particularly for doctors who back in the past used to work 24/7 in communities with no additional backup, and that includes backup from virtual care where some specialists can provide advice 24/7 to them to support their patients' needs.

The Hon. LOU AMATO: Thank you very much.

The Hon. WALT SECORD: Dr Nott, I am not sure whether it was you or Mr McLachlan who said that technology changes at the rate of knots and with that there is the introduction of telehealth, which I understand. You said that this coming weekend that there will be nine hospitals that will have a virtual doctors. Do you see that, with the continuation of your struggling to get doctors to work in communities, that you in fact could actually have virtual doctors in most of those hospitals?

Dr NOTT: No. As I said earlier our commitment is to having rural generalists on the ground. That, first and foremost, is doctors that are embedded within primary care in the communities. It was through evidence, actually—

The Hon. WALT SECORD: Okay. Primary care is GPs.

Dr NOTT: Yes, general practitioners.

The CHAIR: I anticipate a point of order.

The Hon. WALT SECORD: No. I am just seeking clarification.

Dr NOTT: Yes, general practitioners.

The Hon. WALT SECORD: Most people outside the Committee would not know the difference between primary care—so primary care are GPs.

Dr NOTT: GPs in the community first and foremost where the evidence shows that for the best health outcomes we should be investing in primary care which, again, is the responsibility of the Commonwealth. We want those primary care doctors to also feel comfortable working in our rural and remote facilities and providing visiting medical officer services as rural generalists.

The Hon. WALT SECORD: Yes.

Dr NOTT: And for us to be able to support them in one way is providing virtual support options. That may be by peers of rural generalists. It may be by providing critical care specialists to provide support or it may be subspecialists into rural and remote facilities.

The Hon. WALT SECORD: Now, in some of the submissions they talk about situations where some of the hospitals in the Western NSW Local Health District no longer provide basic procedures. Can you guarantee that in the 38 hospitals in your local health district that if you showed up with a broken wrist or you cut yourself and you needed stitches that you would be able to get that basic stitching or a broken wrist attended to at all 38 hospitals?

Dr NOTT: So, first of all, care in rural and remote facilities is complex and it cannot be simplified to broken wrist or simple suturing. There are multiple factors which doctors and nurses take into account to determine where patients best receive their care. Over the last 20 years medicine has advanced significantly where today we have subspecialties within specialties. A great example of that for your broken wrist is that today there are hand surgeons, there are foot surgeons, there are knee surgeons, there are shoulder surgeons.

The Hon. WALT SECORD: Okay. Dr Nott, I would like to ask you again: If you get a cut on your forehead, can you get stitches in all 38 hospitals in your local health district—yes or no?

Dr NOTT: No.

The Hon. WALT SECORD: What is occurring at the 38 hospitals? I was born in Canada. I would assume that Canada and Australia have similar health systems. I have been here for 33 years. I think it is logical that you can walk into hospital and get stitches.

Dr NOTT: In regard to our facilities, again, 90 per cent of the care provided is face-to-face and for those times, they can get access to sutures. But where a nurse is there in a facility and does not feel comfortable closing a wound, recognising not all cuts require suturing, then they may need to be moved. I have also been to Canada and a number of communities there and telehealth has been embraced by Canada for a very long period of time. In fact, longer than—

The Hon. WALT SECORD: Okay, but we live in Australia. You and I both live in Australia.

Dr NOTT: You referenced Canada.

The Hon. WES FANG: You raised Canada.

The Hon. WALT SECORD: I was giving context.

The CHAIR: Order!

The Hon. WALT SECORD: What are the basic services that are occurring at hospitals in your local health district? What is the absolute base minimum that you get if you go into a hospital?

Dr NOTT: All of our facilities provide emergency care and inpatient care for patients as required and appropriate to their need. Where a patient turns up to hospital and they require certain aspects of their care, if it is able to be provided within the role delineation of that facility—that means multiple hospitals have various role delineations—some are able to provide more advanced care, others are able to provide more basic care. That has existed for many decades across the system as well. Depending on the role delineation of the facility, patients are able to get the care that they require in terms of that role delineation. If a facility is able to provide the care locally, patients get that locally. If they need to move, they will be transferred by the most appropriate means.

The Hon. WALT SECORD: I did not understand that answer at all.

Dr NOTT: Sure.

The Hon. WALT SECORD: What is the most basic service that you can get in one of the 38 hospitals? What is the absolute base minimum health care that you require that you will get?

Dr NOTT: Any patient that turns up to any of our facilities is able to get the care that they require when it is required. That may not mean that they get it there locally, and that is the most appropriate care. Not all care can be provided in local facilities.

The CHAIR: If we take those escalating steps of moving towards the point of that facility that can provide what is judged to be the current best practice with respect to dealing with a procedure or dealing with a particular situation, surely you acknowledge the potential for time slippages of a person at one point ultimately getting to this point. There has to be absolute certainty that at each juncture the transfer is very smooth so that we do not have this slippage of time. With respect to examples that have been in the paper last year that you would probably be well familiar with—in fact, one gentleman happens to be in the audience right behind you. As it turned out, through no fault of his own, there was a wrong break. The breaks just did not sort of break the right way, and he ended up having to have a toe amputated.

I am not using that and trying to conflate that to say that everything is wrong. But to the extent that there is this prioritising and there is this decision done at a sort of macro level that we are going to escalate things move through stages, when there is the real potential for slippage because there are such pressures on the local level, that must be setting alarm bells off. What I am interested in is how that is being dealt with. With all the evidence that you are well aware that there are issues out there and slippages taking place, what is being done to address that?

Mr McLACHLAN: I am happy to take that question, Mr Chair.

The CHAIR: Please.

Mr McLACHLAN: Every day we serve 800 patients who come to our emergency departments. Every one of those patients is what we call triaged over five stages or levels of triage of a really critical patient that must be seen within two minutes to a patient that over a number of hours will need some level of treatment and advice. Our nurses in every facility have the ability to make that decision and guide the care of those patients. Where we do not have the ability to care for those patients in the local facility, we have got a district-wide team 24/7 of specialist nurses that have the ability to say, "Yes, that patient needs to be moved," and will organise the transport and other follow-up care. That same team also has the ability to call in other specialists to find solutions to keeping the patient locally and providing all of the specialist advice to make sure that if they can stay in their local hospital, that is absolutely possible.

That team has evolved significantly over the past 10 or 15 years. It was an Australia-first team. Our Critical Care Advisory Service was started over 12 years ago by an intensivist in Orange. That has saved thousands of lives across this region through the virtual support that they provide. That has now evolved into a group of paediatricians, obstetricians, emergency physicians and the long list of specialties goes on. The prioritisation that we put in place for all of our staff is to try and ensure that if we can provide care locally then that is absolutely the priority. If we do need to move patients, then in some cases the ambulance service will play a role in transporting patients to the neighbouring larger facility or a plane or a helicopter to make sure that they get there as quickly as possible.

We have also invested in 12 of our own vehicles to make sure that we can leave ambulances in country towns and transport patients away from those country towns through our vehicles and bring them back to those country towns. That extensive network of transport services, we use on a daily basis. We will continue to try to grow that to make sure that patients get to the right place as quickly as possible for the right care, and equally we will continue to grow the specialist services to try and keep patients in their hometown.

The CHAIR: You do understand the current tension that exists here, and forgive me for using this example. In other words, we are not talking about being in metro Sydney where we are simply going across a couple of suburbs when we might transfer someone. We are talking about potentially hundreds of kilometres. You can sort of see how if slippage emerges, those minutes become hours become days. With blood infections and things like that, don't you tell yourself—you are doctors, well at least one of you is—about how that can quickly go very bad very quickly? I wanted to emphasise the point that it is very, dare I say, bleeding obvious to us who are not doctors just looking at the facts presented before us that you can see the scope for slippage. I am not going to foreshadow what our report recommendations are going to be, but certainly it seems to create a particular set

of difficult circumstances whereby if there is slippage, that can soon compound and the compounding of the slippage can have in the worst situation catastrophic outcomes.

Mr McLACHLAN: We absolutely understand that. One thing we cannot change is geography—

The CHAIR: No, I know you cannot change the geography.

Mr McLACHLAN: —but what we can change in our region is the speed at which we make decisions about patients' care, and all of our specialist services are designed to improve that. I can give you an example of a clinical case just recently. A patient came in to one of our small rural hospitals having a stroke. Ambulance brought the patient in. Within seven minutes of being in that facility they were given a drug that is called a thrombolytic drug that breaks down the clot and helps to improve their care. Seven minutes is nearly unheard of in any environment. It is the specialist teams that were able to give the right advice to the local clinicians and deliver that drug. That is one of thousands of examples that we could give of the things that we can now do that we could not do two or three years ago or five and 10 years ago. Our ability as a region to bring specialists to the bedside is quite extensive.

The CHAIR: I understand, but when we heard these, dare I say, horrific stories today—and without going through them again, the individual who had a cook as we understand essentially be with them in the car park because there was no-one else to assist until Fire and Rescue NSW came to provide the lifting assistance or the gentleman who tragically passed away in the shower after being admitted. These become the counterpoints, don't they? I am sure you are aware of that, but these are the counterpoints.

We had witnesses just before you came in and I am sure you are aware of the work they do—the Condobolin Doctor Crisis Working Party. I am sure you are aware that they exist. I presume you have got the mobile phone numbers of the two individuals involved with that organisation—if you do not, I advise you to get them before you leave today—who have got a multitude of examples of these cases that have not gone so well and in fact in some cases have gone very poorly. It is this tension. We do understand that advanced technology improves things and all the rest of it. We have heard many times that the virtual medicine is not a substitute for the practising of real medicine with real doctors and nurses. But I am saying to you that you do not need to put your ear to the ground too closely to hear that there are some very challenging, contradictory positions being put in regard to the way in which this enables health and medicine to be managed.

The Hon. WES FANG: Is there a question, Chair?

The CHAIR: Please do not tell me about editorialising. I have given you a lot of time this morning. We have got representatives from the Government here. I am wanting to make the point very clear—

The Hon. WES FANG: No, if you want to—

The CHAIR: No, if you want to interrupt me while I am speaking—

The Hon. WES FANG: I was not.

The CHAIR: I would desist while I make my point. Do you want to continue?

The Hon. WES FANG: Chair, the number of times you have ruled—

The CHAIR: If you want to continue with this, Mr Fang, we can do it. I gave you wide latitude today.

The Hon. WES FANG: You actually have not, but that is okay.

The CHAIR: I do not think we want to end on a negative note. What I am trying to do is drive the point home—

The Hon. WES FANG: We have got final questions we want to ask.

The CHAIR: It is just really important. Gentlemen, I accept that you have got very big responsibilities. You hold the most senior positions within the LHD. You have been very patient and I am appreciative of the fact that you have been and sat through today. It has been a difficult and long day. I just want to drive the point home that we all do, quite naturally, like to polish up the good results and say, "This is what can be done and is being done. We think this is wonderful." But I want to drive home the point that there are many issues which are of grave concern.

The Hon. WES FANG: You are the Chair. You are not supposed to be editorialising anything. You are supposed to be impartial and ruling. What you are doing is entirely inappropriate right now.

The CHAIR: It is just very important that these matters that you have heard today are taken to heart. I encourage you to engage directly with those people of goodwill and good faith in the community who are trying

to raise the standards. We have just gone three o'clock. If people want to do another round of one question each, we can. Gentlemen, do you have another five or 10 minutes?

Dr NOTT: Sure. Can I just say one thing in response to your statement before?

The CHAIR: You certainly can.

Dr NOTT: I think that is the absolute big takeaway for us with all of the cases where individual patients or communities express concern. We are here to listen. Certainly, being able to take lessons learned away from that in terms of community and in terms of understanding the pressures—and we appreciate that telehealth is not for everybody. We do want to have doctors in communities and we want to work with individual citizens in communities in terms of how we improve our healthcare system. That is the commitment of all of our staff across the region. No-one turns up to work today thinking, "I want to decimate health care."

The CHAIR: That is not being suggested.

Dr NOTT: We all want to work through this. I have grown up here. My friends and family live in this region. I certainly want to work with all the people not just in this room but in the other communities in terms of how we can do better.

The CHAIR: Any final questions from members?

The Hon. WALT SECORD: No, I will cede. I thank you for your time. I will end my questions there.

The Hon. WES FANG: We can leave it. That is fine. Thank you for your appearance today.

The CHAIR: Gentlemen, thank you very much for coming along today. Mr McLachlan, you have appeared twice today so you have taken it twice, from the left and from the right, so I hope you are a strong man.

The Hon. WES FANG: No, he just took it from the left.

The CHAIR: The role is a significantly challenging one, we do appreciate that. But you understand our role is to bring these matters to your attention in the most poignant, clear way to make it very clear what the expectations are. Dr Nott, thank you for the work that you do. We appreciate the work done by the local health district. We understand the geography, we understand the size and we understand the challenges, but we are all working together to see what we can do to lift those standards over time. Thank you very much. On that note, just a final comment. I just wanted to acknowledge before we wind up for the day the attendance of Mr Len Fitton, who sat there very patiently with a photograph of a man well known, Mr Allan Wells, in memory of him. He was a wonderful man. I did not know him personally. Mr Fitton says he was a good old Cobarite. And the father of Jamelle. Thank you so much. That honour that has been given to him over the course of the day is much appreciated.

Could I also acknowledge a gentleman I spoke to at lunchtime who I took the liberty of referring to during my last set of questions. As difficult as it is, you have come today and sat through this. That is much appreciated. On that note, can I thank everyone very much for coming along. It has been a long and productive day. We have enjoyed being here and we will work very hard to take away the excellent evidence that has been given to us through submission and oral evidence to produce the best possible report with the best possible recommendations that will go back to government.

(The witnesses withdrew.)

The Committee adjourned at 15:05.