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 Hermitage Hill, Function Centre, Wellington on Tuesday 18 May 2021

The Committee met at 11:15 am

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Natasha Maclaren-Jones
The Hon. Walt Secord

The CHAIR: I welcome everyone to the fourth hearing of the inquiry of Portfolio Committee No. 2 – Health into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry 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 acknowledge the Wiradjuri people who are the traditional custodians of this land on which we are having today's hearing. I pay respects to Elders past, present and emerging of the Wiradjuri people and extend that respect to other Aboriginals who may be present today or who may be joining us on the live stream.

We are very proud to be able to announce that we are live streaming this hearing today. In fact, I am informed that this is the first time any Parliament in Australia has remotely live streamed a hearing; that is great news. I think it is very important and appropriate that the Parliament as it goes about doing its business, particularly with respect to this public inquiry, wherever it goes makes available the very best technology and facilities for participation by the citizens of the State. Today we will be hearing from a number of stakeholders, including local councils, private citizens, advocacy groups and health services. I thank everyone for making the time to give evidence to support the inquiry, particularly those who join us for the first session this morning.

Before I commence I would like to make some brief comments about the procedures for today's hearing. As I have mentioned, the hearing is being broadcast live via the Parliament's website. It is true that it is the first time and it is being treated as a trial to ensure that we can get any matters ironed out so that we can do this as we go around the State. A transcript of today's hearing will be placed on the Committee's website when it becomes available. Because this is a public hearing of the New South Wales Parliament, Hansard are with us. *Hansard* is the official record of the Parliament. In accordance with broadcasting guidelines, media representatives 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 they may make to the media or to others after they complete their evidence before us. 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 Legislative Council in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice, and that is perfectly acceptable. Written answers to questions taken on notice are to be provided back to the Committee within 21 days. If witnesses wish to hand up documents over the course of giving their evidence, they should do so through one of the Committee secretariat staff who will assist them.

Referring to the audibility of the hearing today, I remind Committee members and witnesses to speak into the microphones. There are two microphones: One is for the amplification of a voice in this room and the one on the tripod is for Hansard. Can people down the back hear me pretty clearly? If for some reason a witness is not audible, just put up your hand and I can ask them to bring their microphone forward. Obviously, that is not a problem at the moment. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing.

BEN SHIELDS, Mayor, Dubbo Regional Council, sworn and examined

ANIELLO IANNUZZI, Deputy Mayor, Warrumbungle Shire Council, sworn and examined

NEIL SOUTHORN, Director of Environmental, Planning and Building Services, Bathurst Regional Council, affirmed and examined

WARREN AUBIN, Councillor, Bathurst Regional Council, sworn and examined

The CHAIR: I welcome our first four witnesses who have joined us this morning. I will invite opening statements. Thank you for the time put into the preparation of your submissions. They have been received and processed, and they stand as submissions to this inquiry. As Mayor Shields would be aware, the Dubbo Regional Council's submission is No. 435. Warrumbungle Shire Council's submission stands as submission No. 382, and the Bathurst Regional Council's submission stands as submission No. 245. You can take them as read. You do not need to refer to them extensively in your opening statements. Members may well have questions arising from the content of those submissions. If you could set the scene for the inquiry with your opening statement and then, if you are agreeable, we will move between Committee members for questioning. We have a good cross-section of representatives from the broad range of members of the Legislative Council. I pass to Councillor Aubin for his opening statement.

Mr AUBIN: Thank you, Mr Chair. Would you like me to stand?

The CHAIR: No, feel comfortable to stay seated.

Mr AUBIN: I feel very comfortable.

The CHAIR: Thank you for asking.

Mr AUBIN: Bathurst Regional Council and our community at large have been and remain concerned about the inadequate level of health services to the Bathurst community. Bathurst is a beautiful city to live in. We do have quite a lot of people beginning to come our way to populate our city. A bit of background for you: In 2008, with the planning for our new hospital, the forecast population for Bathurst was 43,000 by the year 2036. The city population from the Australian Bureau of Statistics at June 2017 was 42,900, so we are about 15 years ahead of ourselves. That does flow into the size and the services that are offered at the hospital at the moment. Our population is forecast to reach 53,000 now by 2036, so that is a fair jump.

But with the advent of COVID-19 bringing about the work-from-home syndrome, we find a lot of city folk are already moving to the country. Who knows what our population is going to be in 2036? It could be way, way more than forecast. At the moment our combined population of the referral towns, Lithgow, Oberon, Blayney and Bathurst is just over 76,000. Our submission outlines how there is a potential for greater collaboration between health practitioners at Lithgow and Bathurst—public and private—that would enhance services available at each location. Can I just touch on the budget for our region?

The CHAIR: Please.

Mr AUBIN: The local health district [LHD] Bathurst budget for 2019-20 was $88.9 million, which was up about 2.6 per cent from the previous year, which is just touching on CPI; Dubbo, $138.2 million; and Orange, $151.1 million. That is the difference in our regions. Bathurst should be getting a much larger slice of that pie. We are way underfunded, and it shows in the service levels that are being offered at our hospital at this stage. The most defining of council's concerns centres on the reluctance of the LHD to recognise that concentrating resources on Dubbo and Orange in the current two-hub referral model of the LHD significantly disadvantages the community of Bathurst and undermines the status of treatment—broken bones are sent to Orange—for basic medical procedures. There have been a lot of facts put in this submission from people that have been sent for the slightest thing, like a dislocated finger and having to travel to Orange to get that fixed. That is just not on as far as we are concerned.

The CHAIR: Can I ask, Councillor, just for the people who might be watching this and are not familiar with the distance, roughly how long is that as a trip just in a vehicle? Just roughly.

Mr AUBIN: On a good run, about 45 minutes.

The CHAIR: Just for people at home who might not be familiar with the geography.

Mr AUBIN: I started an action group on my own behalf. I had surgery in Orange a couple of years ago and I came out of surgery at 8.40 on a Monday evening and when I was told I was fine they said I had to go home. I got transported up to Orange in a patient transfer vehicle; so I basically had to get my own way home, it was

approximately 9.00, 9.30 on a Monday evening, which was unexpected and I had nothing organised. This has been shown through a heap of different testimonials that this is almost the normal, which is a terrible situation. Further, a two-hub model disadvantages the status of Bathurst hospital itself and the capacity of both the public and private hospitals to attract new staff. They are being attracted to positions in Orange because of the scale of services occurring at Orange.

Bathurst hospital is unable to fully function as a training facility. These factors further accelerate the decline of services in Bathurst. It has come to pass, unfortunately, over the period of the last few years that we have lost a heap of specialties at the hospital and we are in dire need at the moment of respiratory medicine, we need cardiac services, there is no coronary care ward. Anybody in Bathurst—and this is a very scary statistic—that has a heart attack will be taken to the Bathurst Health Service and given initial treatment there, but then has to be transported somewhere else, usually Orange or further afield. Our community is saying that is not on. With a heart attack, which are a quite common occurrence, for the Bathurst community not to be able to have treatment in their own hospitals and to have to be transported away, with family getting involved in that sort of thing as well, it is a really poor situation.

Also, there is a huge need for a 24/7 orthopaedic service. As council, we bring a heap of beds to the city in Bathurst. We have five international motor racing meetings per year, plus every other weekend there is a sporting competition going on. We do not have orthopaedic services in the hospital at the weekend, so anyone that has a minor ailment that presents to the emergency department [ED] in Bathurst is straightaway sent to Orange, and that is just not on. Maternity, obstetrics and gynaecology—there is no neonatal intensive care ward; so anybody who has a baby and then has problems are again transported away. And, especially in that field, that involves mother, father, parents, grandparents, all having to travel away. So it is a big uprising in the family.

Basically we have a long list of needs—it is not wants; it is needs. These have to be filled. There is a major, profound lack of senior staff in Bathurst and the health service remains supported in key areas by locums and fly-in fly-out doctors. Approximately 33 per cent of the staff are locums, which brings little to no economic benefit to our city. If the reputation of Bathurst as an attractive town in which to live is damaged because of inadequate health care, the city will not attract new industry or business, and these downstream effects will leave it in economic decline. What a pity that the 2014 Hoyle report was not acted upon. In conclusion I will just give you a couple of lines and I will let the next speaker go. Council has been patient in waiting for long-overdue improvements to health services to the community in Bathurst. Frustration is escalating both in our council and especially in our community. Council hopes the inquiry can encourage the government of the day to prioritise this delivery. Thank you.

The CHAIR: Thank you, Councillor, for a very clear and strong opening statement. It has set the scene for us well on questioning shortly. Do any of you also have an opening statement, or has that been covered off by Councillor Aubin?

Mr SOUTHORN: Thank you, Mr Chair. Certainly Councillor Aubin has summarised it and the submission is there. If the Committee gives me an opportunity, I would like to talk about the economic impact and quantify some of that stuff that a lack of investment in health services creates.

The CHAIR: Did you want to do that in an opening statement or can we do that through questions?

Mr SOUTHORN: Can do through questions.

The CHAIR: Thank you. That would be helpful if we can do it through the questions.

Mr SOUTHORN: There is also one topic in the submission that goes to something not right in the system and I would like an opportunity just to talk through some of those concerns.

The CHAIR: Absolutely. Councillor Iannuzzi?

Dr IANNUZZI: Thank you for the opportunity. I am here representing the Warrumbungle Shire Council. We are a small council—not even 10,000 population; it is a difficult geography, it is a large geography. We have a very poor population in terms of economic measures and it is getting poorer. We have a high Aboriginal population and we have a lot of issues with respect to getting access to adequate health care. The problems we have heard mentioned by Bathurst are even more serious in our shire because even very basic things are getting transported beyond the surgical things we have heard mentioned by Bathurst.

We have four hospitals in our shire: we have Coonabarabran, we have Baradine, Dunedoo and Coolah. The latter three are, in fact, now called multipurpose services [MPS] rather than hospitals, but in many ways they still have to perform the functions of hospitals. Weekend and after hours it is very common to not have medical cover at three of those hospitals, and at Coonabarabran at times we struggle as well. So there have been times in our shire that there has been no medical cover throughout the shire. I think that is a very dangerous situation and

a very sad situation. I would hope that this Committee and its findings and its recommendations may lead to an improvement in the provision of health services to those most in need.

It is also worth noting that—it has already been mentioned—there is a problem in the system, there is a cultural problem. In fact, I think it is beyond a cultural problem; it is a governance problem. Your biggest problem in the health system in New South Wales is governance. Secondary problems are those of money and those of communication, but there is no point communicating well and spending bucketloads of money if your governance systems are not right, and I believe they are far from right. I think you need to look beyond the LHDs and look at NSW Health as an organisation—its top-down approach, its poor culture, its very managerial style, its inflexibility. If you can address those problems then you will give the LHDs the ability to do things and to be more flexible and more agile and, therefore, get the job done. As things stand at the moment, I cannot see any way of moving forward to improve these problems whilst NSW Health remains so at apart and so unaccountable. You really have a problem there that you need to fix. Thank you.

The CHAIR: Thank you, Councillor. If I could also, just for the record, acknowledge that you are a medical doctor. I think it is worth acknowledging that and to thank you for the particular insights you are able to bring through that training.

Dr IANNUZZI: I am here to represent the council, but yes I do have other roles. For the information of the Committee, I have been a visiting medical officer [VMO] in the Western LHD for 25 years. I have owned my own practice for 25 years. I have also got very intimate involvement in urban general practice. My wife and I own a practice in Cammeray as well; so we really understand the difference between rural and urban medicine. I am also a clinical associate professor at two universities, so I am heavily involved in medical education, and I serve on a number of important committees at the Federal level as well. At the LHD level I am heavily involved in training of hospital doctors, but that is a role that is about to cease. That is a concern in itself, and perhaps we can talk about that later.

The CHAIR: Thank you very much. I thought it would be useful to have that on the record to give us a particularly intimate perspective on the matters that we will be looking at this morning. Mr Shields, welcome.

Mr SHIELDS: Thank you, everybody. It would be remiss of me as the mayor of this area not to welcome you all to Wellington. I suppose it is ironic that we are meeting in a former Wellington hospital right now. I have very, very similar issues to the health situation in this area but very different at the same time. I feel as though I am wearing two hats because I am the mayor of Dubbo and also now Wellington, which was forcibly merged with Dubbo. The main issue I wish to raise with you today is the dire state of Wellington's health. This town services a population of 10,000, and living within it are 5,000 people, and yet there is only one doctor practising at Wellington Hospital.

We have a situation where Wellington does have social problems. We do have a low socio-economic population here in Wellington. It is not as easy for a lot of Wellington residents to simply get in a car and travel to Dubbo for medical treatment. They have to rely on GPs here in Wellington. Apart from the local Aboriginal Medical Service, which does a fantastic job here, we only have one practising GP. That is something which in my mind is appalling. I believe on the Federal front we have a massive problem with Medicare. It is obvious that we need a sliding scale with Medicare so a higher rate is paid to bush doctors and doctors in harder to reach locations, similar to what the State already does when it comes to teachers.

We should not necessarily be paying Medicare to some of those well-off areas of the State. It is not about paying more money into the health system; it is about making sure that what money is spent is going to the right places. There is so much anecdotal evidence here in Wellington that I could give you. If I put a call out to the community to "give me your health stories", I would be flooded probably with 200 in a day. I will give you the story of a young lady who turned up to Wellington Hospital. It turns out she had appendicitis. She waited all night.

The CHAIR: Is this a recent example?

Mr SHIELDS: This is a recent example at Wellington Hospital. She waited all night for a doctor. She was only just told that she had appendicitis early in the morning, so the best she could do to get to Dubbo with this appendicitis problem was to drive herself. That is unacceptable; it really is. It is really frustrating for me, as someone from Dubbo, as this newly merged council—effectively Wellington merged with Dubbo because there were a lot of social problems, there were a lot of problems with funding, and it was decided that to bring Wellington up it would be best if it were merged with Dubbo.

On the local government front, yes, Wellington is improving fantastically. There are so many new facilities that have gone into this place—everything from new pools to new tourist attractions. There is a lot more being spent on urban infrastructure. But I have to say, coming from the State, I do not necessarily see that same increase going into the bread and butter issues of Wellington. Again, only having one doctor here is unacceptable.

As much as they claim, "Oh yes, we are advertising, we are advertising", the reality is that they could get more doctors if they really tried. My frustration is that we are getting on with the job here in Wellington in turning it around. We have had a massive increase in development applications [DAs] coming in. In fact, for the last couple of years of the former Wellington Council there were next to no DAs going in; now we have dozens going in for Wellington. Wellington is on the growth, but I really need the State Government to come to the party too and help Dubbo Regional Council pull Wellington up even further. Thank you.

The CHAIR: Thank you. Before we progress to questions, it was remiss of me not to welcome the State member for Dubbo, Dugald Saunders, who joins us today. I understand he will be joining us tomorrow. Sorry, I should have mentioned it at the start—I passed over it—but you are most welcome, Mr Saunders. Thank you for making yourself available. We will commence our questioning, starting with the Opposition, the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you for your submissions. We have been through them and we appreciate them. I would like to start my questions with the deputy mayor of the Warrumbungle Shire Council. Are the examples provided in your submission genuine examples?

Dr IANNUZZI: Yes, they are.

The Hon. WALT SECORD: They are genuine examples. I just wanted to clarify that. In your submission you say there are four hospitals in the Warrumbungle shire. What hospitals are they?

Dr IANNUZZI: Coonabarabran, Baradine, Coolah and Dunedoo. The latter three are now classified as MPSs.

The Hon. WALT SECORD: Yes, I am familiar with that.

Dr IANNUZZI: But this is one of the things that we are dealing with here. It is this opaque governance, this failure to define things properly and to communicate well. Are they hospitals or are they MPSs? At times the doctors and the nurses are expected to perform to the level of a high-level hospital—someone comes in with a major trauma. At other times they are told, "You are just a nursing home, and you are not going to be staffed and resourced properly." We have got to address these issues.

The Hon. WALT SECORD: In your submission you say that there are four hospitals. You also say:

> It is not uncommon for the hospitals in [the Warrumbungle shire] to run out of basic antibiotics.

Dr IANNUZZI: Correct.

The Hon. WALT SECORD: What do you use antibiotics for? I know you are a professor, a doctor and a councillor. Just for the benefit of the members of the Committee and for people viewing the hearing, what are antibiotics?

Dr IANNUZZI: Antibiotics are used to treat infections.

The Hon. WALT SECORD: Do you not think that in fact it is extraordinary that four hospitals in New South Wales would not have antibiotics?

Dr IANNUZZI: I think you will find that more than four hospitals suffer this problem. I am not saying that there are not any antibiotics in the hospital, but antibiotics are complex and you need different antibiotics for different conditions. And, sadly, there are times—and those times are too frequent for my liking—where we run out of basic antibiotics to treat basic conditions, particularly after hours. Say a mother brings in a child with a throat infection or an ear infection. We have had times where we have not had even the basic antibiotics. I am not talking about antibiotics you use in the intensive care unit at Royal Prince Alfred Hospital. I am talking about basic things to treat basic conditions.

The Hon. WALT SECORD: You have run out of basic antibiotics at these hospitals, so what do you as a doctor do if you are in a hospital and you run out of antibiotics?

Dr IANNUZZI: You apologise to your patient, explain to them the situation and how regrettable it is. You send an email to management, hoping that they might address the problem. Sometimes it is addressed; sometimes it is not. You try to find alternative solutions. You hope that perhaps the pharmacy down the road might still be open and somehow you can find the antibiotic you need that way. Sometimes you choose a second- or third-line antibiotic that may not be as appropriate or as efficacious. That is just life as a rural doctor in a small town these days.

The Hon. WALT SECORD: Not by your own choice, you are forced to make do or to cut corners.

Dr IANNUZZI: Correct.

The Hon. WALT SECORD: We previously conducted hearings and heard evidence in Deniliquin and Cobar. In Cobar we were told that a number of hospitals did not have blood supplies. Do you have blood supply in the four hospitals that are in your shire?

Dr IANNUZZI: No, we do not, and that is a concern that doctors have raised for many years.

The Hon. WALT SECORD: So you have run out of antibiotics and you have no blood supply. Do you take emergency patients in those hospitals?

Dr IANNUZZI: Yes, we do. The issue of blood supply is complex, though, and in fairness the need to give blood and to carry blood is nowhere near what it used to be once upon a time. Having said that, Coonabarabran is on two highways and road trauma is not an insignificant problem on two highways, plus we have a national park and there is trauma there as well. I would have thought that perhaps having blood at one of the facilities in the shire might make some sense. What we do get though is this continual obstruction from NSW Health and the blood bank itself. It would be unfair to blame such a problem on the LHD itself. Now, I think the LHD could do a lot more pushing back against these policies that I do not think are serving us well, but these are problems that we see at the State level.

The Hon. WALT SECORD: But you do say that at times you have run out of antibiotics and there is no blood supply?

Dr IANNUZZI: The antibiotics problem is an LHD problem. It is an LHD administration problem at the pharmacy level. The blood problem is a State problem.

The Hon. WALT SECORD: You said there are times when there has been no doctor on call in those four hospitals in the shire. Does that happen very often?

Dr IANNUZZI: It is very rare because Coonabarabran almost always has a doctor. We fight tooth and nail to make sure we have doctors in Coonabarabran and the residents of the shire know that they can gravitate to Coonabarabran and be seen face to face. At times that comes at great personal sacrifice for the doctors in Coonabarabran because we end up carrying the can for the other towns in the shire.

The Hon. WALT SECORD: What do you mean by that? Do you find that you are doing extraordinary hours to support the community?

Dr IANNUZZI: Well, we all have lives. We all have families. For some of us our families do not live in the district anymore. There are study commitments and personal commitments. Sometimes, if the LHD cannot provide locums or find doctors or recruit enough, we end up having to modify our personal lives and our family lives just to make sure that someone is around to do the work.

The Hon. WALT SECORD: You talked about how three of the hospitals are MPS hospitals. Do you find that they are relying on telemedicine?

Dr IANNUZZI: They do rely very heavily on telemedicine.

The Hon. WALT SECORD: In your submission you say, "Telemedicine is a vexed subject"?

Dr IANNUZZI: Very much so.

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

Dr IANNUZZI: Telemedicine is a term that has become very common nowadays but it means so many different things, so you need to be clear on what you are talking about. Telemedicine in the community, with GPs working under Medicare, is one thing. Telemedicine as a specialist tool to reach out to remote patients is another thing. Telemedicine trying to keep hospitals afloat and keep emergency departments afloat is yet another thing and it is the most complex of those three that I have just mentioned.

The Hon. WALT SECORD: What is the wait time for an appointment with a GP in your shire?

Dr IANNUZZI: In the shire it is hard to generalise because each town has its own complexities and I would like to think that all GPs have systems in place where acuity can come into it. In Coonabarabran at the moment the waiting time has blown out to somewhere between one and two weeks. There have been times when it has been five weeks. There have been times when it is one day. It just depends on who is around and what is going on.

The Hon. WALT SECORD: Councillor Shields, we were told that there is a wait in Wellington of two to three weeks. Is that your experience in Dubbo?

Mr SHIELDS: Yes, it certainly is. There are a lot of people in Dubbo who are struggling to get a GP. It also is not helped by the fact that we have got so many new people arriving in Dubbo and moving to Dubbo. They find it very, very hard to get a GP. That is the basis of it and it is up to two to three weeks, yes.

The Hon. WALT SECORD: Two to three weeks. Does that impact on the hospital itself? Do people find themselves presenting with triage categories 4 and 5 at the hospital?

Mr SHIELDS: They are presenting to the hospital when realistically it should have been handled by a GP, so that does flow on to the hospital. But in defence of the Government, it has put a significant amount of investment into Dubbo health services. I honestly cannot stand here and just throw doom and gloom on the Government. Both the Federal Government and the State Government have put a lot of investment into health in Dubbo but not necessarily in the right areas and those basic health services, particularly here in Wellington, are being totally left behind.

The CHAIR: We will go past the time to conclude to make sure everyone gets about 10 to 12 minutes.

The Hon. EMMA HURST: I might move on to Councillor Aubin. You made an interesting observation in your submission that Bathurst Hospital seems to have difficulty obtaining and retaining staff even though other sectors in Bathurst do not have the same problems attracting staff. Do you think that that relates to the fact that it cannot function as a training facility—I think you mentioned in your opening statement?

Mr AUBIN: Yes.

The Hon. EMMA HURST: Is it also because it is missing services? What do you pinpoint as some of the issues there?

Mr AUBIN: From my perspective, I guess, the Orange hospital has really gone ahead leaps and bounds in numbers of staff and specialists. I think Neil Southorn can actually get some numbers for you on that, which are fairly damning. There is not a doctor that wants to train in an area where there is no support and that is what we find in Bathurst. They would much rather train in an area such as Orange or maybe even Dubbo where, if they are coming out into the region, there is actually support.

The Hon. EMMA HURST: What do you mean by support? What sorts of functions?

Mr AUBIN: Well, other doctors to bounce off and that sort of thing. There is just nothing. I can quote numbers. In obstetrics and gynaecology, it has to or it should have four specialists operating in that department and we have got one. We cannot do any training there. In the emergency department it is the same thing. There is not a major doctor there—a Fellow of the Australian College of Occupational Medicine, or FACOM—so therefore there is no training facility there; nothing at all. That is what we need in Bathurst to actually get the hospital starting to build again, is to get some training facilities started. We really need the actual training facilities and for more doctors to take up positions in Bathurst. As you say, why can they not? We get a lot of feedback from doctors in the hospital saying it is a cultural thing in the hospital. There is a problem in the running of the hospital, the bureaucratic side of it, and that is where the problem lies. We really need to get more in for a medical health centre rather than a bureaucrat centre. I feel that is where the problems lie. But if you want to get Neil Southorn to quote you some figures there, if that is—

The Hon. EMMA HURST: Yes, I thought it might be a good opportunity to go back to something that Mr Southorn said in his opening statement about the financial impacts, which I think would probably relate to that other question as well. Could I get you to speak to that?

Mr SOUTHORN: Thank you. I have some data from the Australian Department of Health which goes to its health workforce data of 2019, and that is divided into Central West local government areas. One of the indicators is the number of medical practitioners per 10,000 head of population: Bathurst has 32.3. The New South Wales benchmark is 44.6. So Bathurst has minus 12.3 compared to the benchmark per 10,000 head of population. Orange has—and I have no problem with Orange having the right level of service but it is the distribution of that service—77.7 medical practitioners per 10,000 head of population. If you translate that to the population of the local government area rather than per 10,000 then Bathurst is minus 53 medical practitioners for the population against the New South Wales benchmark and Orange is plus 141. Dubbo is plus four—so, on the benchmark.

Of course, the regional cities operate for a population catchment that goes beyond their local government boundary. But if the population of Lithgow is added to the population of Bathurst as part of a broader catchment—and the Lithgow community is served by the Nepean Blue Mountains Local Health District and not the Western NSW Local Health Districts, but if it was then that would be minus 102 medical practitioners compared to the New South Wales benchmark. We all have a lot of sympathy for and we worry about our more remote and smaller colleagues in local government in New South Wales, but this is Bathurst, a premier regional city and it is still not anywhere near the New South Wales benchmark. Pharmacists—Bathurst, minus 15, compared to the New South

Wales benchmark. Orange, plus 19. Physiotherapists, minus 16; dentists, minus 10. Nearly every category of medical service is, by that benchmark, under-serviced.

If those 53 medical practitioners were in Bathurst to bring it up to the New South Wales benchmark, that would create 94 direct jobs, using the National Institute of Economic and Industry Research methodology; that would have an economic impact of $8.7 million every year. There is a jobs multiplier because every one of those professional positions brings a ripple effect through the local economy, through the New South Wales economy and through the national economy, and that would create 137 additional indirect jobs. It is not just the human side of these issues; it goes to the economic welfare of the community as well.

Ms CATE FAEHRMANN: What has been particularly shocking with some of the evidence we have heard so far, as well as submissions, is not just the fact that regional and rural health services do not seem to be meeting the needs of the population, but there also seems to have been a deliberate winding back over a number of years or decades of those services. I point to your submission, Dr Iannuzzi. You state in your submission that there is evidence of the deliberate stripping of equipment and medication in Coonabarabran hospital. You state that the LHD has deliberately stripped from the hospital surgical instruments, obstetric labour beds and cardiotocography machines. Would you care to expand on that?

Dr IANNUZZI: Yes. I arrived in Coonabarabran 25 years ago and the level of instruments and the level of beds and services and what we were allowed to do was significantly more than it is now. Sadly, these downgrades happened with no communication and no consultation, which is doubly sad because on the one hand we keep getting told, "Oh, yes, we're having meetings. We want to consult. We want to work as teams." But sadly, it does not happen that way. This is what I mentioned earlier about governance; the governance is shocking. There is no point having meetings and no point pretending that you are consulting. There is no point having health councils if they are not going to be listened to and if they are not going to have any ability to effect any change.

Ms CATE FAEHRMANN: Just to be clear on this: You just used the word "downgrade", so a decision is made to downgrade services to remove things such as certain surgical instruments.

Dr IANNUZZI: Yes.

Ms CATE FAEHRMANN: Is that because there was less need and therefore a downgrade was necessary because there wasn't any need for the service?

Dr IANNUZZI: No, I am not talking about that. I am talking about basic things that are still in need—basic surgical instruments. I am not talking about things that are used for open surgery in a theatre. Of course, if we are not doing those things, those things do not need to be in our hospital. But things like basic suturing equipment so you can repair lacerations, things like instruments to remove foreign bodies from ears, noses and eyes—these are basic things that were there. Doctors come in good faith and nurses come in good faith expecting these things and knowing those things are there, and then you turn up to work one day and they are literally gone.

Ms CATE FAEHRMANN: You are saying basic equipment like suturing equipment has been taken from the hospital because the LHD has deemed that doctors do not need to use them anymore—that they don't want patients stitched up at that hospital? This is extraordinary information.

Dr IANNUZZI: Again, I think it is dangerous to politicise this and I think it is dangerous to blame this necessarily on the LHD. These are NSW Health policies that then get thrown in front of us to bamboozle everybody. The excuse for the surgical instruments would be as follows: "Well, we can't sterilise them in Coonabarabran and Coonabarabran is not a surgical facility, therefore they should not have this level of instruments." They are basic instruments—instruments that you would find in any GP practice. Instead they give us these cheap and nasty disposable instruments that are very hard to work with. I have had situations where patients have come into the emergency department with lacerations and I have literally gone down to my office to bring back decent instruments so I can repair the laceration, or the patient gets sent to Dubbo, or the patient gets sent to the office. It is ridiculous that such a thing has to happen, and the same can be said in many small rural hospitals.

Ms CATE FAEHRMANN: Has the medical staff requested that you be provided with the basic level of surgical instruments when you found out that they were taken away?

Dr IANNUZZI: Many times we ask and many times we are told we are not a surgical facility or we cannot—there is always an excuse and there is never anyone that takes responsibility. This is what I am saying about the governance; there is no chain of command. It is all opaque and there is no-one ever responsible for anything. This is a really bad governance issue that you have and you need to fix it. Unless you fix it, you can spend all the money you like; it is never going to get better. This is why doctors and nurses disengage, because they feel like they are not important. They feel like they are just cogs in a big wheel in a big machine and they are

not taken seriously. The patients are the ones who lose out, ultimately. At the end of the day, if a doctor—particularly doctors who are not invested in communities—has patients who come in like this, they will just say, "Okay, get in an ambulance and go to Dubbo. There is no point in me wasting my time and getting stressed about it." The patient is the one who loses out.

The Hon. WES FANG: Just back on the point around surgical instruments and the like, it is not your testimony that there isn't anything in the hospital that can actually perform those procedures. It is that instead of having the instruments which require cleaning and the decontamination that you would see in a larger facility, you have the one-time use items that will do the same job. Is that correct?

Dr IANNUZZI: They might do the same job sometimes, but not all the time.

The Hon. WES FANG: So even though you have a preference for the use of those ones, there are still those items in the hospital to do the job. It is that they are a single-use item as opposed to a re-use item, is that right?

Dr IANNUZZI: There has been a deliberate downgrading of the instruments. You cannot do fine repair of lacerations with cheap and nasty disposable instruments. It is just not possible. If I had some here I could show you, but there are times when you need good instruments to do the more fine work. Sadly in some of these hospitals—Coonabarabran is where I know best—they were there once and now they are not there anymore. It is very silly that—I do not think there is any good business case and there is no good clinical case to explain why such things have happened.

The Hon. WES FANG: I understand that. I just wanted to make sure that people understood, who are watching this today, that there is still the ability to get, say, suturing done at the hospital. They may have got the opinion that it was not available.

Dr IANNUZZI: No, no. We are not pretending that there aren't any instruments at the hospital. What we are saying is that the instruments that were once there are not there and the instruments that we now have are not as good.

The Hon. WES FANG: I understand. Thank you for that. Mr Shields, you said that Wellington could be in a better position to move ahead if the hospital was better staffed with doctors.

Mr SHIELDS: There is no doubt about it. If there was a young family, for example, thinking Wellington is the place to go—they might be skilled parents, which we desperately need—once they get wind that the Wellington hospital has only one doctor, they quickly have a different attitude to wanting to move to Wellington. The biggest concern that I have when it comes to that one doctor is, as I said before, we do have a low socio-economic population here in Wellington who cannot necessarily get in the car and drive that 45 minutes to basic health services.

The Hon. WES FANG: I have some great news. We have been to the hospital this morning and we met with the staff and the management there. They have employed more doctors. We have full-time, 24-hour-a-day cover, with doctors in the hospital for 10 hours a day at least for the hospital—

The Hon. WALT SECORD: Sorry, were you at a different hospital?

The CHAIR: Order! I just think we need to be very clear about what we were told this morning.

The Hon. WES FANG: Yes, let us—

The Hon. WALT SECORD: That is not what we were told this morning!

The CHAIR: No, let us—I think it is like—

The Hon. WES FANG: Walt, I know the stunt you want to try to pull, but let us make sure that the facts are on the table here. I just want to make sure that we have those—

The CHAIR: I think the confusion was between you saying "24 hours" and then "10 hours".

The Hon. WES FANG: There is coverage 24 hours a day and, as I said, there is a doctor in the hospital for 10 hours a day. There are now four doctors employed at the hospital.

The CHAIR: That is a proposition that I think is a bit different from what we heard. In any event—

The Hon. WES FANG: Okay.

Mr SHIELDS: May I respond to that?

The CHAIR: Please.

Mr SHIELDS: It should not take the mayor and the chamber of commerce president of Wellington to go around and get 1,200 signatures to embarrass the health service and the Government to get those extra doctors. It should have already been there.

The Hon. WES FANG: No, they were already employed. Anyway, that is—

The Hon. NATASHA MACLAREN-JONES: Can I jump in? Just in relation to staffing, I wanted to get your opinions, particularly from the interaction you have had with local doctors. I understand, Councillor Iannuzzi, you conducted a forum with eight doctors or so. But I am interested to hear—in your opinion or from them—why we are having challenges in getting GPs—and I understand that it is a Federal issue. However, the flow-on impact is if we do not have local GPs and they go to emergency if there is not a local GP available 24/7. In your opinion, what more can we do? I know we have settlement packages and things, but what incentives can be given to get GPs to move to regional areas or to stay in regional areas?

Dr IANNUZZI: It is a topic that could take many days to answer properly. Money is only part of it, but money is certainly an important part of it, so let us talk about that first because that is the thing that you can fix probably most easily and most immediately. At a State level you have the settlement package and it has fallen way behind. It is so far behind now that it is not worth our while, unless we are true believers, to certainly do any VMO work during office hours because we definitely lose money. Then, after hours, we have to weigh up whether the money is worth the massive disruption it causes.

The Hon. NATASHA MACLAREN-JONES: If possible, could you just do a bit of a breakdown—or I am happy for you to take it on notice—so that the Committee has an understanding of what the salary is and what the money is?

Dr IANNUZZI: GPs in small towns get two funding streams, you could say. You have your office practice—your surgery—where you get money either through Medicare bulk billing or the patient pays you a private fee and then the patient gets the Medicare rebate. That is one stream of income. The other possible stream of income is your VMO work, which in New South Wales traditionally is on a fee-for-service basis. You get paid a fee for being on call and then a fee for service, depending on what you do. If you are not working, you do not get paid. If you work, you get paid. The fee varies depending on the time of day and what is wrong with the patient. Treating an emergency is paid more than treating a basic problem; getting called out at midnight is paid better than getting called out at 10.00 a.m.

That package has served the State very well and it continues to serve the State very well. I do get very concerned when I keep hearing from all sorts of quarters that somehow fee for service is failing. Fee for service is not failing. Fee for service is agile, it is fair and it can get to places that otherwise would not be penetrable on a salaried or blended payment-type system. That agility and that flexibility is really important. However, there has been a failure by NSW Health to engage well enough with rural doctors to address the obvious holes in the package that develop over time as clinical needs change, as expectations change and as the technology changes. There is a massive need to do a one-off indexation, I would say, of 20 per cent to 30 per cent at least to get us competitive again against the locums and against the doctors in the offices.

But we also need to address the red tape and the different expectations that technology—in particular, the computerised health care—has brought. For example, one thing that the rural doctors have been lobbying for is to have an acknowledgement that when you admit a patient and discharge a patient there now is a lot of paperwork that is expected of us that was not the case 30 years ago when that package was set up. We now have to load all the medications onto the computer. We need to do admission reconciliations. When a patient goes home we have got to write discharge letters and send them to relevant parties. That all takes time. You cannot expect that the standard fee of a five- or 10-minute consultation on a ward round or a basic emergency department patient is adequate compensation for that. It is little wonder that doctors are choosing not to do the work because we see this obstinate approach by NSW Health. They just say, "No, no, no." Their default is just to say, "No, you can't. No, you can't." Of course doctors are going to get upset and of course they are going to go for a walk and not come back. That is what you are seeing now.

The Hon. WALT SECORD: I will be really quick. I would like to speak to the two gentlemen from Bathurst. In your opening statement you said there were 42,900 people in Bathurst.

Mr AUBIN: In 2017.

The Hon. WALT SECORD: There would be more than that now? How many people do you reckon are in Bathurst now?

The CHAIR: Approximately.

Mr AUBIN: Approaching 45,000.

The Hon. WALT SECORD: In your evidence you said there are no neonatal services in Bathurst. A community—

The Hon. WES FANG: No, he said neonatal ICU—

Mr AUBIN: No, intensive care.

The Hon. WALT SECORD: Because I was going to say to you that neonatal is intensive care for premature and sick newborns.

Mr AUBIN: Correct.

The Hon. WALT SECORD: Just so we are all on the same wavelength. Again, what was the population that you estimated in the city of Bathurst?

Mr AUBIN: Now?

The Hon. WALT SECORD: Yes.

Mr AUBIN: About 45,000.

The Hon. WALT SECORD: What does that mean to the community of Bathurst if there are no neonatal services? Do you have a situation where—

The Hon. WES FANG: No, no.

The Hon. WALT SECORD: —mums and bubs are split up, separated?

Mr AUBIN: Yes, that was what I was saying. Exactly. If there is a problem in birthing then the whole family is separated.

The Hon. WALT SECORD: What happens? Does the mum stay in Bathurst and the baby goes to Orange, Dubbo or Sydney? What happens?

Mr AUBIN: I think the mother usually goes with the baby but fathers, grandparents, sisters, brothers are all left behind. It should be a time of happiness and celebration. But if something goes wrong in a birth, obviously it is distraught. To have the family separated in that time is just not on. With the city of Bathurst growing at the rate we are—we are one of the fastest-growing cities in regional New South Wales. We are trying to attract people to our city. We want people to come and live in our city. But if they find this sort of thing out, especially young families, that is probably enough to deter them not to come. In my statement I did say that the demise of the health system could be the demise of our economy.

The CHAIR: Just to balance it off, I invite a Government member to ask a final question.

The Hon. WES FANG: I have one on that subject. Councillor Aubin, do you know how many neonatal intensive care units [NICUs] there are in New South Wales?

Mr AUBIN: Sorry?

The Hon. WES FANG: Do you know how many neonatal ICUs there are in New South Wales?

Mr AUBIN: I do not, no. I would not know. Do you?

The Hon. WES FANG: Well, I used to work—

The Hon. WALT SECORD: Do you?

The CHAIR: Just so we are clear—you know what I am about to say—this is a gotcha sort of thing. You do not set things up quite like that. You know what I am saying here, Mr Fang.

The Hon. WES FANG: I was married to a paediatrician and I used to fly for Child Flight, so I used to come and pick up kids and take them to the—

The CHAIR: Is there a question coming?

The Hon. WES FANG: Sorry?

The CHAIR: Is there a question coming?

The Hon. WES FANG: There are four NICUs in the State, including Canberra. Places like Wagga Wagga and Orange do not have them either. It is such a specialist—

Mr AUBIN: I think you will find Orange does.

The Hon. WES FANG: A tertiary retrieval centre? There are four.

Mr AUBIN: I thought Orange did.

The CHAIR: That is a point made. Natasha, do you want to—

Ms CATE FAEHRMANN: That is their question done, surely?

The CHAIR: Very quick. Last one.

The Hon. NATASHA MACLAREN-JONES: I have a question in relation to the role of nurse practitioners and whether or not you think there could be great opportunities for recruiting of nurse practitioners in our rural and regional hospitals.

Mr AUBIN: Absolutely. You only have to look at—you go back to the number of beds in the hospital to the number of beds that are actually in the hospital that are serviced. We would like to see every physical bed in that hospital serviced. Because of the number of nurses who are employed in our hospital, there are obviously beds just sitting there unused. I have a letter here that was sent to me by a doctor from Bathurst. He is a VMO. It states exactly—his conclusion was that Bathurst hospital needs more beds. Evan at this time of the year, before the flu season has even hit, the worsening bed crisis is happening now. We had a bed block even last weekend. It is happening all over the State, I know, but to actually be happening in our city and our hospital is quite distressing for us. We find that operations are being put off because they have not got the beds to put patients in after the operation. So it needs to improve. We really do need improvement in this situation. It is just rubbish as it is.

The CHAIR: Councillor, I will need to draw a line there.

The Hon. WALT SECORD: Can we get a copy of that letter, if it is not private correspondence.

The CHAIR: We have finished the questioning. We have gone well over. I have given some latitude given the, dare I say, high quality of the evidence coming from the local government representatives and Dr Iannuzzi's medical expertise. A question has been raised about the letter referred to by Councillor Aubin. You do not need to make a decision on that now. There may be some material in it that needs to be redacted. It might be a private letter, I do not know. The Committee secretariat can give you some guidance about that and how you might make it available, if you wish to do so.

Mr AUBIN: We were looking at doing, after this meeting, a quick submission for the facts that may have been missed that we can put in.

The CHAIR: May I suggest that the Committee secretariat gives you guidance in regard to matters that might be related.

Mr AUBIN: Yes, that is fine.

The CHAIR: Gentlemen, thank you so much. As I said, I deliberately went over. I know not all Committee members are happy with that. That means it is going to come out of our lunch break, so don't worry. We could talk for longer, I am sure, but there is a limit. I expect there are some questions on notice and if you are agreeable the Committee secretariat will follow up on questions that were taken on notice but also supplementary questions that may arise after members have read the Hansard transcript. Thank you all very much and I appreciate the thoughtfulness of your submissions and the quality of your evidence this morning.

(The witnesses withdrew.)

SAMANTHA GREGORY-JONES, Registered Nurse, NSW Nurses and Midwives' Association, sworn and examined

SHEREE STAGGS, Registered Nurse, NSW Nurses and Midwives' Association, sworn and examined

The CHAIR: I welcome our next set of witnesses. I apologise for the lateness of calling you, but we will not crimp your time to much. I undertake to do that. Thank you for your respective submissions and, in some instances, follow-up submissions that arose from further information provided. They have all been processed and stand as submissions to the inquiry. I invite both of you to make an opening statement. Could you keep them reasonably tight. Your submissions contain the substance of what you want to say, so you do not need to repeat that per se. It would be most productive if you could keep your opening statements reasonably tight and then we can open up the questioning. Are you happy with that?

Ms SHEREE STAGGS: Yes.

Ms GREGORY-JONES: Yes.

The CHAIR: Thank you.

Ms GREGORY-JONES: My name is Samantha Gregory-Jones. I am a registered nurse [RN] at a small facility in the Central West. I have been working at this facility for 3½ years and have attained multiple roles. I work in a class D community hospital which provides an acute service, which includes10 acute beds, two emergency department [ED] beds and an ambulatory care service. The facility is very old, poorly designed, insecure and includes multiple buildings which are filled with asbestos. The facility was opened in 1922 and has only had minor refurbishments due to the community disagreements regarding its heritage status. As the only registered nurse on duty, I am often working in the separate emergency department in isolation. I am a proud and respected member of my community who believes that just because we are privileged enough to live in a rural area, we still deserve the state-of-the-art care which the system has promised us.

The CHAIR: Thank you very much. That was very precise, very tight and to the point.

Ms SHEREE STAGGS: Good afternoon, inquiry members. As a member of the NSW Nurses and Midwives' Association, I thank you for the opportunity to speak about my experience working as a registered nurse in a rural multipurpose health service. Nurses are vital in providing safe patient care and I appreciate you listening to my concerns today. The facility I work in has eighteen permanent residents, one respite bed, 12 acute beds and three emergency beds. Nursing staff for these 34 beds are two registered nurses, one enrolled nurse and two assistants in nursing [AINs] for the morning and afternoon shifts.

The night shift has one registered nurse, one endorsed enrolled nurse, or EEN, and one AIN, and a security officer is available for some night duties but not every one. The health service includes dialysis, community nurses, community midwives, an early childhood nurse and an Aboriginal health worker. These positions are not full-time. Our health service manager is working across two more facilities and our nurse manger has no dedicated clinical hours since the health service manager has been shared across three facilities. Gilgandra lies at the intersection of three highways and is 65 kilometres north of Dubbo. It services multiple smaller rural towns and localities which have no hospital or medical service.

Some years ago we lost eight hours of nursing hours in the acute ward on an afternoon shift followed by another eight hours on the morning shift a few years later. Once these permanent hours were removed, there were less people to call when needing to escalate for an emergency or increased bed numbers. This then compounded the ability to take more admissions. If there is no-one to escalate to, then we cannot admit and our bed numbers stay down. It has been a downhill spiral. Essentially six beds have been unofficially closed and are now known as surge beds. Those 16 hours in the acute ward was an endorsed enrolled nurse and was essential when dealing with an emergency and maintaining nursing care to the acute patients while the RNs managed an emergency. Since this change one or two staff members from the aged-care ward need to leave their patients to help in ED and acute when we are busy, leaving residents with inadequate supervision and care. The impact of this is further compounded on night duty when only three nurses are rostered to work across the entire facility.

We recently required staff from other health services to come and work our unfilled shifts. It is a big ask to come and work in a facility that is unfamiliar to them. The nurse manager is also often required to attend to clinical care to cover the shortfall in the roster. If you cannot fill empty shifts or sick leave and staff that are already on overtime, who can we escalate to? As a branch, we have requested, through our reasonable workload committee, an increase in nursing hours and to change the escalation plans. Our requests were rejected, as on paper the numbers do not allow for increased staff from what it is today. However, the rural nurse does many tasks that are not direct clinical care and I am not sure this was taken into account.

In larger facilities there are staff employed to do these tasks, such as wardsmen, social workers, pathology and the ordering and unpacking of nursing and pharmacy supplies. We wheel in the videoconferencing unit and sit in on consultations with a virtual doctor when no doctor is on call. We leave the acute and ED wards to check medications and attend clinical reviews in the residential aged-care ward, leaving a nurse alone back in the ED and acute. After hours we change the oxygen cylinders over when they run out. We answer every phone call. We replace staff when someone calls in sick. We do all of this on top of our nursing care that is required by our patients and residents.

Finally, the supply budget is too low. We often run out of supplies, so we borrow from other health services. We try to use alternatives and we try to conserve where we can safely. Medical supplies like dressings, incontinent pads, infusion equipment, oxygen masks and many more are expensive but are necessary to provide safe and effective care to our patients. I argue that $3.57 per bed per day is not enough to provide adequate care. This could also be said for the community health supply budget. Rural nurses live and work in our communities and by the end of our shift all we want is to have provided safe and efficient health care to our patients and residents. Increasing nursing hours and the supply budget are some of the first steps in providing adequate and safe care for rural people in New South Wales.

The CHAIR: Thank you, Ms Staggs. I acknowledge and thank the NSW Nurses and Midwives' Association for their participation in this inquiry.

The Hon. WALT SECORD: Thank you both for what you do. Thank you for your dedication. Ms Staggs, you mentioned that you work at Gilgandra MPS.

Ms SHEREE STAGGS: I do, yes.

The Hon. WALT SECORD: And Ms Gregory-Jones, you work at?

Ms GREGORY-JONES: Canowindra hospital.

The Hon. WALT SECORD: You mentioned, Ms Staggs, that at your MPS you find that you are forced to borrow and ration—you are nodding in agreement too, Ms Gregory-Jones. Both of you are saying the same thing. You are forced to ration and you run out of incontinence pads. Tell us the things that you run out of.

Ms SHEREE STAGGS: Most of the emergency and life-saving equipment we do not tend to run out of. We do not need that very often. We need that only on occasion and generally we have that and we only need it in small numbers. It is the everyday stuff like the incontinence pads or the dressings and the suture equipment sometimes. Often what you want is not there. We have had to borrow incontinence pads over a weekend from the other aged-care facility in Gilgandra, which is not run by NSW Health.

The Hon. WALT SECORD: Would you have to have medical staff hop in a car, drive there and get them and then come back?

Ms SHEREE STAGGS: It is close enough that we walk. We usually meet in the car park.

The Hon. WALT SECORD: You meet in the car park.

Ms SHEREE STAGGS: Yes. And sometimes they have had to borrow stuff from us, at times. But more often it is us from them.

The Hon. WALT SECORD: If you run out of these supplies, how does that impact on your patients?

Ms SHEREE STAGGS: It depends on what we are running out of, but it can be anything. I can give you an example. If one of our aged-care residents has a skin tear, which they knock the top of the skin off, they need a dressing. The staff will come to their storeroom to find the right dressing. If it is not there, they might come up to the community health cupboard if this is after hours and try to raid our supplies. If we do not have it there, which sometimes we do not, they will find an alternative. But that might delay wound healing. It might then mean that the dressing has to be changed more often. That can cause pain for the patient and it means there is a possibility of more infection. It also just takes longer to look in all the cupboards of all the places that they might be stocked, to get lucky.

The Hon. WALT SECORD: Ms Gregory-Jones, do you have similar example?

Ms GREGORY-JONES: Yes. It is a common occurrence for us that we run out of antibiotics, unfortunately.

The Hon. WALT SECORD: You run out of antibiotics also?

Ms GREGORY-JONES: Yes. We are stocked by a hospital that is located 30 minutes away from us. We do not have our own pharmacy department. We do our own store's ordering, which goes to this location and

they send it across. So we can only order on certain days. If we, for example, have a patient, and we have a limited stock—for example, a regular medication we use might be cefazolin.

The Hon. WALT SECORD: What is that for?

Ms GREGORY-JONES: It is a very common antibiotic which you might just use for a general infection or a laceration or anything. Just two days ago we had three patients on this medication and were only allocated from the pharmacy two boxes. That only lasts us one day. We had to contact the RNs at this other hospital and get them to deliver it. Sometimes it might be a nurse from that hospital driving past us who might drop it. Sometimes we have had somebody who is in IGA who we know is in this location pop past and grab it for us because we cannot leave the building to get it. Otherwise, if we cannot organise a way, sometimes the courier will bring it the next morning at one o'clock in the afternoon. Otherwise, the patient misses out, unfortunately.

The Hon. WALT SECORD: You used a word in your opening statement—you said that the hospital was also insecure. What do you mean by that?

Ms GREGORY-JONES: We do not have a security guard. After hours, there may be myself as the registered nurse and one enrolled nurse. We do not have a security guard. Our emergency department is accessed by a swipe card but everything else is not. We have doors inside the building which—you can just walk out the door from inside. They are not locked from the inside. Nobody can get in but anybody can get out. So often whilst we are running the ward, we can have a dementia patient who walks out the door. A couple of weeks ago we had someone who walked out the back door at three o'clock in the morning while two other nurses were attending patient care. There was a very soft alarm that alerted them. The patient was out and consequently had a fall. It happens commonly. Anybody can just push the door and out you go. We have had another patient who during handover was unsupervised because the patient was in their room having their breakfast. Unalert to us, he was down the alleyway. He just walked out the building while nobody was watching. It happens.

The Hon. WALT SECORD: I noticed this one thing, that neither one of you have mentioned doctors at any point.

Ms GREGORY-JONES: Yes.

The Hon. WALT SECORD: Do you have doctors in your hospitals?

Ms GREGORY-JONES: We are very lucky. We have three doctors who work with us, but they are on a rotating roster. They are not with us 24/7. They will come in for a triage 1 or a triage 2. If they are a 3, a 4 or a 5, we do most of the treatment ourselves. Then the doctor will be contacted as alot of the diagnostics is done via telephone.

The Hon. WALT SECORD: Not even by telemedicine but by telephone?

Ms GREGORY-JONES: Telephone. We ring them and they might say, "Yes, send them to wherever for an X-ray, you can put the cast on, you can give them this medication." And then they will ring at the other end, "Okay, I have got the results. It is broken", "not broken." So we are doing the treatment and we rely on the diagnostics from them, who are in their own practices looking after their own patients at the same time.

The Hon. WALT SECORD: Do mistakes happen?

Ms GREGORY-JONES: I am sure they might. Nothing too drastic has ever happened. We are all very well-trained nurses, we are all very experienced and we have obviously great clinical judgement. But it opens a big door of mistakes. It definitely does. Particularly when the one registered nurse has also got 10 patients on the ward plus the emergency department.

The Hon. WALT SECORD: Ms Staggs, do you want to add anything to that?

Ms SHEREE STAGGS: We are very similar. We, most of the time, have doctor coverage. But there are days, and sometimes up to a week, where we will have to use the virtual on-call remote doctor through the videoconferencing. At night after, I think, eight o'clock we go to the virtual system so our doctors are not working for a week straight, 24 hours a day. If they are in town on that day, if we had a triage 1 or 2—a good emergency—we could call them and they would come. But that is if they are on call and they are in town on that day.

The Hon. WALT SECORD: You may have heard—I do not know if you have or not—that previously we held hearings in Deniliquin and Cobar and there were several examples of support staff at the hospital—tea ladies and cleaners—assisting with patients. Have you found yourself in similar situations where you have had to have support staff in the hospital support you?

Ms SHEREE STAGGS: It has not happened as often it sounded like with some of those submissions but, yes, we have. It is actually written in our escalation plan for emergency departments. Once they have utilised

other clinical staff, like community nurses or the educators who are only there business hours, they may need to use non-clinical staff. We have had non-clinical staff helping out in aged care or on the ward if necessary.

The Hon. WALT SECORD: Have you had similar experiences, Ms Gregory-Jones?

Ms GREGORY-JONES: We have. Fortunately it is not too commonly occurring, but I would have many examples of it happening. There is one example I would like to share, though, where a patient attended the emergency department. He was acutely unwell but he was also aggressive. It was very fortunate that it was daytime because otherwise it would have just been an absolute disaster. That meant our HASA or health—what do you call them? A health and security assistant. We do not have a full-time security officer but we have a health and security assistant. It was fortunate enough that he was on duty that day and came to assist us. But we relied on virtual health to assist us in this incident. Our security officer, or HASA, was himself injured. We had to wait 20 minutes for police to arrive, so unfortunately we had to restrain this person.

The Hon. WALT SECORD: Who restrained the patient? You?

Ms GREGORY-JONES: Whoever was available. As unethical as that may be, we had to do what we had to do for our safety. The paramedics were with us and the nurses. We just had to protect ourselves. We were put in a very terrible position. We spoke to the virtual health assistant. We have got a camera that they can see what is happening. They watched the incident unfold and because, when the police arrived they were happy that this patient was secured, they let us wait. They said, "That is fine. It is not urgent. You are fine." It was five hours for this patient until he left, which resulted in two nurses being taken off the floor, which then meant our administration officer—an old lady—was on the floor answering the buzzers, taking the patient to the toilet, so were the cooks, while the health service manager was called in from another facility to ring around staff to get them to come in early for their shifts because there just was nobody available. It happens.

The CHAIR: There is still a little bit of time.

The Hon. WALT SECORD: I can continue.

The CHAIR: No, you can come back for a second bite, but what I am saying is it will be the time issue. You have basically got 4½ minutes.

The Hon. WALT SECORD: Okay. I want to go back to the sharing of supplies—

The CHAIR: We will not be coming back now. We will not be circling back.

The Hon. WALT SECORD: Okay, no, circle and then I will—

The CHAIR: Right. Okay.

The Hon. EMMA HURST: You cannot have both.

The Hon. WALT SECORD: Circle.

The CHAIR: Yes. Deputy Chair?

The Hon. WALT SECORD: I want my second bite.

The Hon. EMMA HURST: Thank you both for coming today. Ms Gregory-Jones, I am following on a bit from questions from my colleague about the insecurity of the building. You talked a lot about the insecurity for patients, but you also mentioned in your opening statement that you are often working in isolation as well. I am also following on from the example that you just gave. What sort of insecurity is there for staff that are working in these hospitals?

Ms GREGORY-JONES: The only securely locked area is the emergency department. Our nurses' station is not lockable. There was another incident only maybe a month ago where there was a patient who was aggressive and unwell who forced the staff to go inside the nurses' station. Unfortunately they could not lock the doors. The patient was trying to get through the doors. They had to put some chairs on the doors whilst they waited for the ambulance. They rang the emergency services and they said, "I am sorry, this is not urgent, so it is going to be a 30-minute wait." In that time they sat there and they waited whilst this patient was aggressive. It is all surrounded by glass as well, so the patient had the blood pressure machine and was hitting it on the window trying to break the glass. They just tried to sneak out and lock all the fire doors and seclude this person while we waited. We have asked for swipe access to all of our areas, but that so far has not been approved because the system, the building itself, is just too old and it will not support it. But it is a work in progress.

The Hon. EMMA HURST: In the example that you gave just before you said, "Thank goodness it did not happen at night." What would have happened? Would it have been a situation like that with one nurse trying to lock themselves away?

Ms GREGORY-JONES: Yes. I suppose the only difference is we would not have had that security member. At night it would just be myself or whoever and one other person, so there is no security. After 6.00 p.m. all the cooks and cleaners, everybody is gone.

The Hon. EMMA HURST: Are you worried for your personal safety each time you go into work?

Ms GREGORY-JONES: Yes. Sometimes you go to the emergency department door and you do not know what you are going to walk in to, and you walk in there by yourself. I could give you a multitude of examples. Just over the weekend I was just working with my colleague. We have had eight patients on the ward; a few of them are rehabilitation patients, so they need to be moved with two or three assistants. Then I had four patients in the emergency department, so I had to leave my colleague, leave my patients, attend to the emergency department on my own. I cannot hear what is going on in the ward. When I walk out of the ward, there are alarms going off, which I cannot hear in the emergency system, because there is a patient who is trying to leave the building who has got dementia and nobody is there to watch them.

The Hon. EMMA HURST: Wow.

Ms GREGORY-JONES: Yes.

The Hon. EMMA HURST: With the understaffing as well and the issues surrounding that, what kind of pressure are you guys feeling on the ground if you wanted to take holiday leave or sick leave?

Ms GREGORY-JONES: Immense pressure. I can tell you a very personal story. Just this weekend my two-year-old boy was burnt. I was the registered nurse who was treating him. I had to watch him be the patient. I was on duty. Nobody else could come and cover; it was eight o'clock at night. Him and his father turned up at the emergency department. I had to treat him like anybody else when he is just, "Mummy, mummy." Sorry mate, I am your nurse. I had to do his blood pressure. I had to rip the skin off his wounds, treat him, give him medication because nobody else was there.

We did not have appropriate dressings, so we had to drive yesterday to Westmead Hospital. I was then told I was not allowed to be with him because only one parent could be with him, so I had to sit downstairs outside in the cold and listen to him via video just screaming in pain. Then we had to drive back last night; we got home at midnight. Then we were told that obviously he cannot go to day care for a week. I now have to break it to my boss that I cannot work for a week, which means somebody else will have to—I do not know who. We have got four registered nurses and we are all there.[1]

The Hon. EMMA HURST: You have all got each other's back.

Ms GREGORY-JONES: Yes, exactly.

The Hon. EMMA HURST: But at the same time, when something happens it is just very stressful. Ms Staggs, do you have the same experience?

Ms SHEREE STAGGS: I have actually stopped taking extra shifts in the emergency department. I have a Graduate Certificate in Emergency and I have been a nurse for 20 years. I used to love working in the acute ward and the ED. I moved from Dubbo to be with my husband in Gilgandra and I have a young family. Once they started taking hours away, I did not feel safe and I did not feel that I could do my job to the best of my ability because I did not have the backup that I once did when I had that extra nurse. I have not done a ward shift since last year after one shift that I just felt I could not do it safely, and I am not putting my registration forward anymore. I work in the community, nursing part-time, and I used to pick up some extra shifts to help when someone calls in sick or when someone is on holidays. I do not feel I can do that safely anymore, so I have stopped doing that.

The Hon. EMMA HURST: Fair enough. In the association's submission there was a lot of talk about on-call nurses and doctors having to travel a long way to the hospital. For the benefit of the Committee, have you experienced that as well where you have had to look for somebody that was far away who would have to come in and the pressure that that puts on the staff while they are waiting for those people to be able to come in and fill last-minute placements?

Ms SHEREE STAGGS: Some of our staff live over an hour away on properties or in other towns. But we have had to get staff from other health facilities to fill our vacant shifts when someone has called in sick or had an unexpected family member issue that they needed to be off for and we could not cover it with our own casual staff or our own part-time staff. The nurse manager often does her shift and then does an overtime shift; so

[1] In correspondence to the committee dated 23 June 2021, Ms Gregory-Jones corrected her answer to "We have got six registered nurses and we are all there".

there is someone that is trained in ED to be there to triage, because not every registered nurse in our facility has that emergency experience. It is a big ask to come from Bathurst or Dubbo and you have never stepped into Gilgandra, to just hit the ground running and take over and you are in charge of the entire facility—34 beds. And that has happened—

The Hon. EMMA HURST: Without support because it is already understaffed. Is that what makes it so hard for somebody to step in, because sometimes you might be working in isolation?

Ms SHEREE STAGGS: Yes, that, but also like for us we have got 19 aged care residents who have a very dedicated team of AINs and ENs looking after them and know them really well; they treat them like their own family. But when something goes wrong with them these nurses are coming in, they do not have any of their background history, and to try and figure that all out in their notes and actually know that patient really well and do best for them, as well as trying to run an emergency department with multiple patients as well as an acute ward, that is a big call for a registered nurse who works there all the time, let alone someone that has never set foot in that facility and does not know where the bathroom is. You have come and got handover, "This is where things are", and that is it. They might have support from one other registered nurse, but that is usually a junior or an inexperienced registered nurse.

The Hon. EMMA HURST: Thank you.

Ms CATE FAEHRMANN: Thank you both for coming in and giving evidence today, and thank you for the work you do and for the frankness and honesty of your evidence, which I think is really important and probably particularly difficult in smaller communities to do so. I am sure I can speak for everybody in saying how much we appreciate that. Ms Staggs, a couple of times now you have mentioned when the permanent hours of work were removed or when they started taking hours away. Could you expand for the Committee on what that is and when that was?

Ms SHEREE STAGGS: I have tried to find the dates but I was not, I guess, paying much attention. I had young children, I was working part-time, but I remember how it felt when they first decided that—I think it probably goes back to we had a couple of GPs that were regularly in town and the 12 beds were full often, and once they left, or they stopped taking patients and did not do on-call anymore because they are working down to retirement, our bed numbers were not full all the time and that then impacted. They said, "Well, you're not full all the time now so you don't need those eight hours a day." That was on the afternoon shift.

I am just talking about acute and ED; this is not residential aged care—their staffing numbers have not changed at this stage. It went from two registered nurses and an enrolled nurse down to just two registered nurses. Some afternoon shifts, if you are having a good shift it is manageable, but if a lot of patients come into that ED you have got one nurse trying to look after multiple ED patients, or someone that is critically sick, when you really need those two registered nurses looking after that patient, and you have still got your other patients on the ward. So sometimes we have to call the aged care staff to come and help us either in emergency or on the ward.

We struggled with that and we found it okay, and then in the last couple of years they have now taken that third staff member from the morning shift. Any nurse can tell you that morning shift is probably the busiest shift—people need showers, you usually have to call other health services to arrange transport or to go to Dubbo for a CT, you are dealing with family members, you are doing their admissions, you are doing their discharge, you are doing a doctors' round, all while ED patients can come in. That is 16 hours a day we do not have now that we used to have.

Ms CATE FAEHRMANN: Because you also said that six beds have been unofficially closed at Gilgandra, that it is an MPS, is that right?

Ms SHEREE STAGGS: That is right. They are unofficially closed; they have been deemed as surge beds. When I put my submission in it was four. So we have got 12 acute beds. They made four surge beds, which meant when we got really busy and we had more admissions we could open them if we had the right number of staff.

Ms CATE FAEHRMANN: You are shaking your head.

Ms SHEREE STAGGS: We do not have any extra staff to call in. Sometimes we admit over that number, but in the last six months it has been deemed that eight was too high a number so they have made it six. So there are essentially six beds there that we try not to use because we do not have the staff to staff them.

Ms CATE FAEHRMANN: If you had the patients there that needed the beds, you still could not use the beds because you do not have the staff?

Ms SHEREE STAGGS: Essentially, that is the way it should work, but we are not going to turn patients away. So we might have an extra two and we will try to do our best, but it is not ideal and it is not safe.

Ms CATE FAEHRMANN: Ms Gregory-Jones, do you have any comments in relation to the questions I have just asked as well?

Ms GREGORY-JONES: We are in a bit of a similar position. When I said earlier that we have got 10 beds, we are staffed for 10 beds. We have got physically 15, but they are the same there—surge beds you could call them. So we are only staffed for 10 but we have physically got 15. In saying that, we will not turn patients down. Sometimes we might have 12 patients. We will use our escalation plan—that does not mean we will get anybody, so it might still be those same two nurses looking after 12 patients plus the emergency department.

Ms CATE FAEHRMANN: What reasons have been offered maybe to you or what do you believe are the reasons that there has been what seems to be a systematic winding down of resources? Is it because there is not the need for it? Ms Staggs?

Ms SHEREE STAGGS: We have not really been given any reason other than when they have done their staffing review the bed numbers are not as high as, I guess, they once were, so we do not need those extra staff, or those staff that we once had. I have not really been given an explanation.

Ms CATE FAEHRMANN: Does it seem to you that there have been decisions made to reduce the staffing and resources for some reason—a clear decision has been made by the Government?

Ms SHEREE STAGGS: This has been happening over the last 10 years at the most. They have just reviewed and said, "Your numbers are not there. You don't need that staff member. You've got to find a way to work without that eight hours a day."

Ms CATE FAEHRMANN: This is a parliamentary committee looking into, obviously, health services. What would you say now in terms of what you need to make your hospital where you work sustainable for the workers, the people who work there?

Ms SHEREE STAGGS: I think for our facility—and every facility would be slightly different because it depends on their bed numbers and their set-up—we need those 16 hours back. But I would also say we need a fourth staff member in Gilgandra on night duty, and I can give you an example of why. I was a patient on night duty. I do not go to hospital unless I really need it. I had to wait at the front door for the nurse to come and get the doorbell—there must not have been security that night; I did not see the security guard. That is okay, I knew that that would happen.

She came and took me down to ED. There were two other patients there; so she had three patients in the emergency department, plus her acute ward. The other two staff members from the aged care facility had to come and help her triage, do obs on me and the other two patients that were there, and then we got seen by the virtual doctor. They were frantic for that hour until I was stable. They did a wonderful job; I felt I got good care. I do not know who was looking after the other patients, I could not see that. They were there with me and the other two patients in ED.

Ms CATE FAEHRMANN: With the aged care, for example, nobody was looking after them, were they?

Ms SHEREE STAGGS: Someone probably came for five or 10 minutes and they may have not been, and then one would have gone back. But they are working on their own and if they did not come and help this nurse she would be on her own looking after emergency patients and the acute patients as well.

The CHAIR: Which Government member would like to start?

The Hon. WES FANG: Thank you very much for coming today. Ms Gregory-Jones, it is phenomenal that that you have gone to Westmead and back and then come here today. I thank you for doing that. We greatly appreciate it. I hope your son will be okay. I want to talk about the supplies issue. Is it about a delay between ordering and delivery or is it a timing issue like you were talking about with the pharmaceuticals that are only delivered on certain days? What do you think we could do to assist in making sure that the required stocks are in and at hand?

Ms SHEREE STAGGS: I think I can answer. Are you okay to answer?

Ms GREGORY-JONES: I think it is difficult because some days two boxes of an antibiotic is fine but the next week it might not be because three people who need it come in. So it is a really difficult thing. But the fact that we only have a pharmacy two days a week on a Monday and Thursday means that we have to be very forward in preparing. But we cannot predict the future, so it is very difficult, yes.

Ms SHEREE STAGGS: There are two issues. One is logistics because if we order on a Monday we might get it by Friday. Sometimes it might miss the truck or I don't know what happens, and we might not—

The Hon. WES FANG: How often do you get a delivery?

Ms SHEREE STAGGS: Twice a week, on Tuesdays and Fridays.

The Hon. WES FANG: Where does it come from?

Ms SHEREE STAGGS: I think it all comes from Sydney or Orange. It depends probably on the item. If it is a normal supply, it is a bit quicker. Sometimes we have to order stuff that is non-stock for more specific things. So that is one issue. The other issue, I have done the ordering for the hospital for the nursing supplies before, and I had to cut my order down. I always did the full order and then every time I have to cut it back to the budget. One time I had to cut it back by over $1,000, and I would have liked the stuff that I cut off; I just had to reduce the numbers. So we got a bit of everything but probably not really what we wanted. And it ebbs and flows. If I have six patients one week but I have 12 the next week, the budget is the same. One week maybe we will not run out of things because we have only had a very quiet week and there have not been patients with multiple drips. How much equipment you are using depends on what is wrong with the patients. The aged care facility mostly is pretty standard probably, but they do not always get the right dressings.

The Hon. WES FANG: Sorry, as in they deliver the wrong ones?

Ms SHEREE STAGGS: No, sometimes the ones we need are not there. They are not the most appropriate or best practice. And the community health budget, we are always running out of things. You probably find the same.

Ms GREGORY-JONES: Yes.

The Hon. WES FANG: So it is not so much an issue really of delivery and timing; it is just being able to predict what items you might need in the future with the patient care that you have to provide.

Ms SHEREE STAGGS: I think we can probably predict mostly what we need because it tends to be the same things most of the time but it is: When are we going to need it? If I do not have a burn this week, I have a bit of a supply there in case we do. But if I have used that up and I end up with two or three patients with burns, we will run out. And if we order, there is that delay, so we will try to find something else or we will borrow from another facility like Coonabarabran or Gular or somewhere else, yes.

The Hon. WES FANG: Obviously, it is our job to make sure we report back and provide recommendations. So I was just curious as to how you thought we might best be able to tackle some of these issues. Thank you very much for your insights.

The Hon. LOU AMATO: Thank you both for the great work you do. For the benefit of the Committee, can you tell us about the level of palliative care, particularly in relation to pain management?

Ms SHEREE STAGGS: I do quite a bit of palliative care in my community health work. I look after patients at home until they need to come into a facility, so I deal with the GPs, their own GP, to do that. But in the hospital we have one palliative care bad. Mind you, all the residential aged care patients, if they were at the palliative part of their life, we would just nurse them in the bed that they already have. Pain relief for palliative care patients depends on the doctor prescribing and the ability of the nurse to advocate on the patient's behalf—whether their pain relief is managed well or not. We have access to palliative care services. They will do a review and recommend changes in medications if things are not working. Has that answered your question?

The Hon. LOU AMATO: Yes. I was wondering how the level was out there and whether people were going without.

Ms SHEREE STAGGS: I think most of the time we provide good palliative care, but we do have some difficulties with doctors, especially if you get locums who maybe are not comfortable with ordering strong narcotics to help people's levels of pain and agitation.

The Hon. LOU AMATO: I only ask the question because of its relation to some of the other supplies you are short of. I was hoping it was not the same case in relation to the pain management of those in palliative care, that is all.

Ms SHEREE STAGGS: There have been times if someone has been on really strong, high levels of pain relief medications when we have had to get a staff member who was shopping in Dubbo to pick up some supplies from the pharmacy there to bring out so that we have enough. That happens from time to time, yes.

The Hon. NATASHA MACLAREN-JONES: I have two questions. One relates to nurse practitioners. I am a former nurse, so I am a big fan of them. I asked the previous witnesses about nurse practitioners. One of them indicated that, yes, there is a greater need. I am interested in whether you can elaborate on one of your recommendations, which is about seeing an increase in nurse practitioners, particularly in rural and remote areas, and how that would work.

Ms GREGORY-JONES: I think it is an absolute necessity. I myself would love to become one of them. It is one of my inspirations. As I mentioned earlier, a lot of the nurses, we are FLECC-trained, so we have first line emergency care courses. A lot of the treatment, because our doctors are not available, we are giving that treatment and just relying on the diagnostics. I think it would be financially very beneficial for the Government to be employing nurse practitioners instead because we are actually there. We are there on the floor; we are not at our own practice down the road. I think it is also great for the community. There would be the potential to run clinics for minor things as well, which would take the pressure off the GPs as well because there is no capacity for more patients in the clinics at the moment. And with the population growing and people moving a bit further west, we are seeing a bit of an increase in the need for people to find GPs. Unfortunately, that means more emergency presentations for simple GP things.

The Hon. NATASHA MACLAREN-JONES: Are there any challenges that you see relating to having nurse practitioners in the fact of placements but beyond, actually saying, "This position is reserved for a nurse practitioner"?

Ms GREGORY-JONES: I guess finding people who actually want to come out and do it, the education, like if they would have to travel to Sydney or things like that, and the funding.

Ms SHEREE STAGGS: Also, I think that nurse practitioner would have to be on top of the nursing staff that you already have.

Ms GREGORY-JONES: Yes, that is right.

Ms SHEREE STAGGS: That would be replacing the doctor. If you cannot get doctors, could we get nurse practitioners? It would be nice to know we could.

The Hon. NATASHA MACLAREN-JONES: Yes. The other question relates to the first recommendation about Aboriginal community-controlled health services and increasing access for Aboriginal people. Could you elaborate on what you mean by "community-controlled"? I am happy for you to take that on notice if you want.

Ms GREGORY-JONES: Yes, I am happy.

Ms SHEREE STAGGS: I have not put that in my submission. That is probably from the union. Yes, we will have to take that on notice.

The Hon. NATASHA MACLAREN-JONES: Yes, that is fine. That is no problem at all.

The CHAIR: Government members still have time. We are being scrupulous about this.

The Hon. WES FANG: I will ask briefly about the pharmacy issue. If you need something urgently, is there a method of transporting stuff urgently to you from where the pharmacy is located. Where is it?

Ms GREGORY-JONES: Our closest is in Cowra, so that is 30 minutes away. Our second option, our after-hours option, is Orange. Our emergency system is we wait for the courier, which comes the next morning. That is it.

The Hon. WES FANG: Other than the antibiotics issue that we have covered, do you tend to run out of much stuff or are you pretty well-stocked normally?

Ms GREGORY-JONES: I think we are pretty well-stocked. We do have quite a good range of pharmacy. When I say we are broad, we have a lot of stuff but it is very basic stuff. So any specific medication that people are on we do not have, including insulin. We do not provide insulin, so it is the expectation that patients bring their own. Sometimes the patient comes in with a medication that we do not stock. It is a basic rule that if they are being transferred from a different hospital then, during our handover, we will ask them, "Can you please bring this medication? Because we do not have it." And if it is Friday night at nine o'clock then we cannot get it until Monday.

The Hon. WES FANG: What about schedule 8 [S8] drugs? Do you do the checking between the two of you?

Ms GREGORY-JONES: Yes.

The Hon. WES FANG: So if the patient is written up for those S8 drugs, you are actually able to give them to them? There are no issues with that?

Ms GREGORY-JONES: Yes, that is fine.

Ms SHEREE STAGGS: The issue sometimes is time.

Ms GREGORY-JONES: Yes.

Ms SHEREE STAGGS: If there are only two of you on and it takes two of you to go and get this drug—and it is not a very quick process because you still have to do the checks and balances. If they are both in the pharmacy doing that then who is looking after the patients? That could also be said when I have got an emergency patient who is going to be ventilated while we wait for a retrieval and who needs S8 medications, I have—

The Hon. WES FANG: When you say ventilated, do you do that intubation?

Ms SHEREE STAGGS: I do not do intubating. But if the doctor has they need countable drugs to do that process.

The Hon. WES FANG: So you will have a doctor there as well then?

Ms SHEREE STAGGS: Yes. Or even if I needed to give them morphine for their fractured leg, I have to leave that patient and walk 30 to 50 metres up to the pharmacy and I have to find another staff member to come and check it with me. The same could be said in aged care, which is through another door. When they need their pain relief for their regular pain or their breakthrough pain or their palliative care type pain, because there are no registered nurses there the majority of the time, I have to leave the acute and ED patients to go and administer that. At eight o'clock in the morning, during that round, there might be five or six of those patients needing five or six different medications. I am over there for half an hour. We might not always run out. In our residential aged care the patients' medications come from the local pharmacy, so we have to arrange scripts. Sometimes we run out of things because the script has not been done and we have to chase the doctor to get that done and then it has to come up from the pharmacy.

The Hon. WES FANG: So you mean the doctor has not actually written the—

Ms SHEREE STAGGS: Has not actually—so they have done the medication order up where we administer it, but they have not actually written the script like you and I would get for antibiotics. There are two systems: one for aged care and one for—

The Hon. WES FANG: One for the acute?

Ms SHEREE STAGGS: —the acute, yes. They are done differently. So it takes a lot of time to manage and to make sure that we do not run out of those scripts and medications for those patients.

The Hon. WES FANG: Thank you for your insights.

The Hon. WALT SECORD: Ms Gregory-Jones, I just want to get this correct, which MPS are you employed at?

Ms GREGORY-JONES: Canowindra. We are not an MPS. We are an acute service.

The Hon. WALT SECORD: You said that there is no insulin at your—

Ms GREGORY-JONES: Yes, we have insulin pens but it is an expectation of the pharmacy that we do not routinely stock them. We have to order them specially. Due to patient safety, it is basically bring your own.

The Hon. WALT SECORD: So you have to order insulin or it is BYO insulin?

Ms GREGORY-JONES: Yes, correct.

The Hon. WALT SECORD: Ms Staggs, in your earlier evidence you talked about the difficulties of ordering and things like that in budgets. If you were properly funded then you would not have to cut corners and you would have supplies, is that correct?

Ms SHEREE STAGGS: Yes.

The Hon. WALT SECORD: Does the same apply to you, Ms Gregory-Jones?

Ms GREGORY-JONES: Yes.

The Hon. WALT SECORD: So you are forced to cut corners on what you order in for the patients because of budgetary constraints?

Ms SHEREE STAGGS: Yes.

Ms GREGORY-JONES: Yes.

The Hon. WALT SECORD: You spoke earlier about being called upon to do things in your service. Do you find that you are doing things that you never expected that you would do as a nurse—things that you are called upon to do?

Ms GREGORY-JONES: What do you mean called upon?

The Hon. WALT SECORD: I guess, procedures or treatment or pain relief and things like that. I am sure that it is a vocation and you want to continually upskill and get better so you can provide services, but do you find that you are doing things that you never expected that you would be called upon to do?

Ms GREGORY-JONES: Yes. Sometimes it is nine o'clock at night and I am assisting with an X-ray or I am putting casts on. I never thought I would be doing those kinds of things.

The Hon. WALT SECORD: Why do you find yourself in that situation? Is it because there is just not enough staff?

Ms GREGORY-JONES: Because there is nobody else available to do it and for the patient's benefit and the patient's safety we will do whatever we can to make sure that they get the best treatment. One of our medical officers is able to X-ray. We only have X-ray two days a week. But sometimes—if it is a small child, to prevent them having to travel the 45 minutes or an hour to Orange—we will do it after hours. But it is myself or the doctor or whoever is in charge who will be doing all those things.

Ms SHEREE STAGGS: I think you need to remember that not everybody can travel 45 minutes—

Ms GREGORY-JONES: No, that is right.

Ms SHEREE STAGGS: —to go and get a cast on or an X-ray. Some people do not have cars or the money for fuel or they have got three kids and no support. So how do they take the injured child and three others to an emergency department? Yes, sometimes we can organise an ambulance or hospital transport but they then have to find their way home at the other end.

Ms GREGORY-JONES: And organising things like an ambulance, putting them on the portal, doing all the administration stuff—

Ms SHEREE STAGGS: It takes time.

Ms GREGORY-JONES: —I did not see myself doing that.

The Hon. WALT SECORD: Do you find yourself also personally supporting people?

Ms GREGORY-JONES: Definitely.

The Hon. WALT SECORD: Doing work like social work and that kind of thing?

Ms GREGORY-JONES: Definitely, yes. We have a social worker who works in our town—I think once a day.[2] She works offsite, in the community. We do not have social work services or things like that, so we are doing lots of extra roles.

The Hon. WALT SECORD: Thank you for your time and thank you for your help today.

The CHAIR: I have one quick question. Ms Staggs, you talked about palliative care and specifically about pain management. But of course palliative care, particularly at the very end of life, is much more than pain management. It is also deals with medication to help the patient deal with anxiety and distress. Were you also encompassing that in your comments about palliative care? In other words, are you saying that medication beyond basic pain management medication, such as medication to deal with the stress and anxiety, is not available and it really is just dealing with pain management?

Ms SHEREE STAGGS: No, it is not that it is not available. I find it harder with palliative care to get what I would perhaps recommend for symptom management. Because sometimes it is not dangerous drugs like pain relief. Sometimes it is other symptoms like breathlessness or anxiety or urinary retention. There are lots of different symptoms. Some doctors are very good at it and some doctors are not sure about it but they are willing

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[2] In correspondence to the committee dated 23 June 2021, Ms Gregory-Jones corrected her answer to "We have a social worker who works in our town—I think once a week".

to take advice from us or palliative care services or other doctors. But sometimes we really struggle with other doctors to convince them that this patient is in pain and does need more than what has been ordered at the moment. But there are rules around ordering these medications.

The CHAIR: Yes, they are very powerful.

Ms SHEREE STAGGS: So some of them are a bit more reluctant. I think we give great palliative care at Gilgandra. I think the struggle is just trying to balance the doctor's experience or knowledge and what we want for our patients, and what the patient wants and needs.

The CHAIR: Yes, there is a lot to put into balance there.

Ms SHEREE STAGGS: So it is not particularly that we are running out, it is just trying to get a—

The CHAIR: No, I was not suggesting it would run out, but you had specifically mentioned pain relief and I was wondering about the medications to deal with the other aspects such as anxiety and distress and the like. Thank you both very much. Your evidence has been very enlightening and it has been great to be able to ask you questions to elucidate what was in the submissions. Nurses are very much at the coalface, to use a cliché, and your examples today give us deep insight into just how close to the coalface you are. We would like to thank you very much for the wonderful work you do for your communities.

(The witnesses withdrew.)

(Luncheon adjournment)

HAROLD SANDELL, Former President, Rotary Club of Warren, sworn and examined

ALISON CAMPBELL, Member, Warren Health Action Committee, affirmed and examined

KITTY EGGERKING, Member, Gulgong Petitioners, affirmed and examined

KATHRYN PEARSON, Member, Gulgong Petitioners, and Private Citizen, sworn and examined

SHARELLE FELLOWS, Member, Gulgong Petitioners, and Private Citizen, affirmed and examined

The CHAIR: This afternoon in our first session after lunch I welcome a number of individuals who can bring some firsthand knowledge and information regarding matters of health and medical services in and around the area. Please relax. I know this is probably for some, if not all of you, your first parliamentary hearing.

The Hon. WES FANG: That is what I said; we don't bite.

The CHAIR: Yes. We're all friendly, so to speak. Some people are going to ask you questions; in fact, many people will. Just answer the questions as best as you can. We are very pleased to have you this afternoon. Thank you for your submissions and for making yourself available to come this afternoon. It is much appreciated. For the record, with respect to the people at the table, a number of submissions have been formally made to the inquiry. They have been processed and stand as submissions to the inquiry. You can take it that those submissions have been read by all Committee members. In making your opening statements, which I will invite in a moment, there is no need to go through what is in your submission in detail. Rather, perhaps set up an overview and particular salient points that you would like to make and then we will open up the hearing for questions. I understand, Mrs Campbell, that you will be making the opening statement, and that it is effectively a joint opening statement.

Mrs CAMPBELL: Correct.

The CHAIR: Would you make your statement.

Mrs CAMPBELL: On behalf of Warren Rotary and the Warren Health Action Committee, thank you for the opportunity to speak on one of many health issues in our community of Warren. We are located 550 kilometres north-west of Sydney and 125 kilometres west of Dubbo, which is our nearest regional centre. We have many gaps in our health services that seem to be getting wider. Some two years ago, with the support of our Federal member and the Warren Shire Council, Warren Rotary took a lead role in trying to establish a 10-bed, dementia-specific unit with a respite facility within the Warren Multi Purpose Health Service. To date we have had very little success and Rotary's lead role has now been taken over by the Warren Health Action Committee, strongly represented by many stakeholders in our community, including the shire.

Dementia is the single greatest cause of disability in older Australians and accounts for 52 per cent of all residents in residential aged-care facilities. It is the second leading cause of death in Australia at present. The Warren community fundraised and built Calara House some 25 years ago as a low-care facility, with the emphasis on creating a homelike environment. It later became part of the current MPS, with a written agreement at the time that there would be no loss of amenities to the existing and new residents. With the introduction of Aging in Place by the Federal Government, Calara House is now attempting to cater for high-care residents, which it was never designed for. It is not a dementia-friendly environment and this makes it more stressful on all residents and the dedicated staff who work there.

Our request for a dementia-specific unit is not a suggestion that we create a separate area and lock the more confused residents away. Rather, we are asking for a purpose-designed area in the MPS that allows more security, more privacy and, at appropriate times, more interaction with the other residents. Warren's population aged over 65 is greater than the State average and our median population is five years older than the State average. By 2025 it is estimated that 318 people per day will be joining the population with dementia in Australia. Warren needs more residential aged-care beds and they need to be of a smaller care environment and dementia specific, as this has been proven to increase the quality of life, reduce rates of depression and reduce hospitalisations for people living with dementia in residential aged care.

Frail, elderly residents also need to remain within their community with their extended families. Sending residents to Dubbo or elsewhere is not a viable option for these people. It causes great distress for the resident and their families in the most vulnerable stage of their life. They have spent a lifetime giving to their community and deserve to remain living within their community. Warren is a can-do community and, as we have done many times in the past, would support the development of a dementia-specific unit with a respite facility. The local Country Women's Association have time-barred funds available for our aging community and action is needed now. We have to also change the way we are attracting and upskilling our local health and aged-care staff if we are going

to staff this unit. We need greater communication and cooperation with our local health district because the current model is not working for the Warren community.

The CHAIR: Thank you. That was a very clear and precise opening statement. I am sure it will be the basis for questioning from Committee members. Doctor, would you like to make an opening statement?

Dr EGGERKING: I had better make it clear at first that I am not a medical doctor; in fact, my only experience of hospitals was as a young woman being a psychiatric nurse, which then meant that all doctors in hospitals were salaried employees of the Government. I came to Gulgong two years ago, went to the local MPS and said, "What do you offer?" They said, "No, we don't have many services here. You're in the bush now. In fact, get used to it. Don't speak out."

The CHAIR: Can I just ask: With respect to the Gulgong Petitioners, which include the three of you, what was your discussion between yourselves? Will there be a single opening statement that you would make? Because you are from the one organisation, it would be very unusual for us to have three opening statements.

Dr EGGERKING: Well, given that the other two have put in their own submissions, I was presuming that each would make their own statement.

The CHAIR: That is a fair point. They are separate submissions. I understand the point you are making. Each will be provided with an opportunity. But given there is a degree of overlap, if you could bear that in mind. Please proceed.

Dr EGGERKING: I will be very brief.

The CHAIR: Take your time. I don't want to rush you, but just bear that in mind.

Dr EGGERKING: No, that's fine. Unlike other country towns, Gulgong at least is fortunate enough to have a medical practice with two GPs, but for more than three months our MPS was without a doctor. Ms Fellows and Mrs Pearson started a petition and that, along with some media attention and the terrible death of Dawn Trevitt, eventually led to a new contract for the previous visiting medical officer [VMO]—our local GP Dr Yahya—to be reappointed. We are lucky to have Dr Yahya, though we do not believe that the arrangement is sustainable.

How he can continue to run his busy practice and be on call at the MPS remains to be seen. In the past week cracks have begun to show, if an outburst on the local community Facebook is any indication. In our opinion, the current VMO system is unworkable. We believe that there should be at least one full-time doctor at every MPS whose salary is paid for by the Government. On another matter, we three would be willing to serve on the Gulgong Health Council if the terms of membership were changed. At present members are forbidden from speaking out, which therefore means there is no point being a member.

The CHAIR: Mrs Pearson, would you like to make an opening statement?

Mrs PEARSON: I am a petitioner, but I also sent an individual submission.

The CHAIR: Yes, indeed.

Mrs PEARSON: I am a community member. We have a business in the main street. When we started our petition we dropped it off outside the IGA every morning—that was my job. We followed it with a submission box—I am sure you have all read—inviting people to tell of their experiences with telehealth at the local MPS. We were very concerned that we did not want the staff down there to feel criticised. It was a very difficult line to tread. But that box went up after our petition closed, and because I took the box up every morning and got it back at night so many people were stopping me in the street—I could hardly get a few steps. They were telling us about their stories. I am glad we have got three voices here because we really need to be telling these stories.

The difficulty we found was that along with our petition we were lobbying members of Parliament. We were writing letters to the health department and to our local health district. We kept coming up with resistance and the message that everything is fine—"Everything is great with our system." We started our petitions in September. On 25 September I got a letter back from one of the directors of Health in the southern section—I am a little bit unsure of her title—stating they have had no adverse results from the use of telehealth in Gulgong hospital. But we had documentary evidence to the contrary. Sadly, that was after a local community member had died there with just the telehealth doctor. To say that there have been no adverse outcomes related to the use of the virtual rural generalist service, or VRGS, at Gulgong was not true. Up until the present time that has been the line that the health district people have taken.

Only a couple of months ago Ms Fellows and I went to Dunedoo. They are not in our local health district but it is a very close town. They were having a public meeting. It is not easy to get people to go to a public meeting

in a small town unless they are really fired up—and they were. We sat in as outsiders but we were there to support. People got up and spoke; it was heartbreaking. The panel consisted of two doctors, one who had a vested interested in telehealth and another who was a person from the local health district and was based in Dubbo. They did not take their stories on board. To a person, they responded to that community meeting with, "Everything's fine. You are so lucky here. You have got a great little doctor"—but she was there 16 per cent of the time. One man worked it out. He got up said, "For the entire week she is here 16 per cent of the time." She went on maternity leave in May. I do not know what has happened up there to replace her.

But these people's stories were so bad we could not believe that nothing had happened between the time we started our petition and this public meeting. Everything was still the same. Nobody was admitting that there was a problem. We had sent off our letters and sent off these submissions that were put in the box. I got a letter back from the acting CEO of Western NSW Local Health District. He described our accounts as "unjust, inaccurate and uninformed commentary". We were insulted; we were outraged. They were true stories!

The CHAIR: Who said that, sorry? Who signed that letter, or who wrote that letter?

Mrs PEARSON: The acting CEO of Western NSW Local Health District.

The Hon. WALT SECORD: Do you have a copy of that letter?

Mrs PEARSON: It was 18 November. I do have a copy of that.

The CHAIR: What is the person's name, could I ask? Who was the person?

Mrs PEARSON: Sorry?

The CHAIR: What is the person's name?

Mrs PEARSON: Am I allowed to say his name?

The CHAIR: Yes.

The Hon. WALT SECORD: Yes!

Mrs PEARSON: His name is Mark Spittal.

The CHAIR: That is fine. I am not familiar with the gentleman's name; that is why I am asking you. That is fine. That was the correspondence you received. What was the date of the correspondence?

Mrs PEARSON: It was 18 November. Interestingly, four days later in our submission box we got four hate letters, our little group, on health department letterhead saying that—

Ms FELLOWS: Anonymous letters.

Mrs PEARSON: Anonymous letters, no less.

The CHAIR: But on letterhead?

Ms FELLOWS: Yes.

Mrs PEARSON: There were three on letterhead and one handwritten in a very childish script saying, "We are proud nurses down at this MPS. You are undermining us. We feel very unsupported." We knew that this was a concerted effort by someone—we did not know who—to undermine our efforts to improve the health care in our town. It was almost unbelievable, the blank wall that we kept coming up against. But there is a real health crisis. We only see Gulgong—well, no, we see further than that. We see it is New South Wales-wide. But our anecdotes are based on what we have seen. Sadly, six weeks ago in the middle of the night my husband was struck down with excruciating pain. He is here now; I had better not go into too much detail.

The CHAIR: No, there is no need for that.

Mrs PEARSON: Knowing what I knew, I was very worried. Do I ring an ambulance? Where is it going to go? We knew there were problems with them having to go to the nearest MPS. I rang the hospital and I got a nurse all—

The CHAIR: Sorry, you rang which hospital?

Mrs PEARSON: I rang Gulgong MPS; sorry, I call it the hospital. I got—it would either have been the RN or the enrolled nurse who helps her because we only have two people on at night and they are stretched to the max. The fear in her voice was palpable. I hardly got my sentence out to say my husband has severe pain and she said, "Don't come here." She said, "Put him in the car and go to Mudgee. We don't have a doctor here." That was quite frightening. That is why we are here: people are scared. I was a bit scared. I mean, I could drive to Mudgee

but a lot of people cannot. I do not like to see that fear. We are here because we had to keep pushing right to this inquiry to get our voices heard. We are really happy to be here and we are really glad that you are listening because our health system is in crisis. Please, we do not want to hear that everything is okay because it is not. Thank you.

The CHAIR: Ms Fellows, would you like to make an opening statement or would you like to open up for questions?

Ms FELLOWS: I might just verbal! No, I would. In a nutshell, we are here because the situation in Gulgong is due to a contractual dispute with the doctor who was in the town. The constant narrative from the health department has been, "Attracting doctors to rural and remote communities is a challenge." In our case, our doctor was there. We sought to understand why that contract had not been renewed. I have it in writing that the issue was about the provision of affordable services. We then heard that Coolah also had lost their doctor, who had been there for seven years. Again, it was reported on the ABC that it was about the provision of affordable services. It was very, very difficult to try to establish what the contractual dispute was because we were told that things were commercial in confidence. I actually wrote, as I was advised to, to the local area health manager, Sharon McKay. I wrote:

> I write to enquire why the contract with the doctors at Gulgong Medical Centre was not renewed with the Gulgong MPS?
>
> What were the terms of the contract that were unacceptable?
>
> This has resulted in the service being without a doctor now for months and it is simply not satisfactory. There is widespread community concern about the situation. The virtual generalist service is no substitute for—

a hands-on doctor. It goes on:

> While the nursing staff are doing a wonderful job the situation is untenable. Please advise what steps have been taken to expedite the appointment of a doctor.

The constant response we got to that was that they had advertised and no-one had applied. This goes to the heart of the matter, I think: that the rural settlement package and the whole model for how we staff rural and remote areas needs revision. Dr Eggerking and Mrs Pearson have already mentioned the Queensland model, where they have a senior medical officer permanently appointed to these smaller centres—it is smaller centres where it is particularly a problem Mark Coulton, pleasingly, you are probably aware, announced the other day that—and you probably heard Dr Iannuzzi speak to this as well—the Federal Government is going to offer an increased Medicare rebate based on a sliding scale of remoteness.

My point is the New South Wales Government need to do something similar in rural health scholarships so that we do not have rural health scholarships where people are trained at government expense and then end up working in large regional centres such as Coffs Harbour and Byron Bay, et cetera. The money needs to go where the rural need is, and it is out here in small centres and remote areas. We have to fight and we have voices, but there are many disadvantaged communities that do not have voices. People should not have to fight for health care, which is a basic human right.

The Hon. WALT SECORD: Hear, hear.

The CHAIR: Thank you. That is a very passionate and strong opening statement.

The Hon. WALT SECORD: Thank you all for your time, your submission and your opening statement. Dr Eggerking—

Dr EGGERKING: Kitty is fine.

The Hon. WALT SECORD: Okay, Dr Kitty. You are a PhD, so I will call you doctor. You mentioned in your opening statement that cracks are beginning to show. What were you referring to?

Dr EGGERKING: Just in the last week on our Gulgong community Facebook page there has been a whole slew of comments about our GP. Some of them have been supportive but many have been quite nasty. I do not think it is worthwhile talking about. People on Facebook are anonymous and they just vent their spleen. Some of it can just be dismissed as far as I am concerned. But it is an indication that perhaps the doctor is being stretched into many directions.

The Hon. WALT SECORD: In your opening statement when you talked about the lack of services and the response that you received you said that you were in the bush now. I would like a response from your two colleagues. You nodded, Ms Fellows. How do you feel about people saying, "You live in the bush, accept it!"

Ms FELLOWS: I think I have made my views pretty clear on that really. We should have adequate health care. If you have read my submission, I was terribly fortunate. I have lived and worked in Gulgong for 37 years and we had the services of two very dedicated doctors who staffed that hospital 24 hours a day, seven

days a week. I am so grateful that when my children were little, that service was there. It was a full hospital. It was not a multipurpose service, which is in effect—and I know others will speak about this—a reduction in services. It is not acceptable. To take Dr Eggerking's point further, the reason why our doctor is under so much strain is back in November, western area health said they would advertise for a second VMO at the hospital, but all they are offering is a standard fee-for-service rural settlement package. So, of course—and I have had discussions with our local member about this quite recently as well—no-one has applied because it is not an attractive enough option. That is the reality—to come out relatively unsupported and accept that package.

The Hon. WALT SECORD: What has been the impact on the doctor and the nurses at the MPS?

Ms FELLOWS: They are pretty well stretched to their limits, I would imagine. I would also add that it was very difficult for us to establish exactly when the doctor was in attendance and when we were reliant on telehealth. My understanding is that from eight to six, Monday to Friday the doctor is on call, and then for triage four and five, possibly he can be called on weekends. So it is still not 24/7 coverage face-to-face with a doctor.

The Hon. WALT SECORD: What do you do when you have a major health incident? Do you decide you are not going to go to your MPS but you are going to drive somewhere? What goes through your mind?

Mrs PEARSON: Well, fear basically. Fear and wondering what the best way forward was and what the best thing to do for the best outcome was. The community knew that the doctor was not at the MPS for several months. So we hear a lot of older people say to their relatives, "Just don't take me down there." They still do not know the doctor's VMO rights have been established, but then in my husband's experience he was told that there was no doctor there. So you are sort of caught; you do not know what the best thing is to do.

The Hon. WALT SECORD: How did you feel when the nurse said to you on the telephone when your husband had acute pain, "Don't come here."

Mrs PEARSON: I was not surprised because of our campaign. I was confronted but not surprised. The next day my husband was admitted to the hospital and that very night, the two nurses who were on were recording measurements of a particular hormone in his blood that indicated he could be about to have a heart attack. They were taking these measurements and sending them through, I think, to the telehealth doctor in Dubbo, who said, "Well, look, I want to see those readings taken throughout the night." I left my husband at 8 o'clock in the evening and when I went at 8 o'clock in the morning, not one reading had been taken and they were supposed to have been taken two-hourly through the night. The two nurses said, "We did not have time." They were too stressed. Even when he was there and I was with him, the RN was trying to do the measurements of this hormone and her assistant was standing to the side making faces, like, "I need you down in the other part of the hospital." There are only two of them. There are the aged care, the acute beds and whoever comes into emergency. So they are frightened.

The Hon. WALT SECORD: How many patients were the two nurses in charge of?

Mrs PEARSON: I was not sure. We were the only ones in emergency. I know there were a couple in the acute, but there were six aged care as well. I do not know what was happening behind the scenes because it is locked off. But yes, those two are expected to cover the whole area.

The Hon. WALT SECORD: You are three strong individuals and I know you can put your case forward and stand up for yourselves. I get that very clear impression. What about other people in the community? Ms Fellows, do you want to comment on that?

Ms FELLOWS: That is why we started a petition, because they did not have a voice, basically. People really did support that petition. Mrs Pearson has already mentioned how we have a box. We did not accept any anonymous statements; they all had their name on them. When it came to putting them in that huge appendix that we sent in, we did say, "Do you want it anonymous?" but we knew who they were. They wanted these stories told but they perhaps did not have the confidence to do that themselves.

The Hon. EMMA HURST: I have a general question for the Gulgong petitioners group. The case of Dawn Trevitt obviously highlighted some of the serious problems with a major overreliance on the telehealth services. Do the local people feel safer with a doctor reinstated now or is there a continued nervousness about an overreliance on that system?

Dr EGGERKING: We are just not clear of when the doctor will be available in the hospital and when there will be telehealth. It is all part of this commercial-in-confidence nonsense that goes on. We need to know in our town what services are available and when they are available, and not to know is really stupid.

The Hon. EMMA HURST: It almost sounds like your health is a gamble as to when you are going to go in to get health care. It could go either way.

Dr EGGERKING: Yes.

Ms FELLOWS: People do not know when they present to the emergency department whether they are a triage one, two, three, four or five. When people present to emergency they expect to see a doctor. That is it in a nutshell.

The Hon. EMMA HURST: Yes, definitely. I have some questions for Mr Sandell and Mrs Campbell. For the benefit of the Committee, what are some of the problems you identify as being associated with sending serious dementia patients to Dubbo or other facilities further away? What does that mean for the patients and families on the ground?

Mrs CAMPBELL: The history in Warren is that there has been a number of dementia patients, especially the early-onset dementia patients that are physically very strong and very active and quite terrifying for frail elderly people living in a facility to be cohabitating in the same dining room and same lounge room area. And it has no locked unit at all. So if there is a wanderer and they cannot be kept locally, then they have to be sent to a larger regional centre like Dubbo. That means a family member that lives in the town of Warren has to drive 125 kilometres, one way, to be able to see their loved one. The town of Warren is actually in the very top corner of the shire. The shire runs for another two hundred and something kilometres to the north west, so you could have an easy-peasy four-to-six-hour round trip to see your loved one. To sustain that, you know—

The Hon. EMMA HURST: Have people actually moved out of the area because they have found themselves in that situation?

Mrs CAMPBELL: No, they just do the miles. But it is really not sustainable because they might only see their parent once a week, or their mother, depending on the age of the person with dementia. They are having to drive a lot of kilometres and a large expense. Some of them just cannot afford to do it. It is quite a burden.

Mr SANDELL: If I may, one thing I would like to point out is usually when you get that older, confused resident, because our facility is not designed for wandering or somebody aggravated, if they are moved on—their partner is usually a similar age. So usually you are asking a 70-to-80 or 80-plus year old to drive at least an hour and a half to Dubbo to see their lifetime partner. It is no good.

The Hon. EMMA HURST: I can see how emotional you are getting. Is that really tearing families apart? What if that other partner cannot drive or does not have access to transport?

Mr SANDELL: Absolutely.

The Hon. EMMA HURST: Is that something you guys are hearing and seeing in the town?

Mrs CAMPBELL: Yes. Public transport is as good as non-existent in Warren. We have a community transport service Monday to Friday but the volunteer drivers are very elderly themselves.

The Hon. EMMA HURST: And obviously transport in and of itself cannot be the solution because there are so many other issues associated with that.

Mrs CAMPBELL: Yes. And Warren is very much an aging population.

The Hon. EMMA HURST: Does that mean that this problem is going to get worse?

Mrs CAMPBELL: It is going to get worse. When we went from a hospital to a multipurpose service we did get above average beds, and those bed numbers have increased over the years. But it is still not enough. We are still sending local residents out of town—not just dementia, all sorts of residents. But dementia is our biggest problem.

Mr SANDELL: The other problem that compounds it is the nursing and the professional staff and care workers. We have moved from a training program that was basically locally or even district or centrally motivated and worked for years. Because of shortages, the soft option has been to call a contractor to be able to get fly-in and fly-out staff, and it is making a bad situation worse. We have to start training at a local level. We have to train up our staff. We have to give them some job opportunities and career paths so if they take the job on at 16 or 17 when they leave school, there is a career path for them. This is what is happening. They are underpaid, they are overworked and no career opportunity. We are going to continually go backwards, absolutely.

Ms CATE FAEHRMANN: I am interested in your views generally about multipurpose services. I will start with the Gulgong Petitioners. Do you think they have been better for the community or not?

Ms FELLOWS: Speaking personally, I think—actually, not just personally. There is a common thread around town that services have gone backwards in that we had a fully functioning hospital 10 years ago with a paediatric ward. We had a very primitive but we did have a functioning X-ray facility. Not that there was minor surgery or maternity services at that stage, but in effect the number of beds have been reduced. It is quite common for an MPS only to be staffed by one registered nurse and one other nurse. One of the problems with the telehealth

was that doctors would be giving a consultation and saying, "Right, take that patient for an MRI." The nurse would say, "There is no MRI." "Right, send them for a CAT scan." "There is no CAT scan." "Send them for an X-ray." "No, we do not have an X-ray." I think perhaps the MPS model—and I understand that it is quite complicated when you were talking about the aged-care funding—it is tripartite funded. But I am not sure that it is actually fulfilling the function that it is meant to do in rural communities, especially as it seems difficult to put doctors in them and to attract them, so with that lack of support that a larger hospital or larger facility might have.

Mrs CAMPBELL: Can I say, Warren has had an MPS for over 20 years. Mr Sandell was very active in securing a multipurpose service in the very early days of them being introduced. It did allow us to have aged-care beds in Warren, and the community could see that it was required. It functioned very well for a long time. I think the problem is that the current local health district has actually lost sight of the fact that a multipurpose service was designed to suit each individual community's needs—so the size of the population in Gulgong versus the size of the population in Warren or Nyngan or wherever else. That MPS was built to suit that community, staffed for that community, services for that community. I think over the last 10 years a one-size-glove-fits-all idea has crept in and they are now trying to make all those multipurposes exactly the same with staffing, management, doctors and everything. That is where it is failing. I think they have worked exceptionally well in the past, but they have lost sight of what an MPS is meant to achieve.

Ms CATE FAEHRMANN: That is a very broad statement to say they have lost sight of what it was meant to achieve, so I just want to delve into that a little bit. I think from most of the submissions and evidence we have received, there does seem to be less staffing as a result of multipurpose services. Is that correct? I will just note that Mrs Pearson and Ms Fellows are nodding their heads. Would either of you like to comment?

Mrs PEARSON: Definitely. We have lived in Gulgong for a long time and of course you have seen a large reduction in staff. A lot of the people who used to work there years ago, walking around town you think, "Yes, when I was down there, there were three nurses in the children's ward. Yes, heaps." Now they are calling on the cook, in two of the written statements from people telling of their experiences at Gulgong MPS with the staff shortages. In two of those written submissions they mentioned the cook being called in to help. Yes, definitely, the cook did not used to have to help in a medical capacity.

Ms CATE FAEHRMANN: I will come back to that in a second. What has happened to the population of Gulgong over the last 10 years?

Dr EGGERKING: It is starting to burgeon.

Ms CATE FAEHRMANN: You are saying it is starting to increase, Dr Eggerking. So we did not see 10 years ago—it was not like there was a sudden decline in the population to justify what has happened?

Mrs PEARSON: No, absolutely not.

Ms CATE FAEHRMANN: So it is not a reason of population.

Mrs PEARSON: It is one of the fastest growing areas in the State.

Ms CATE FAEHRMANN: Is it?

Mrs PEARSON: The Central West, yes—Mudgee and Gulgong, yes.

Ms CATE FAEHRMANN: Just going back to the cook helping, could you expand on that? The cook helping how? Not with the food.

Mrs PEARSON: No. Although she does do that as well.

Ms CATE FAEHRMANN: I am sure.

Mrs PEARSON: I know Mrs Trevitt's daughter, Hayley, is going to speak to you later. She would have full details of that. But we are privy to a witness account who on the night that Mrs Trevitt passed away, she was in the next room waiting for her own emergency care, which did not happen. The cook came in to speak to her and perhaps perform some sort of counselling role and let her know what was happening. There was another occasion when Mrs Barbara Seis, who also sent a submission, when her husband was pronounced dead via the telehealth camera, her family was not allowed into the room due to COVID restrictions. The cook went and advocated on her behalf and said it was inhumane and could the family please go in. The cook gets quite a mention in some of those Gulgong submissions and she is a very reliable person; she is great.

Ms CATE FAEHRMANN: And clearly doing an incredible job.

Mrs PEARSON: She is doing a great job.

The Hon. WES FANG: Thank you very much for coming in today and sharing your insights. It is really valuable for all of us to hear. I will start with Mr Sandell. Firstly, congratulations to the Rotary Club for all the advocacy you have been doing. It is great to read your submission. What do you think can be done now to progress the work around getting those spots for aged care and dementia? What can we do as a government that might help us to help you do that?

Mr SANDELL: What we have done from Rotary being the lead role, we have started the Warren Health Action Committee, and that is specifically designed so all the community is involved. Every section of health care, council, education, we are trying to bring them all in so we can move forward on training and upskilling because there are things out there, nobody knows about them and there are a lot of things that need to be done. But one of the biggest issues I have seen—and I am speaking personally here because I chaired the first health council on the MPS when it started. Five years later or four years later I gave up. I gave up for the reasons that have been talked about here today. We have got to start communicating with local communities. Do not be frightened of their input; embrace it. Fifty per cent of the funding for Killara House was raised locally.

Ms CATE FAEHRMANN: Amazing.

The Hon. WES FANG: I saw the $760,000, and that is amazing from a community to be able to provide that.

Mr SANDELL: That was just from Rotary, that $60,000, to transform a room in the MPS that was not properly used. That was raised by Rotary. Then we did the security fence, $8,000; half the money for our sporting complex, which I know is not health but this is a community that you are talking about. Talk to them; let them have some input. It is a win-win situation. We have got to do it.

The Hon. WES FANG: I can see the passion that you have got. I think it is very much a community drive as well that you are doing. Ms Campbell, have you got some insights as well?

Mrs CAMPBELL: I honestly think the Department of Health has to come to Warren and sit down at the table with the Warren Health Action Committee and help us move forward. Working with the LHD is getting nowhere, so I think the Department of Health needs to come to the table.

The Hon. WES FANG: For the Gulgong residents, obviously we have spoken about the need to attract doctors. Through a number of hearings that we have had we have found that throwing money at the problem is not always the case. In fact almost to your point, it is about what a community can provide to the doctors as well. Do you have some insights as to what you think we could do to attract more doctors to regional areas? Because we all know how wonderful our communities are, but we have just got to sell that to other people and sell the community and also the role. Do you think it is just money or do you think that there are other things that we can be doing?

Mrs PEARSON: I have a son who went through medical school on a rural scholarship; he is a GP. He at no stage was required to work in the country even though it cost the State an awful lot of money. I feel a bit disloyal here. But he got his degree and he is now working on the coast. He is 32; a doctor of that age does not feel supported in the country. It is not just about money. He said he feels guilty, "I should be coming back to Gulgong and helping you guys." But they are not skilled enough at that stage; they need mentors. In the past I think they joined a practice where there were other doctors to mentor them, and that is where he is now, so they have got a support team. It is a lack of support from the medical aspect as well that is a problem. It is not about the moneys.

The Hon. WES FANG: It almost sounds like a chicken-and-egg approach though because if you have not got the people there to support them, people do not want to come. When they come then you have got more support for other people to come. Is that sort of how you see it?

Mrs PEARSON: I feel if they were bonded in some way—I know that is not a word that people like to hear. Teachers bonds were done away with back in 1980 and everyone threw their hat in the air. But I think in some way, those going through on these rural scholarships—and they are quite common—are then allowed to work in areas that are not rural. I do not think Coffs Harbour is a rural area.

Mrs CAMPBELL: I have a daughter doing third-year in an undergraduate medicine degree. She is one of 25 in the rural program with the University of New South Wales at Port Macquarie. She is the only child that comes from west of the coast.

Mrs PEARSON: Really?

The Hon. WES FANG: But just to your point with your son. Let us say he was bonded. If he was coming back to you, how do we provide that support to him?

Ms FELLOWS: We need to do what Queensland does. They invest an awful lot of money into training rural generalists and they have been very successful at it. We have expertise. I missed it this morning, but you would have had Dr Iannuzzi here. He is probably very modest, but last year he won an award for training rural GPs. We have that expertise here, but we do have to look at systemic change with rural health scholarships and we do have to look at financial incentives—we really do—because the current model is clearly not working. We all come from very supportive communities and make our doctors welcome. Our doctor is part of our community. But, let us face it, financial incentives are not the whole story. I know it is complex, but it is certainly going to be a big factor.

The Hon. WES FANG: He was very modest, but you could tell when he was introducing himself that he was very accomplished and had provided the community quite a lot of service.

Ms FELLOWS: Yes.

The Hon. NATASHA MACLAREN-JONES: In your opening remarks, Ms Fellows, you referred to some hate mail that you had received.

Ms FELLOWS: I think that was Mrs Pearson actually.

The Hon. NATASHA MACLAREN-JONES: Mrs Pearson, sorry. I am just interested to have a copy if you are willing to give it to the Committee. First of it all, it is very serious if people are using official letterhead or if they are doctoring official letterhead and are not actually from an organisation. It would be very good for the Committee to have that to then be able to refer that on to be looked at. If we could get a copy and any of the other correspondence that you would like to table as well.

Mrs PEARSON: I am a little bit concerned about that in that I felt these were nurses who were perhaps not terribly well educated. They were childlike letters and I did not take it any further at the time. Ms Fellows was away. I just felt that it was a bit sad; they had been groomed to write these letters. But I would actually prefer I think as a community not to take that matter any further.

The Hon. NATASHA MACLAREN-JONES: That is okay.

Ms FELLOWS: They all began the same way. All the letters sort of started off like almost a copy letter: "I wear my uniform with pride," et cetera. I was away but Ms Pearson wrote a very lovely letter in reply saying that at all times we support a nurse's work and it was actually her working conditions without the support of a doctor that we were really concerned for.

The Hon. NATASHA MACLAREN-JONES: No, that is fine.

The CHAIR: I note, just to be very clear, that the use of official letterhead—

Mrs PEARSON: We knew that.

Ms FELLOWS: Yes, we knew that.

The CHAIR: It goes without saying. Thank you all very much. There may be some supplementary questions from members after they have read the transcript and your very detailed and thorough responses. What would normally happen is that the Committee secretariat would liaise with you over those supplementary questions and there is normally a 21-day turnaround time to return those to the Committee secretariat. Just before you leave, thank you very much, it has been most insightful. The submissions were good but it is even better to have that opportunity to dig down and ask you some questions. I share the Hon. Wes Fang's comments, Mr Sandell, and all the others that there is extraordinary work done by communities. Communities are not just standing there saying to someone else, "There is a problem, fix it." They are doing their very best to bring matters forward but even themselves taking it into their own hands and doing very commendable things like raising money and what have you, so thank you all very much.

(The witnesses withdrew.)

SALLY EMPRINGHAM, Private Citizen, sworn and examined

RONDA PAYNE, Private Citizen, affirmed and examined

CHRISTOPHER PEARSON, Private Citizen, affirmed and examined

HAYLEY OLIVARES, Private Citizen, affirmed and examined

The CHAIR: We will get underway. Thank you all very much for coming along this afternoon, particularly you, Mrs Olivares, with your most difficult circumstances. There is a strong sense of condolence from all members in regard to the death of your beloved mother, Dawn. We want to communicate that to you before we start. Your submissions to the inquiry have been received and duly processed. Mrs Olivares, yours is submission No. 575 to the inquiry. Mr Pearson's submission is No. 214 to the inquiry. Ms Payne, your submission is No. 583 to the inquiry—that is the formal number it is given when it is received and it is listed on the inquiry's webpage. Mrs Empringham, your submission is No. 199. They have all been received, processed and uploaded onto the inquiry's web page. You can take them as read by the Committee members. So in your opening statements, which I will invite you to do shortly, there is no need to read from them, but rather perhaps draw some of the salient points out and set the scene, because what we would like to do once we have completed the opening statements is to, if you are agreeable, open it up to some questioning.

No doubt we are going to be covering some difficult issues in this discussion in the next 45 minutes or so; so at any stage if you need to have a pause, feel free to pause, have some water and just, as best you can, take it at a pace. We are not going to rush or push you; we will just work our way through it and I am sure we will cover everything satisfactorily. I presume that all of you have an opening statement of some sort to make. Does everyone have an opening statement? We will start with Mrs Olivares. Thank you so much, once again, for coming along and we acknowledge the circumstances that are before us.

Mrs OLIVARES: Good afternoon, Chair, and Committee members. I thank you for the opportunity to be here today. I sit before you as a daughter whose mother fell victim to an inadequate and ill-equipped medical system. My parents moved to Gulgong in 1989. I completed my schooling there and my mother contributed over 20 years of her teaching career at those same schools. She was a beacon of hope for many struggling students and families over those years. Her loss continues to be felt deeply by our family and across the Gulgong community. On 15 September 2020, my mother was unwell, there is no question about that. She was picked up by ambulance and taken to the Gulgong Multipurpose Service, a facility that had been without a doctor for months. NSW Ambulance protocols at that time mandated that she must be taken to the nearest medical facility, with paramedics knowing there was no doctor service in that facility at the time.

She was triaged category 1 on arrival by a registered nurse and, according to NSW Health, should have been seen by a doctor within two minutes. Instead, it took 35 minutes for any communication to be established with a doctor by telehealth, during which time my mother's condition significantly deteriorated and within an hour after initial contact she was dead. The Government directed what our family was led to believe would be an independent review into the events of that afternoon. Perhaps that is what they wanted us to believe they would do. What was done was a root cause analysis, completed by a panel of internal NSW Ministry of Health staff, with no independence whatsoever. It was a conflict of interest and the report reads as such. In fact, the liaison officer our family was appointed for the duration of the review identified she indeed knew my mother from a previous presentation at Orange hospital some many years ago when she had a shoulder replacement.

The liaison officer had no problem in passing comment to me on my mother's personality and her aversions. This was my first red flag that this review was problematic and possibly full of bias. The report did identify inventory shortfalls, including needles and headsets. It confirmed staff concerns around resuscitation efforts my mother received, due to the fact there was only one working headset that could connect to the telehealth system as opposed to two, which in turn confused staff around the rate of compressions during resuscitation. It identified limited knowledge around the scope of practice between MPS staff and paramedics. Yet the report concludes, and I quote, "This did not affect the patient's final outcome in each of the areas identified above."

My mother died alone, with no family present. She would have been terrified. We were not afforded the opportunity to see her, with an individual outside of our family identifying her deceased body. It was 13 days later that I got to say goodbye to her at a viewing at the funeral home. We had no contact from any doctor or medical practitioner from Western LHD. I had no idea what happened to my mother on that afternoon of 15 September until I read the root cause analysis report provided to me in January 2021. Despite strong requests, our family was denied a post-mortem examination. The original cause of death, as communicated to our family by a police officer the day after my mother's passing, was later contradicted on a coroner's certificate.

In my opinion, there are numerous non-evidentiary conclusions drawn in relation to my mother's cause of death. No pathology was taken and no doctor physically saw her before or after her death. There have been numerous comments by senior health department employees and government representatives that a doctor at the Gulgong MPS that afternoon would, and I quote, "not have made a difference in this lady's case". I am not as convinced, nor do I accept that that makes what happened that afternoon, or to the hundreds, if not thousands, of other individuals who have experienced inadequate health care across New South Wales, acceptable.

When did we get to the point that the level of health care you should expect to receive not only depends on your postcode but also on your likelihood of survival? At what point did it become acceptable to have a multipurpose service open for business with an emergency and ambulance sign out the front and no doctor inside the walls? It is false advertising. It fills the community with false hope that they will receive appropriate care should they need it when in fact that could not be further from the truth. The system is failing. It failed my mother, our family, the community, and it will continue to fail unless acknowledgement turns into accountability. There must be change. There must be system reform, appropriate allocation of resources and cultural change in the leadership where, instead of deflecting and defending, they commit to redress. People are dying; families are broken. We cannot continue to ignore this issue.

The CHAIR: Thank you very much for a very clear and strong but measured statement. We cannot imagine how you feel in the circumstances, but you did not allow your emotions to take you away. It was very frank and clear. Once again, on behalf of the Committee, I offer condolences for the terrible loss of your mother.

Mr PEARSON: Thank you for the opportunity to address the inquiry. I will be brief. I have supplied you with a fact sheet with facts numbered one to nine, which I may refer to. I hope you find that useful.

The CHAIR: Mr Pearson, would you be good enough to table that fact sheet?

Mr PEARSON: I am sorry.

The CHAIR: That way we can duly process it as a document to this inquiry.

Mr PEARSON: Yes, thank you, I will.

The CHAIR: We are talking about the same document, are we?

Mr PEARSON: Yes, my opening statement.

The CHAIR: You have tabled that as your opening statement. To be clear, the document is headed "Opening Statement" and then, underlined, "Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW". It has your name on it. On the third page you have highlighted the names of some jurisdictions.

Mr PEARSON: Yes, indeed.

The CHAIR: Please proceed.

Mr PEARSON: Thank you. I speak as a resident—a private citizen—of Gulgong, having lived there for some 37 years. Gulgong District Hospital—I think that term "district" is very a very important word—once proudly served a large hinterland. We had 28 beds—men's, women's and children's—an operating theatre, a maternity section, a maternity ward, X-ray facilities and a helipad, which was built by the community. The services provided in that grand building—not unlike this one where we are today—were reduced to the point of closure in 2010, followed by a demolition of the premises in 2015, leaving us without a dedicated facility. Unfortunately the new MPS is inadequate in size and in the services provided.

In the early days, like many parents in Gulgong, I was pleased and felt safe in the fact that 24-hour care was available for children and anyone else in the area. It beggars belief that the abovementioned services have been reduced in spite of the population growing at the rate that it is. I refer you to the statistics at the back: points (1), (2), (3) and (4). Forced amalgamations within the health system, stripping of equipment and assets—often funded by the community—and faceless administrators without local knowledge or an interest in the community all highlight a need for a new business model for remote, rural and regional health service delivery in New South Wales.

Not a day goes by without some preventable horror story coming to light. I realise that not every regional town can have a base hospital, but I do feel that any existing health facility in every regional town or city should provide 24-hour care to the community by qualified staff, certainly by a GP in the form of a GP or visiting medical officer [VMO]. Surely this is a basic right in a First World country. To phone Gulgong's MPS after hours and be told, "Don't come down here; go to Mudgee", is not acceptable. There is scant regard for the condition of the patient or for how you are going to get to Mudgee et cetera. It is just a fob off.

In my opening statement I mentioned the model of health care. I refer to that lovely gentleman from Warren who, earlier today, referred to the Government "embracing the community". Again, I urge you to look at recommending or considering the reintroduction of the old hospital board system, perhaps in a new guise, because the existing system of health councils is a toothless tiger on a very short leash, whereas the old hospital board system in Gulgong was made up of 10 people. They had the ability to hire and fire, they oversaw the duties of a CEO and a matron, and it provided a conduit for the community to take their concerns directly to the health department via those very capable, professional volunteers, who I dare say saved the Government a lot of money in the long run due to the hours they spent on the job providing a much, much better level of service than there is now. To that end, I thank you for your time and I welcome questions.

The CHAIR: That was a very helpful opening statement, which you have provided in writing. We much appreciate that, particularly those specific references notated in the opening statement.

Ms PAYNE: Late in 2019 through the night I thought I was having a heart attack. Of course, I stupidly waited until six o'clock to go to the hospital, but that is what one does. When I went to the hospital, fortunately there was a doctor on board at that point in time.

The CHAIR: Sorry, just to be clear: This is the Wellington Hospital?

Ms PAYNE: This is the Wellington Hospital. They took the blood test, went away, came back and said, "Definitely no heart attack. No worries." But he said, "I found something else in your blood test that needs to be dealt with." He did not tell me much more at that point. He asked me who my GP was, and he said that he would have all the information for them there and that I needed to make an appointment fairly soon. As it turned out, I had a blood cancer where I make too many red blood cells. If it had not been found at that time, who knows when it might have been found? But I was lucky that there was a doctor on duty. If there had been a nurse there, I probably would have just had the heart attack, nothing would have happened and then I would have gone home. For starters, we need doctors and we need them there all the time. Swap to the present day. Last week on Tuesday I had a scan in Dubbo. They told me that it would be delivered to the practice, to my doctor, on Tuesday afternoon.

The CHAIR: Your doctor being located where?

Ms PAYNE: Here in Wellington. So it would be there. That was fine. When I got home I rang and made an appointment to see the doctor about it. Unfortunately that was last Tuesday. It is now Tuesday again and the first available appointment with the doctor is next Tuesday. We just keep hoping that it is not too bad, but that is the way medicine is at the moment for us here because we have so few doctors. Making an appointment—whereas once you could get one very quickly, that is no longer the case. People have talked about it before but, having trained as a teacher, I was given a scholarship and then I had to go and do my country duty before I was allowed to choose where I would go. I really have trouble understanding why we cannot put some money into training doctors or assisting them with their training to have years of practice—the same sort of thing going on. I would rather have a young doctor who really does not know quite as much as the old doctor, than have no doctor at all. It is unfair to the nursing staff and everyone else. So I think encouraging that is important.

Maybe it is time to change what I call the registration process—but someone suggested it was a Medicare number or something that doctors get when they have graduated and are ready to start work—and have some of those numbers attached to health areas so that at some point the doctor has to go to a health area that may not be quite as good as the one at Baulkham Hills or Manly or wherever they would like to be so that we can get more doctors here to take the pressure off the people that are already working here. Dr Spencer is still working long after I gave up my career. It is a difficult situation, but something needs to be done. So, thank you very much, that was my opening statement.

The CHAIR: Thank you for your suggestions. What you have elucidated is what we have heard from other hearings and some of the ideas you have put forward are also similar to what we have heard elsewhere, but they are very valuable contributions. Mrs Empringham?

Mrs EMPRINGHAM: I live at Nevertire, which is a blink-and-you'll-miss-it town about midway between Nyngan and Warren, so those are the hospitals that we frequently—well, when we need to—use. That just gives you a bit of context. We are an hour and half from Dubbo and the property that my husband manages is another half an hour from Nyngan, so it is effectively 2½ hours from Dubbo. Our experience of those MPS local hospitals is that they are having more and more services cut, that they are often without doctors or if there is a doctor it is a GP who has worked all day and who is also the VMO, which has its own issues attached to that in terms of overwork.

A lot of the doctors are foreign trained. In essence, there is nothing wrong with that, but the reliance in rural Australia upon foreign-trained doctors and locums is creating a whole other set of issues in terms of lack of continuity of care. There is no attachment to the community. There is no context known around what the

community needs and the issues that that community faces. There also is, unfortunately, often a communication issue as well. My feeling is that these MPSs are being stripped of services. The nurses are fantastic and the services are new and modern, but they do not have doctors and they are not providing facilities. They are essentially becoming nursing homes and palliative care units for the most part. I can give some little examples.

I was pregnant and working in Nyngan and I had to pick up my daughter from day care and drive two hours to Dubbo, on my own, to have a complication checked with my pregnancy because there are no prenatal services, there are no maternity services and there are no child services any longer in those hospitals. One of my daughters broke her arm not long ago during harvest and it was a three-hour round trip to Dubbo to have her arm X-rayed. We have an X-ray unit in Warren and we were told not to go five minutes up the road but to go to Dubbo. There was no explanation given other than that was just what we had to do. When it came to be reviewed it was exactly the same situation—a three-hour round trip.

One of my daughters, probably about a year or two ago, just had run-of-the-mill gastro, but when we presented to Warren Hospital we were told that they could not hold her for more than six hours and that we had to go to Dubbo. Again, there was no real explanation given other than that they no longer cared for children in the facility. In another accident—we have got jackeroos and young children, so things happen quite often—I had a child who fell off a horse. They did actually have a helicopter waiting to go in Orange, but we were taken into Warren and told there that we had to be transported to Dubbo for observation.

Again, that was fine, but when we were in the ambulance going to Dubbo they let slip that that actually meant that Warren had no ambulance service. So, in an emergency, there was nothing left in town. The guilt that I felt about that was just absolutely appalling, that a whole town would be left without an ambulance because my child cannot be seen in Warren and has to go to Dubbo. I also think that then becomes an issue for Dubbo. Because these local hospitals are no longer able to facilitate and look after their community, everything goes to Dubbo. It is a month-long wait for a GP appointment and it is six months to see a specialist.

I am a teacher and I have got kids in my class that are waiting six months. That is six months of their school career that they have lost because they cannot hear or they have got recurrent tonsillitis or there is some behavioural problem which if you were in Sydney you would see a paediatrician about, I am pretty sure—I am not there. I cannot imagine that this is an acceptable situation for these kids. That is one twenty-fourth of their schooling that they have lost due to the inability to see a doctor. I also think it then becomes an issue of there being a three-tier system of medical access.

There are those that can go to Sydney, like my family. We go to Sydney to see an endocrinologist because when we started seeing one there was not one in Dubbo and we have continued that relationship. But that is a 1,200 kilometre round trip. Then there are the people who can only afford to go to Dubbo and wait that six months and see whoever is there. Then there are the people who can only afford to go to Warren and see whoever or no-one. There is a socioeconomic cost as well. It is in terms of travel and it is in terms of access and it is in terms of education and knowing how to access those services.

I think that there is flow-on effect mental health-wise as well to patients in these rural areas, to the nurses that are trying so hard and to the families. I do feel that the hospitals are understaffed. They are under-resourced and, as a result, patient health and wellbeing over the long term is compromised. I know in the teaching profession, up until not that long ago, there was a point system. There were incentives to go to rural areas and there was extra funding. I think if you value something you put money towards it. I know the Government is probably going to say, "Well, we can't afford it", but you cannot not afford it.

All of your food, your fibre and all of your exports are being created west of the Great Dividing Range and we are struggling to access health care. I mean, honestly, my husband says, "Unless it is a spinal injury, you get in the car and you go to Dubbo", because that is just the reality and that is an hour and a half away. I am sure the economic cost of those type 2 diabetics that are not getting early treatment and those kids that are not getting medical intervention when they need to and so their education is suffering and their work prospects are suffering—you know, whatever money is being taken out of these local hospitals is being lost in the economic fallout of what is happening in these rural communities.

The Hon. EMMA HURST: Thank you so much, Mrs Empringham, and thank you all for coming today and sharing these stories. It is really important that we hear from you all, so thank you. I know there are going to be a lot of questions for this group, but we are going to stick to seven minutes.

The Hon. WALT SECORD: Thank you all for your efforts. Mrs Olivares, thank you for your evidence. I know it is very, very hard. You have been very strong today. How did you and your family find the strength to stand up to the local health district and find out what happened to your mother?

Mrs OLIVARES: I live in the city. I live in Canberra. So, first of all, I guess for me when I found out the day after Mum had passed that there was no doctor at the hospital I was appalled. I am comfortable in Canberra. We have a great medical system and I guess I did not realise how much we took it for granted. It is not hard to find strength when you find that people do not have the same access to critical services that you do. The Gulgong community has given so much to me and my family over the years and for me, when I found out after Mum's passing that the community had been advocating for this issue in the months prior to her passing, I felt an obligation and that now they had a voice and a poster child, I guess—which is a disappointing way to put it, but my mum then became the face of what the catastrophic result of this problem can be. Until they had that, nobody was really listening to them. So I would not say that it necessarily was strength. It was circumstance and the fact that the community had already been trying to get this issue addressed well before my mum had passed.

The Hon. WALT SECORD: I understand that the local health district has apologised to you and your family. Is that correct?

Mrs OLIVARES: Not directly. So, outside of the root cause analysis, I had no contact from the Western Local Health District. Publicly, absolutely I did. We received lots of condolences in the public forum. I got to the point that when I spoke to any of them I said, "I don't want to hear your condolences anymore. I just want to hear what you are doing to fix the problem."

The Hon. WALT SECORD: Now, the feedback from the community—has Gulgong hospital improved since the passing of your mother?

Mrs OLIVARES: I do not know because I do not live there.

The Hon. WALT SECORD: Okay. Would you mind if I asked the other members?

Mrs OLIVARES: Sure.

The Hon. WALT SECORD: Mr Pearson?

Mr PEARSON: Yes. Can I have the question again, please?

The Hon. WALT SECORD: Since the passing of Mrs Olivares' mother, has Gulgong hospital improved?

Mr PEARSON: To the extent that we now have a VMO—albeit with limited hours, as pointed out by the previous group of speakers—yes, I would say there is a slight improvement, but only in that area inasmuch as we do have a part-time doctor on board.

The Hon. WALT SECORD: We heard evidence earlier today. Several people have referred to a cook at the hospital providing assistance. Do you know anything about that?

Mr PEARSON: I was not there on the evening but the statements by those, corroborated by quite a few there on the evening, certainly point to that. I would not disbelieve it at all, knowing the people as I do.

The Hon. WALT SECORD: Mrs Olivares, is there anything you would like to add or observe about that?

Mrs OLIVARES: Yes. I received a statement from the lady who was in the adjoining room to my mother in the MPS on the afternoon of Mum's passing. I have her statement, if you would like to hear the reference to the cook.

The Hon. WALT SECORD: Yes, please.

Mrs OLIVARES: This is from her account, obviously, of her attendance at the MPS:

> We arrived at the MPS at around 4.30 pm. The Nurse on duty took me in to the room and was getting my details. While she was doing this an ambulance turned up with another patient. This patient was put in the ward adjoining the room where myself and my husband were. Understandably she had to leave me to attend to this patient who appeared to be very unwell. My husband and I could hear everything that was being said. As Gulgong MPS does not have a VMO the nurse was relying on a Dr through Telehealth. There was only 2 nurses on duty at the time as I heard someone ask if there was anyone else there and they were told "No". That person then asked who was looking after the other patients in the MPS at that time and the answer was "the cook". I believe that there was 2 Paramedics present as well. I heard the Paramedics say that they had been unable to get a cannula into the patient before bringing her to the MPS. I don't believe the Nurse was able to get one in either and then I heard the Nurse saying that she was trying to get an IO in. It was at this stage that I heard the Nurse basically pleading for assistance from the Paramedics but they said they were unable to do what she required.

The Hon. WALT SECORD: It sounds like the cook helped out. Thank you.

The Hon. EMMA HURST: I might just jump in. I have a few questions for Mrs Empringham. You mentioned in your submission that there is an X-ray machine in the hospital but nobody that can use it, and you had to travel one of your children—how long?

Mrs EMPRINGHAM: It is a three-hour round trip to Dubbo.

The Hon. EMMA HURST: And was your child in pain?

Mrs EMPRINGHAM: Yes, she was. My husband rang Warren and was told, if he was concerned about her arm, to go to Dubbo. There is an X-ray machine in Warren.

The Hon. EMMA HURST: I understand from your submission that you have made a very personal decision not to have more children.

Mrs EMPRINGHAM: Yes.

The Hon. EMMA HURST: Is that because of the lack of health care?

Mrs EMPRINGHAM: Yes, that is exactly right. I have two friends who have delivered children on the side of the road. I have had complications with pregnancy and had to drive myself two hours to Dubbo to be checked out. There is no prenatal care. There is no maternity care. There is basically nothing in an emergency. One of our neighbours lacerated his forehead. He went to Nyngan and was told there was no doctor. They rang Warren. They were told that they had a doctor but no suture kit, so he had to drive half an hour to Nyngan and then he had to drive an hour to Warren carrying his own suture kit. That is the level of care that is provided.

The Hon. WALT SECORD: No suture kit—was that at the hospital?

Mrs EMPRINGHAM: Yes, that was at Warren.

The Hon. WALT SECORD: No suture kit at Warren hospital?

Mrs EMPRINGHAM: Yes.

The Hon. WALT SECORD: So what do they do at the hospital?

Mrs EMPRINGHAM: I have no idea. Look, as I said in my opening statement, the nurses are fantastic. I know them personally. They are wonderful people, but they are operating—it is basically a medical centre with a palliative care unit and an aged-care unit. That is how it appears to me as someone who is part of the community.

The Hon. WALT SECORD: How long ago was that—the suture kit issue?

Mrs EMPRINGHAM: The suture kit was probably two years ago. My youngest child is now 11. I am talking about my experience but, in saying that, the broken arm was at harvest last year. That is November. There has not been a huge amount of change, from what I can tell, in that amount of time—that you cannot assess a broken arm and X-ray it in a hospital.

The Hon. EMMA HURST: Yes, wow. Obviously you love your community and you are a real part of that community, but if someone was to come in with a young family and ask if you would recommend that they move into the area, what would you say to them?

Mrs EMPRINGHAM: If they had prior or existing health conditions, I would say, "Don't." I still feel that our health is a gamble where we live. It really is, and that is one of the reasons why we do not have any more children; it was not something that I was prepared to do. I do live in fear that if something happens—we have had jackeroos fall off motorbikes and have lacerated livers. There is a whole range of things having young people and horses and motorbikes about. It is a gamble whether you are going to get care. It is not care as in—obviously they all care and they do their best, but care that actually prevents you from passing away is a gamble. You know that a decent amount of emergency medicine care is an hour and a half away. Probably 10 years ago another one of our neighbours had her thumb ripped off by a horse; a lead rope got caught around it. They got her to Warren. She was flown to Dubbo. It was eight hours before she even got to Sydney. Now, they could have driven there in six hours. It is that sort of medical delay, and it is time and again. It is story after story. It is not an isolated incident.

Ms CATE FAEHRMANN: This inquiry has heard pretty much from most members of the community and stakeholders about what seem to be cuts to health services in regional, rural and remote New South Wales over the past 10 years, say. Do you agree with that statement? Do you agree that that is your experience as well?

Mrs OLIVARES: Absolutely.

Ms CATE FAEHRMANN: Mr Pearson?

Mr PEARSON: Yes, most certainly. Yes.

Ms CATE FAEHRMANN: Ms Payne?

Ms PAYNE: Yes.

Ms CATE FAEHRMANN: Mrs Empringham?

Mrs EMPRINGHAM: Yes.

Mr PEARSON: When you look at what Gulgong had some 10 years ago—28 beds, a matron and a CEO all on site. That is terrific. And yet we face this very rapid population rise stymied by the postcode system, which you may find interesting, and yet our services are being reduced.

Ms CATE FAEHRMANN: Yes. So it is not like there is this comparative reduction in population to justify a Government decision to reduce healthcare services.

Mr PEARSON: Definitely not, no.

Mrs EMPRINGHAM: I think the other issue is that it is all being centralised. As someone else said—I cannot remember who it was—we do not expect a base hospital in every town. But there has to be a level of care, especially emergency care and prenatal care; it is a timely thing. You have patients who are coming from Bourke to Dubbo. Dubbo is the cut-off line for any sort of care west of the State. That is a huge area that they are servicing. No matter how big or efficient your base hospital is, you cannot do that well over that distance.

Mr PEARSON: And is it a false economy where you have to have two ambulance officers off duty—so, being paid penalty rates—driving a patient a long distance to get to a base hospital? Are the incremental costs to reach that point less than having a facility available in the home town? I do not know; I am not an economist or a government official, but it rather looks like it may need revisiting. Centralisation is a great thing, but only if it works.

Ms CATE FAEHRMANN: Mrs Olivares, your mother passed away in a multipurpose service centre which was a hospital, which at one point would have had a doctor available. Is that correct?

Mrs OLIVARES: That is correct, yes. Not only that, but there was a doctor in town who had the previous contract to service that MPS. At some point the Government made a decision that whatever financial differences there were between what the doctor wanted and what the Government was willing to give him were not viable enough for those months to reach an agreement to reinstate that doctor. My mother died in a multipurpose service with a doctor in the town who the Government would not contract to support that service.

Ms CATE FAEHRMANN: How do you all feel when you hear that, for example, this Government has spent $14 billion on a Western Harbour Tunnel in Sydney as part of a $17-something billion transport spend—

The Hon. WES FANG: Chair, I am going to—

Ms CATE FAEHRMANN: —or $1 billion on an ANZ Stadium rebuild?

The Hon. EMMA HURST: Are you calling a point of order?

The Hon. WES FANG: I think that is a point of order, yes. I just think—

Ms CATE FAEHRMANN: What do you think in terms of what priorities—

The Hon. EMMA HURST: You need to call a point—

The Hon. WES FANG: No, I will give you the opportunity to jump in, though.

The Hon. EMMA HURST: Sorry?

Ms CATE FAEHRMANN: —this Government is giving regional health compared to other priorities?

The Hon. EMMA HURST: You are not calling a point of order?

The Hon. WES FANG: No, that is alright.

Ms CATE FAEHRMANN: Mrs Olivares?

Mrs OLIVARES: It is disproportionate. I feel like regional and rural New South Wales are forgotten.

Mr PEARSON: Yes, I agree with Mrs Olivares on this. It is well and good to have new infrastructure. It may be good for the city, I do not know. But we are not talking about new infrastructure in the country; we are talking about existing infrastructure that needs maintaining and upgrading according to the population growth and the needs of the community.

Ms PAYNE: Having lived in Sydney for quite a while, I think the Government would be much better off trying to find a way to have people using less cars in the city. Building extra tunnels and things is only going to put more people on the roads and make travelling in Sydney really appalling, whereas at the moment it is just appalling. I have lived in Wellington now for 20 years or something, but I think we need people's health more than we need extra car travel and buses and trains. It would be much better for the whole world.

The Hon. EMMA HURST: I will have to cut it off there and move over to Government questions because it has gone quite a bit over time.

The Hon. WES FANG: Thank you all very much for appearing today and sharing your stories. Just leading on from the political point that Ms Faehrmann was trying to make, which I do not think is really fair—

The Hon. WALT SECORD: I thought it was pretty good.

The Hon. WES FANG: We know that even if we spent double or triple the money it is attracting people to our areas that is the issue. How do you think we can do that better? Ms Payne, I read your submission, which talked about getting people to come here to Wellington.

Ms PAYNE: I started my teaching career in the country because that was where I was sent. Because I was on a scholarship I had to go wherever they said. That was the way it was. I did some country service, did some city service and I came back to the country. It is one way to get people to come: if we paid for part or all of their education and said, "If we do this for you, you have to then either pay all the money back or you go to the spot where we say we need help, we need doctors, we need whatever" and go that way. To be honest, if I have got a beginner doctor looking after me and we are going to use the screen to talk to another doctor, I would rather have a trained doctor than the trained nurse. The doctors themselves could get help from other specialists and other people around and it takes the pressure off the nursing staff.

The Hon. WES FANG: If you do not mind me asking, when you were a teacher and you were asked to come to, say, a rural or regional area—

Ms PAYNE: Forget "asked"; I was told. I was just given the, "There you are"—

The Hon. WES FANG: I was trying to be polite!

Ms PAYNE: No, no, we just went wherever.

The Hon. WES FANG: When you were told where to go, were you provided support by other teachers or by the department to—

Ms PAYNE: I went to a high school—I went to Narrabri for that. I just appeared as every first-year teacher does. Fortunately there was another music teacher in the school so I was not alone there, as such, because it was a bigger school.

The Hon. WES FANG: We heard earlier that some of the concerns would be around putting a junior doctor in a town where they would not be supported.

Ms PAYNE: But most schools have senior teachers as well as junior teachers, so there was never a problem with that.

The Hon. WES FANG: But how do you think we would address having, say, just a junior doctor?

Ms PAYNE: In a town Wellington's size, if you have got a junior doctor there are two clinics. One would assume that there would be some more experienced doctors in those two areas where they could get help. Would it not then be easier for a doctor to get the help from another doctor through the telehealth system than it is for the patient or for the nurse? At least the doctors would be talking the same sort of language, whereas the nurses are slightly different.

The Hon. WES FANG: It is valuable to get this input because we are trialling different things, such as doing rural medical schools where people will do all their medical training in a rural or regional setting—

Ms PAYNE: But that does not mean they will work in the country.

The Hon. WES FANG: No, but we are hoping that they will. I grew up in Wagga and I moved back to Wagga after I had a career. We are hoping that these people will train there. But also, how do we get them to come to other places, like Wellington or Gulgong, and embrace that community?

Ms PAYNE: There is a part of me that says if we have just paid for it all, this is where you go. I do not think you have to necessarily—if I have just got a free education, and as a doctor it is going to be a lot of money, why should they not be able to say, "Well, we paid for that. This is where you go." You spend two or three years

there and get some experience. I think that we are being so—we do not have to be that kind to them. We have been kind enough to pay them—

The Hon. WES FANG: I think—

Ms PAYNE: No, but we've been kind enough to pay them—

Mrs EMPRINGHAM: Can I just say something? Sorry, Ms Payne. I was a teacher training 17 years ago, so we are not talking about a terribly long time. I was a targeted grad, I went to Coonamble and I fell in love with the town. I think unless you go, you do not know—and quite often people do stay. It is the incentive to go there in the first place. I completely agree with Ms Payne: If you are getting something for free—you do not have to take anyone up on that—there needs to be something given back to these towns. There should be scholarships. There should be incentives on offer. I liken it to mining. No-one would choose to live in half the places that there are mines, but they pay enough money that people go there. This whole idea that we cannot get them there: money talks, I am sorry. If you pay people enough they will go. I am quite prepared to be proved wrong, but I am convinced that incentive schemes and paying people money will get them there, if the mining industry is anything to go by.

Ms PAYNE: And how much does it cost to become a doctor? It must cost a fortune! If the State pays a fortune, I think the State is entitled to say, "This is where you can go."

The Hon. WES FANG: It is a multifaceted problem and I do not know that there is one solution. But it is getting this input that is really valuable for us.

Ms PAYNE: There would be lots of poor, smart people who would happily have it. It is alright if you have got a wealthy family and they can pay for your education.

Mr PEARSON: It needs to be seen as an investment. Even in Gulgong, as progressive as the town is, when the elderly retire they think, "We need to go to Mudgee or Dubbo or somewhere where there is a hospital and where there are doctors readily available." If that were done in these other smaller centres I think the flow-on effect would be immediate because the schools would improve, the doctors bring families with them, and people are encouraged to move to the town because there is this basic right of a medical service available 24 hours a day. I do not think it is rocket science. I think it is purely an economic matter that needs to be addressed.

Mrs EMPRINGHAM: I think it starts at the university, too. Put aside X amount of places for those people who have committed to working in rural areas. Find the doctors to support those people. That is what happens in education. I do not see that it is any different.

The Hon. EMMA HURST: Thank you all so much for coming here today to give your evidence and your stories. I know some of those stories were very hard to share, so we really do appreciate you coming forward. I do not think any questions were taken on notice. Again, thank you for coming today.

(The witnesses withdrew.)

JOAN STAGGS, Private Citizen, sworn and examined

CAROL RICHARD, Private Citizen, sworn and examined

DIANE SIMMONDS, Private Citizen, sworn and examined

The Hon. EMMA HURST: I now welcome our next witnesses. Do you all have a short opening statement that you would like to read?

Mrs JOAN STAGGS: Yes.

The Hon. EMMA HURST: I will start with Mrs Staggs.

Mrs JOAN STAGGS: Mine is the same as in my submission. The purpose of this communication is to express my concern about the Gilgandra multipurpose facility. Originally in 2019 I passed on these concerns to the hospital board and to the local member of parliament. At the time I had a friend who was chronically ill, so I was visiting her on a daily basis. Sadly, things have not improved at all it seems. It is no criticism of the staff at the Gilgandra multipurpose centre at all, but the points are in my submission and I will talk to them later. Thank you.

The Hon. EMMA HURST: Thank you. Mrs Richard?

Mrs RICHARD: Yes. I have some papers I am going to ask to be tabled.

The Hon. EMMA HURST: Yes, thank you.

Mrs RICHARD: I have summarised the points in the other—

The Hon. EMMA HURST: Perfect. Thank you very much for supplying this. You may start.

Mrs RICHARD: Thank you. Though there have been other inquiries in the past—New South Wales in 1997 and the Senate inquiry in 2007—issues for country people remain constant and serious. In 2007 the Australian Medical Association [AMA] concluded that limited access to health services is a significant issue for people living in rural and remote Australia. An inadequate supply of hospital and other health services and workforce shortages in these areas were identified as key factors. This is exactly the same case in 2021. From January to March 2021, Coolah had no resident doctor, nor was there a doctor at Dunedoo. A doctor was appointed to Coolah and commenced in March. He has limitations on schedule 8 drugs and is not able to do mental health plans. This is of high priority in this district, with the major disastrous bushfire in 2017 followed by drought, severe storm events, the current horrific mouse plague, High Court case over eviction orders for 17 resident owners at Coolah Home Base park and now proposed land resumptions with high-voltage transmission lines over prime agricultural land.

Though many Coolah residents with chronic and ongoing medical conditions have found new doctors in Mudgee particularly, there is still high demand in Coolah for GP services. Regrettably there have been a number of incidences of dissatisfaction with the service provided, in particular relating to mental health issues, waiting times and an inability to obtain referrals. Coolah was promised two more doctors, one in a supervisory capacity to oversee the practice of Brenshaw Medical in Coolah. *The Bush Telegraph* says that this is delayed through issuing Medicare provider numbers.

These other points are older points. In March 2018 the Coolah Hostel community committee was formed to negotiate the return of the aged-care hostel to the community for the original $1 transfer fee. Western NSW Local Health District has apparently forgotten the issue while the lovely building sits empty and deteriorating. Telehealth has limited appeal to many older people, particularly in regard to mental health problems. There may be a breakdown in understanding the constraints of rural districts where a telehealth doctor authorises an overnight ambulance transfer for a locally assessed non-urgent case, leaving communities without paramedic support. Paramedics in Coolah have identified one serious discrepancy that occurs in rural towns. Specifically in Coolah, we have defibrillators at sporting venues but none in the main street that are accessible 24/7. Improved equity in health requires greater investment in those factors outside the formal health system, not just increased access to illness-oriented services.

In Coolah we have several local, highly trained nurse professionals who struggle to find a work-friendly environment under the high pressure of poor support services and overload that forces their resignation in favour of their own health and relationship outcomes. We have become reliant on contract nurses and nursing assistants, who do a remarkable job under very trying conditions. As recently as two weeks ago a person under the effect of drugs hammered on the doors of the MPS at night for admittance. Police were phoned but said they would come in the morning. A critical incident report was filed.

Under the worst-case scenario, the person could have gained access by force. In addition to the high workload of nursing staff, the domestic staff are also under the pump. The MPS has a huge floor area with many sitting rooms and individual bathrooms and GP consulting rooms. One staff member has requested an 18-hour fortnight and with additional call-ins ended with 83 hours in a month—unsustainable for her with a family and farm to consider. These assistant staff members provide a huge backup to assistant nurses in patient care and welfare, bringing a pleasant social presence to the oldies. Thank you.

The Hon. EMMA HURST: Thank you so much, Mrs Richard.

Mrs SIMMONDS: Diane Simmonds from Mudgee. My husband and I have been constant receivers of local doctors' and nurses' kindness and expertise over the last few years, and we have witnessed firsthand the medical staff run off their feet, struggling to cope. It is very distressing to witness. I came to Mudgee 41 years ago. In the early years I had the following operations in Mudgee: gallstones, the old fashioned big zip method; nose operation; hysterectomy; et cetera. Now gallstones, for instance, is a much simpler keyhole operation, but it can't be done in our local hospitals. You have to go to Dubbo. Why?

In about 1999 I started working at the *Mudgee Guardian* newspaper as a journalist. One constant story was our deteriorating health system. We were losing doctors and hospital facilities. Operations in Mudgee were disappearing to city centres. The children's ward disappeared. The whole second floor surgery ward disappeared. It became a multimillion dollar office space. CEOs were being rewarded for cost cutting with bonuses and career advances. Big cuts, yet we were a thriving tourist town and our population was increasing, not decreasing. Our needs were increasing, not diminishing.

As an aged person, let me tell you what it is like travelling long distances to a city hub. My husband had nine weeks' radiotherapy at Orange. He suffered horrible side effects, including loss of bowel and bladder continence. While driving him home on discharge, we had a flat tyre. My husband got out to help me but his bowel gave out. There we were, two old people on the side of the road, one undressed trying to clean up and the other one trying to help him and fix a flat tyre. My spare was too damaged to use, so we had to sit there for an hour and a half waiting for a tow truck to take us into Wellington. Travelling hundreds of miles—

The Hon. EMMA HURST: Take your time.

Mrs SIMMONDS: Travelling hundreds of miles when you are sick is not a day trip in a flash, modern car. When you are very sick, it is traumatic. My husband temporarily lost his sight last year from a stroke. We were sent to Dubbo for an MRI. I drove him. We waited in the ED all afternoon to discover Dubbo hospital did not have an MRI. It has now. The doctor admitted him, a lovely doctor, and said in the morning she would discharge him and send him to Orange, which is about 2½ hours away. There was no patient transport available, so I drove him. We sat in the Orange ED for hours. They did the MRI and discovered he had had a stroke. But he had to go back to Dubbo hospital because they said he was Dubbo's patient and Orange did not have a bed for him. So I drove him back to Dubbo. Again, in Dubbo we sat in the ED again for hours before he was admitted. I did complain about this but in a lot of spin the officials denied that it happened and said he was monitored at all times. Well, there was no-one in the car but me monitoring my husband.

I understand the need to centralise some expensive, highly specialised equipment, but travelling hundreds of miles for basic medical treatment that 20 years ago could be done in the local general hospitals is not logical. Health executives—and I know this because of my journalism—are rewarded more for saving money than providing genuine health progress, and they are spending millions on spin doctors to facilitate it and protect it. Health money should be spent on more doctors and nurses who are just struggling so much. We have some wonderful people and we should protect them and we should support them. Health executives, I feel, are turning us into country peasants with Third World health offerings. I could tell you a lot more but I will stop there.

The Hon. EMMA HURST: Thank you so much for that, and thank you all for coming today.

The Hon. WALT SECORD: Thank you, Mrs—is it Simmonds?

Mrs SIMMONDS: Simmonds.

The Hon. WALT SECORD: Simmonds. I apologise because I do recognise your name now. Years ago I think I encountered you when I was a media director to Premier Bob Carr. You were at the *Mudgee Guardian*?

Mrs SIMMONDS: Yes, I was at the *Mudgee Guardian*.

The Hon. WALT SECORD: Yes. I think I encountered you.

Mrs SIMMONDS: I retired 12 years ago.

The Hon. WALT SECORD: Yes, so I would have encountered you. What services are available—is it Mudgee district hospital?

Mrs SIMMONDS: Mudgee had its old hospital demolished after putting that multimillion-dollar, fantastic offices on the second floor in communications, et cetera. So that was all taken away and a new hospital built. It is on the surface a lovely modern building. But everyone is still sent to Dubbo if it is too complicated. I mean, I have been in there with heart problems many times and they have taken wonderful care of me, but my husband has been shipped out, shipped out and shipped out many times. Even in the building itself, there is just so many—it was just slapped up. I just feel that the health department is spending money on all these wonderful buildings, demolishing all our old hospitals and building these wonderful new buildings, and the money is going there instead of going to the patients and the doctors and nurses. Doctors and nurses can work in an old building far better than a new building that is empty.

The Hon. WALT SECORD: Do you know what services are available at Mudgee hospital?

Mrs SIMMONDS: We have got an emergency department, we have doctors most of the time—I understand sometimes we have to resort to the television thing—we have got nurses. I think we have got a maternity ward. I do not think we have a children's ward—I think they all get shipped out if it is not minor. I am not sure what else because, frankly, for the last six years I have been looking after my husband full-time and my hands and my mind has been there.

The Hon. WALT SECORD: I understand.

Mrs SIMMONDS: That is why I can tell you first-hand, watching what happens and watching people work so hard. In my own family I have got a doctor, a nurse and a radiographer. I know how hard they all work and how frustrated and tired they get sometimes.

The Hon. WALT SECORD: Mrs Richard, your relationship or your submission relates to Coolah MPS. Is that correct?

Mrs RICHARD: Yes. And the provision of GP services.

The Hon. WALT SECORD: How do you feel? Do you personally go to Coolah MPS or do you go somewhere else?

Mrs RICHARD: Fortunately, I have not had serious problems lately. I did have a heart check-up and I went to specialist at Dubbo before Christmas. But this year since we have not had a GP, and now we have one who has limitations, I still have not needed his services.

The Hon. WALT SECORD: Mrs Simmonds, what would you like to see happen at your local hospital if we were to make recommendations?

Mrs SIMMONDS: At our local hospital and hospitals across country areas, I would like to see basic general hospitals that can do basic things with a doctor at least on duty—depending on the population, more than one doctor—but people on duty who are not harassed so much by overwork that they can cope with what is happening. I know it is very hard to put expensive—you know, you have got to have your hubs for more serious things. Money for patient transport and thinking about the realities of people travelling hundreds of miles when they are in pain or they are sick or whatever. For children, fancy living in a town that does not have a children's section in their hospital. I am glad my children are grown up.

The Hon. WALT SECORD: Mrs Staggs, what would you like to see happen at your local hospital? Your local hospital is Gilgandra.

Mrs JOAN STAGGS: It is a multipurpose service.

The Hon. WALT SECORD: Yes, MPS, sorry.

Mrs JOAN STAGGS: When it was a hospital, it was a jolly sight better, like everybody else was saying too. I have to agree with so many of the comments about the fact that it seems like it is the people above—the nurse managers and the general managers—who are making the decisions without any community input at all. That is my big concern. My concern with my friend in there, as I have pointed out, was over the Christmas period they told the community nurses that they had to take two to three weeks holiday. There was no choice about it. You have got to take it. The fact that they wanted to stagger it and always have a community nurse person on hand, there was no consideration taken to that. They just have to take their holidays and that is it.

We are at the junction of three highways. There is often accidents. So we are emergency, we are critical care and we are also palliative care in the hospital. There will be two people rostered on there. I have found that because there was everybody away—my daughter-in-law, incidentally, is one of the community nurses. And the

local physiotherapist said to me, "When on earth is she coming back?" I said, "She is on holidays. They have been told they have got to take their holidays." They were being run off their feet—the physiotherapy and all the allied health people—because at that stage all the GPs have a holiday too.

The Hon. WALT SECORD: So who was at the hospital?

Mrs JOAN STAGGS: That is about it, isn't it?

The Hon. WALT SECORD: I am asking you the question. Who was at the hospital?

Mrs JOAN STAGGS: I can tell you, there is two people. I would go early in the morning to see my friend who was terminally ill and the hospital doors would be locked. Because with two nurses there, they had to for their security—you mentioned about a drugged person. This sort of thing happens. So they have got to have the front door locked because there is nobody on reception. So how do you care for all those sections of the multipurpose—it is certainly multipurpose these days. It is not a hospital. It is just trying to look after—so you have got these girls who are trying to do their best to look after the patients they have got there, but they have also got to be safe that they are not going to be attacked inside.

The Hon. WALT SECORD: So two nurses responsible for how many patients?

Mrs JOAN STAGGS: I cannot answer that. I am not on the staff. I do not really know. There is emergency, there is the critical care patients, the chronically ill people—which is my friend that was in there who had experiences that I can relate to, in that she had to have radiotherapy at Orange hospital. They could not accommodate her in there, so they put her at Molong. She had cancer of the spine. She was transported, in many cases sitting up, in this patient transport. She said it just hurt so much getting to have her radiotherapy and to go back from Orange base to Molong—who were nice enough to take her in. Of course, one of the nurses was so good she used to come and visit my friend in Orange because she was from a small community who realised that she had no other family down there and nobody of support. But she was just a number at Orange Base Hospital. The best care she honestly got was in Gilgandra with people that knew her and knew her state of affairs.

Keep this in mind, for the Government, we need that community input because we know what is going on. When it is a decision made in Macquarie Street or wherever it is made about what the budget can be, you get two people who are overworked and probably underpaid—mostly they are not worried about their pay; they are worried about the care of their patients. I have seen my daughter-in-law in tears, worried about what was going on because she is bright enough to realise that—well, somebody had a perforated bowel and she could not talk to any doctor to do anything to back her up. They are the realities that, unfortunately, giving money to people who are further up the food chain, get bigger salaries in probably wonderful conditions, but they are not seeing what is happening to the patients, to the staff and to the communities. My heart goes out to all the people who have spoken in small communities. Dubbo is not an answer for us only.

The Hon. WES FANG: That is why it is important to hear your story.

Ms CATE FAEHRMANN: I want to turn to the submission that this Committee has received from the Government in terms of how it says it is working for regional communities. The Government's submission says that multipurpose services is actually a response to what it sees as challenges of rural and regional health care and it says that this is an adoption of contemporary models of care. The submission says that multipurpose services:

> … increase access to local health care services … that provide sustainable health services in small rural communities to meet the needs of local communities.

Is that happening? Is that your experience with multipurpose services, Mrs Simmonds?

Mrs SIMMONDS: Well 20 years ago the Government could do a lot better. Why can't they now?

Ms CATE FAEHRMANN: So multipurpose services 20 years ago, is that what you mean?

Mrs SIMMONDS: No, not multipurpose. The old hospitals 20 years ago could actually provide immediate health service, basic health services, for their communities. Now that is not happening, especially in the multipurpose units.

Ms CATE FAEHRMANN: Why is that? Is that because of cost-cutting?

Mrs SIMMONDS: I believe so.

Ms CATE FAEHRMANN: Is that less staff for the patient needs?

Mrs JOAN STAGGS: I think so.

Mrs SIMMONDS: Lack of staff is cost-cutting, isn't it, because they will not pay staff. People do not want to come (a) because there is not enough pay but (b) I suppose they are missing out on their career advances

not being in a big public hospital where there is opportunity. If there were some, as people have been saying, scholarships to pay for country doctors and nurses to be trained but also on the need for advancement and being elite, if that country training was seen as a badge of honour because of the variety of experience country medical workers get when there is advancements in career coming, I think that would help as well.

Mrs JOAN STAGGS: Can I also add to that? I am only three years retired from the local high school, which is alongside the multipurpose centre, and I had the role of welfare person there so I was constantly dealing with the hospital or the MPS about things. Twenty years ago, yes, it was better in Gilgandra. We had doctors there with their wives and their children going to the school and they had the sort of services that we are now missing out on. Okay, we are an aging population; I realise that. We have a big need for palliative care. But we have got to get that people that are in the community that they will come back to us. I belong to what we call the Country Education Foundation and I promote people going. We have had several boys and girls from Gilgandra High School go and become doctors and go into allied health. Those people will come back to a country area. We need the GP rural training system, but we need to encourage country people because they understand our community. The person in the city who is doing the figures does not understand the community.

Ms CATE FAEHRMANN: The Government submission does say:

> This submission demonstrates significant progress in the delivery of healthcare in rural, regional and remote areas of NSW.

Everything we have heard today and in the previous two hearings seems to just be the exact opposite of that statement.

Mrs SIMMONDS: Yes. It is not progress.

Mrs JOAN STAGGS: Yes. It is not progress.

Ms CATE FAEHRMANN: The reform to these multipurpose centres and the removal of the hospital wards and all of that that we have heard, from your points of view has that been successful?

Mrs SIMMONDS: No, it is not working.

Mrs JOAN STAGGS: No. The local input, as the gentleman from Warren said, that is what you need. You have to have that local input because they do not understand the fact that we can have those accidents happening, we can get those things happening and we can have the local druggie appearing at the doorway too.

Mrs RICHARD: I would like to say that it is a building; it is not a facility that caters for the community.

The Hon. EMMA HURST: Mrs Richard, you mention in your submission a really good standard of care of the nurses and other staff going above and beyond. Are you concerned that they will get to a point of burnout because they are having to go above and beyond over and over again and doing extra shifts? We heard a lot of evidence today.

Mrs RICHARD: Yes, certainly that is what is happening. We have lost some wonderful highly trained nurses because their lives fall apart outside the hospital because of their hours and the strains and the stresses.

Mrs JOAN STAGGS: Yes.

The Hon. WES FANG: Once again, and I have said it to all the witnesses today, thank you very much for coming in today. I think it has been really important and valuable to get your insights. Talking about the multipurpose centres, as we have been doing for much of the day today, I know there has been a lot of I guess criticism of those, but throughout this inquiry we have heard some good stories as well. Do you have any positive stories? I guess what I am worried about is that there are advantages to the model and there are some good stories that come out of it—something like telehealth. There are a lot of good stories from telehealth around things like the Telestroke Service where they are able to provide stroke services using a specialist stroke doctor who can actually give real-time information and it has saved a lot of people in rural and regional communities. I am really cautious about demonising MPSs and about demonising telehealth. Do you have some of those good stories and do you think you might be able to share them with us?

Mrs JOAN STAGGS: I have got one. With my friend, she was so ill she did not want to come to the oncologist in Dubbo. It was so uncomfortable for her, so we did an audio visual link and she wanted me to speak to the oncologist. It worked really well because basically all she wanted—she did not want visiting medical officers, or VMOs, she did not want radiotherapy, she wanted pain relief. That was a really good solution for both him as the oncologist and my friend because by that stage she was not feeling well enough to do it but she wanted me sit and talk to him about it. That was an advantage, but that is right at the very end of a person's life. There are advantages. The point about the fact that you have got the palliative care, you have got the aged care, you have got the critical stuff in together in some ways, but you have got have the staff. It is no good having the best building in the world if you have got nobody there to work for it. So, sorry, but—

The Hon. WES FANG: You are right, what we need to do is bring the community along with us and engage with them around these issues.

Mrs JOAN STAGGS: Absolutely. Yes.

The Hon. WES FANG: It is really important that you actually shared that story with us because, again—

Mrs JOAN STAGGS: You want something positive; I understand. You will not sleep tonight.

The Hon. WES FANG: No, it is not just that. I just think it is really important that we hear the good with the bad because I think there are issues around the community having trust in this as well. We need the community to trust in our staff in our services as well. Not every story is a bad one, so I thank you for that. Mrs Simmonds, I just wanted to talk to you about your experiences and—

Mrs SIMMONDS: Can I just add to your one about the telehealth thing?

The Hon. WES FANG: Sure. Absolutely.

Mrs SIMMONDS: My husband's stroke doctor has spoken to him numerous times on the telephone with pictures and things and it works. That is good; it is follow-up and it works. He directs—our doctor—to get various tests done and then he has those test results in front of him and then he can talk to Peter about those, and that works. That is another good story about those. But your best good stories are in the doctors and nurses who are trying to do all this work.

The Hon. WES FANG: I think the other thing is I want to make sure that our staff know that they are supported as well. I just fear that sometimes if we keep focusing on the negatives in these aspects—

Mrs SIMMONDS: Yes, I agree.

The Hon. WES FANG: —it is demoralising for the staff, and the staff are doing such an amazing job on the ground—

Mrs SIMMONDS: They are.

The Hon. WES FANG: —and we really need to support them. I just think it is really important that we have those conversations.

Mrs SIMMONDS: My husband and I have had incredible kindness and expertise and help and it has been wonderful, but we have eyes to see what is happening as well.

The Hon. WES FANG: It is those experiences that are really important.

The Hon. WALT SECORD: Wes, let us agree that patients, doctors and nurses are being let down by the Government.

The Hon. WES FANG: No, please, Walt—

The Hon. NATASHA MACLAREN-JONES: We have had a very civilised day, Mr Secord.

The Hon. WES FANG: Yes. Please do not do that, Walt. That is just not appropriate. The last question I wanted to ask you, Mrs Simmonds, was around your experience of being transported, with the transport and stuff, and I guess you providing that transport.

Mrs SIMMONDS: I am 74 and I am driving him around.

The Hon. WES FANG: You cannot be 74!

Mrs SIMMONDS: Yes, I am.

The Hon. WES FANG: How do you think that provision might have been done better? What could we have done, do you think, to have made that a better situation for you and your husband?

Mrs SIMMONDS: I am not quite sure. Perhaps patient transport. He was, and all the men that were receiving that treatment over there—it was a beautiful place to receive the treatment—but he was there for nine weeks, and he is not the only one. Probably more help personally with personal transport, et cetera. If Peter had not have had me he would have been by himself. I do not know how he would have coped. It is a problem going long distances. Another time, going down to Westmead, I was in hospital and Peter waited—a 70-plus-year-old man really ill himself sat in the waiting room all day, waiting for me to have my operation, and I did not go in, for some reason, until the evening, and then I had complications with anaesthetic.

It was after 11 o'clock when they let my husband out the doors. There were no taxis there; no-one offered him any help. In a strange place he had to walk about a mile to where we were staying, and some young fellows

came up behind him. He heard them coming up behind him and he immediately rang our daughter and turned around to face them on the phone and he heard, as they walked past, one of them say to the other, "I told you you should have moved quicker." What could have happened? I do not know the answer. There are a lot of smarter people than me who could think this through. I do not know what the answer is.

The Hon. WES FANG: I guess it is that tyranny of distance that we all face living out here. Your insights into it, they are something that we can try to help you with and try to address, not only for you but for other people. So thank you very much again for coming and sharing that with us. I think we are out of time, are we, Chair?

The Hon. EMMA HURST: Yes, we are.

The Hon. WES FANG: Thank you again.

The Hon. EMMA HURST: I thank you all for attending today and providing evidence. Thank you for coming and speaking with us. We truly appreciate it. That concludes our hearing for today and the broadcast will now cease.

(The witnesses withdrew.)

The Committee adjourned at 16:07.