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 Lismore Workers Club, Lismore, on Thursday 17 June 2021

The Committee met at 11:40.

PRESENT

The Hon. Greg Donnelly (Chair)

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

The CHAIR: I welcome everybody to the eighth hearing of the Portfolio Committee No. 2 – Health inquiry 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, and planning and capital expenditure in rural, regional and remote New South Wales. Before I commence, I would like to acknowledge the Widjabul people of the Bundjalung nation, who are the traditional custodians of this land. I would also like to pay respect to Elders past, present and emerging of the Widjabul people and extend that respect to other Aboriginal people present here today or who will be joining us here this afternoon or who may be joining us on the internet.

Today we are hearing from a number of stakeholders including local community groups, private enterprise, private citizens and the local health district. I thank everyone for making the time to give evidence to this important inquiry. Before I commence, I would like to make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available in a couple of days' time. In accordance with broadcasting guidelines, media representatives are reminded—and I welcome the media who are joining us now and may be joining us over the course of the rest of the day—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 their evidence at the hearing. I therefore urge witnesses to be careful about comments you may make to the media or to others after you complete your evidence to the inquiry.

Committee hearings are not intended to provide a forum for people to make adverse reflections on 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 of the Legislative Council in 2018. If witnesses are unable to answer a question today and want more time to respond they can take that question on notice. Written answers to questions taken on notice are to be provided back to the secretariat within 21 days. Finally, if witnesses wish to hand up documents they should do so through the Committee staff, who are here to support us. In terms of the audibility of the hearing today, I remind both Committee members and witnesses to speak into the microphones. Finally, could everybody please turn their mobile phones to silent for the duration of the hearing.

Before going any further, I acknowledge—as I ought to and is appropriate—the member for Lismore, Janelle Saffin. She is a very well-known member and hardworking member representing the most important electorate of the North Coast, up here in Lismore. It is great to see you, Janelle, and your staff as well. We have got to come and see you. Also, Ryan Park, the shadow Minister for Health, is joining us today with his staff—you are all welcome. There are and will be representatives of NSW Health come in and visit over the course of today, as they have done. They are welcome. Of course and importantly, to members of the public, it is great to see members of the local community here in Lismore and more broadly coming along to this public hearing today. It is great to see you.

SHARON BIRD, Proprietor and Pharmacist, Bonalbo Pharmacy, before the Committee via teleconference, affirmed and examined

GEORGE THOMPSON, Member, Coraki Health Reference Group, affirmed and examined

MARILYN GRUNDY, Branch President, Old Bonalbo CWA, sworn and examined

MAUREEN FLETCHER, Chair, Ballina Cancer Advocacy Network, sworn and examined

The CHAIR: We welcome our first panel of witnesses. Thank you so much for agreeing to come along. The contribution of evidence from witnesses to inquiries is vitally important and inquiries would be much impoverished without people like yourself agreeing to come along and give evidence.

Mr THOMPSON: I am a member of the Coraki Health Reference Group and I would like to acknowledge the presence of two other members of that group here today, Carol Hill and Suzie Carey.

The CHAIR: For the record, I note and confirm that you have all made submissions to the inquiry. Mrs Grundy, your submission stands as submission No. 278. Mr Thompson, your and your organisation's submission is No. 179. Mrs Fletcher, your submission is No. 184. Mrs Bird, you very enthusiastically submitted two submissions—Nos 347 and 423, which, obviously, are to be read combined. They have all been received, processed and stand as submissions to this inquiry. They have been uploaded to the Committee's webpage. I raise that specifically because I will invite you all to make an opening statement. When making that, you do not need to read out your submissions or part thereof; simply set up, if you do not mind, the key points that you wish to present to the Committee at this hearing today. That will enable us, as Committee members, to have the maximum time to go through questioning of you. I will give each of you, one at a time, a chance to make an opening statement. If you could keep it to a maximum of three or four minutes, that would be great. If you have to do a bit of editing as you go through, that is fine. We will start with Mrs Fletcher.

Ms FLETCHER: Ballina Cancer Advocacy Network [CAN] committee would like to thank the Committee for this inquiry. Cancer care is complex and there is no simple answer to improving care. Ballina CAN was established with the support of Cancer Council to be a voice for the needs of the region. Our market research in 2012 highlighted huge differences. Much has changed with improved medical treatments here in the hospital. However, the missing component is care—that is, mental and emotional care. Most cancer patients feel traumatised when hearing the words, "You have cancer."

Our submission advocates for a dedicated care coordinator to be available to support all cancer patients—that is, men and women. This care person should be available at the hospital during treatment and out in community post-treatment. We hear comments like, "I was overwhelmed; I felt totally alone," and, "When I heard the news, I just thought I would die." Support is needed—support for the mental impact of diagnosis, the psychosocial needs of the patient. And support is needed to gain knowledge of what services are available—services needed both during and after treatment. The submission draws on case studies and anecdotal evidence where patients have needlessly suffered because they were not aware of what was available. You can refer to some case studies that I have put forth to be tabled.

The CHAIR: Just to confirm, so we all understand, you are referring to this document that has on the first page "Case Study No. 1" with some stapled additional pages?

Ms FLETCHER: That is right, sir. Just to highlight a couple, we had a man who had had melanoma who had half a nose, so he was socially isolated. He only found out that a prosthetic nose was available when a fellow patient asked at hospital why he did not have it. This highlights the gap within the hospital outpatient system. Also, a woman, after having a breast lumpectomy at the Gold Coast, returned to Byron. Next day, having issues with her wound, she went to Byron hospital. No help was available at all, and the Tweed breast nurse did not return calls. This highlights the gap within community. These two cases are only representative of experiences that we hear from people all the time. For myself, I had a breast nurse and joined a support group, and still I struggled at times. I had never been to hospital before in my life. My treatment took 16 months, and that is a lot of chemo. I do not have family and I do not have children, and I had only been in the area for two years.

Breast cancer has a strong support service outside of the hospital system. The McGrath nurses have a high profile, and they do wonderful work. Our submission advocates for a dedicated cancer care coordinator to work alongside current staff, such as social workers, to support both men and women, be they an inpatient or an outpatient, and when they are back in the community. This position would ensure equity across all cancers. In northern New South Wales the four biggest cancer diagnoses are, firstly, lung, then prostrate, colon and then breast cancer. Only breast cancer has a dedicated nurse. If your diagnosis was one of the lesser known cancers, who would you turn to? A cancer care coordinator would be the point of contact in the hospital or in the community

for emotional support as well as a point of contact for the diverse services available but yet unknown by the general public. If we wish to improve health outcomes in our regional areas, we need to improve care. Thank you for your time and this opportunity to speak on behalf of our community.

The CHAIR: Thank you, Ms Fletcher, for your excellent opening statement. It was very precise, clear and on point for us to be able to ask you some questions. Would you mind if our secretariat liaised with you to obtain a copy of your opening statement to assist Hansard with the transcription? That would be great. That was excellent. Mrs Grundy, would you like to make an opening statement?

Mrs GRUNDY: Good morning, honourable members. I am Marilyn Grundy, and I am representing the views of members of the Old Bonalbo branch of the Country Women's Association of NSW in the upper Clarence Valley. We live in a long, narrow valley bordered by ranges, with the only roads being in the north and south out of the area. The area covers Old Bonalbo, Urbenville, Bonalbo, Tabulam, Mallanganee and Drake. We are a community of many rural properties and smaller holdings with a large number of senior and lower income-earning people. We also have a large First Nation community. I would like to thank and acknowledge all who have provided our multipurpose service [MPS] after closure of the hospital in Bonalbo. We have a good doctor who comes out regularly and stays in the town for three nights. He is here four days per week and is fully booked. He is available for phone consults, for a script clinic, telehealth and support to emergency department and inpatients at prescribed times.

During the interim between the closure of the hospital and the new MPS being built and a doctor being found, most people had to go to Casino or Lismore. Even now some people give up going to the doctor because of wait times, distance and inability to actually attend due to travel, and it all gets too difficult. I have had no medical training, but I feel that I can recognise when medical care could have been provided differently. Our members believe that healthcare outcomes can be improved by overcoming some of the barriers that are imposed by geographic isolation and unpredictable and rudimentary exposure to healthcare professionals.

Clients who suffer with chronic illness and those with varied, complex needs are generally travelling at least 70 kilometres to 100-plus kilometres and travelling for various amounts of time, which can be in excess of three hours, to access private or public allied health services, with almost no or unreliable public transport in our area. Our main problem that we are faced with at the moment is that it is like we have one slice of bread instead of a sandwich containing a nourishing and sustaining filling. We have our MPS and doctor with good staff but could do better with more allied health professionals, another doctor who fills in when our current medical officer cannot be there and more staff with extra qualifications—for example, nurse practitioners, first line emergency care nurses et cetera. I have tabled a folder, which I think has been given out.

The CHAIR: It has, yes.

Mrs GRUNDY: I also wish to thank you for listening to me.

The CHAIR: We are very grateful that you made yourself available to come along today, Mrs Grundy. Thank you for that excellent opening statement, and I acknowledge receipt of the folder. I think all members have a copy, which contains that statement, and that is supplemented by a number of additional pages with some quotations and some tables and what have you, which no doubt we will come to when we get to questions. Mr Thompson, welcome.

Mr THOMPSON: Thank you, Chair. Coraki needs a doctor. We are a community of 2,000 people 30 kilometres south of Lismore. When I first visited Coraki 25 years ago, there was a hospital and three doctors; now we have no hospital and no doctors. The hospital in Coraki, which was called the Campbell hospital after the local benefactor John Campbell, who founded it in 1904, was closed in 2011 following storm damage to the building. The North Coast Area Health Service, as it was then known, decided not to undertake the repairs, not to reopen the hospital, but to redirect the resources elsewhere. Generations of local residents have been cared for in that hospital. Many of them were born there, many of them died there, many of them found employment there, so the loss of the hospital is still keenly felt in the local community.

With the closure of the hospital, the Northern NSW Local Health District instituted a process to develop a clinical services plan to determine how the health needs of the community could best be met, and that plan recommended the establishment of a HealthOne facility in Coraki. The HealthOne was duly built with funding from the New South Wales Government and it was opened in 2017. We now have a very nice, state-of-the-art HealthOne facility in Coraki, which offers a range of community health services. It offers community nursing, physiotherapy, occupational therapy, speech therapy for children, women's health, chronic disease clinics and even, from time to time, oral health. But the members of the Committee would be well aware that the essence of the HealthOne model is co-location of general practice with community health services. It is an integrated and multidisciplinary model of care. It is the GP who directs the care of the patients. It is the GP who makes referrals

to the allied health professionals in the centre. It is the GP, in collaboration with those allied health professionals, who monitors the progress of the patients.

But in Coraki we have a HealthOne with no GP. We have rooms for two GP practices but those rooms are empty. We feel we have a HealthOne without a heart. We know that this problem of a lack of a GP in small, rural communities is not unique to Coraki. In fact, I have had a look through the submissions to this inquiry and I can tell you that the following submissions all draw attention to the absence of a GP or chronic shortage of health professionals: Bonalbo, Eurobodalla, Gunnedah, Deniliquin, Edward River, Manning Valley, Port Stephens, Temora, Glen Innes, Gulgong, Wee Waa, Wollondilly, Mid-Western Regional Council, Coleambally, Warren Shire Council, Broken Hill, Wentworth, Merriwa, Tenterfield, Parkes, Coonamble, Gwydir, Bourke, Hay and Leeton. This is a serious problem; it is crying out for solutions. I know lots of good work is being done all over the State in every local health district [LHD] to develop solutions to redress this lack of medical professionals in rural areas, but I can tell you from our own experience in Coraki and from the submissions to your inquiry that that solution has yet to be found.

We look to you, our elected representatives and community leaders, to come up with solutions that will attract and retain the services of medical professionals in rural areas like Coraki. In closing, can I just add that our group has also included a suggestion in our submission that a GP practice might be more attracted to Coraki if the HealthOne was converted into a multipurpose service model in collaboration with the 49-bed aged-care facility, which is located right next door to the HealthOne. We have also called for the location of an ambulance in Coraki to cut down the turnaround time of one hour, at best, to get an ambulance from the nearest stations at Evans Head and Casino to the Lismore Base Hospital. If we had an ambulance in Coraki, we could cut that time in half. Thank you very much for the opportunity.

The CHAIR: Thank you very much, Mr Thompson. Just a small segue: It is very impressive. I have found as we have travelled—we have been to a number of places around the State—individuals like yourself from local communities identifying an issue and coming together and being extraordinarily intelligent and creative in coming up with proposals and ideas to deal with local matters. The work that has gone into the research to understand the scope of the issue, and then turning your mind to positive, intelligent, reasonable propositions for the State—when I say the State, I mean the Government, including the Executive Government—is very impressive. It has struck me time and time again. We have people coming along from communities, working with us to try and address their local issues. I think, number one, it really reflects on the seriousness of the issue; and, number two, it really falls on those in the positions of power to listen and make appropriate decisions. Thank you for that. Mrs Bird, can I invite you to make an opening statement? If you could keep it reasonably short, that would be great.

Mrs BIRD: Sure. Honourable members, I trained in pharmacy at the University of Queensland and by age of 25 I was chief pharmacist at Bundaberg Base Hospital. I bought my first rural pharmacy in 2002 and Bonalbo Pharmacy in 2015. May I start by emphasising the great positive impact the new MPS has made in our area, which serves approximately 4,000 patients coming from up to an hour away. Palliative care used to be a tremendous failing, with people left to die in their homes at a time when they needed intravenous pain relief and full-scale nursing care. By this stage, their carers are themselves ill and exhausted. This does not happen anymore as we have four inpatient beds, including a palliative care suite. I can also point to greater efficiencies in our local GP practice, which operates out of the MPS. For years there was a three- to four-week wait for an appointment, even as recently as my submissions at the start of the year. But recently, thanks to telehealth, prescription clinics and special clinics just for urgent GP cases, they are now achieving a lot with their limited resources.

Many customers still see doctors elsewhere but would like to be able to see a doctor locally if the capacity were there. Our worst problems occur over the doctor's four-day break every fortnight and around public holidays and holiday leave, when he is not always replaced with a locum. Pharmacists major in minor illnesses, and I can usually treat those, but when it comes to conditions requiring a prescription or conditions that need referral to a doctor, my role is to refer them on for appropriate care. If there are no appointments available for weeks and no emergency doctor, we are out of luck. I often encounter situations where people are in too much pain to travel an hour or more over our rough roads to see a doctor in our larger centre. I can give several examples. We need a locum for holidays, or preferably a second doctor to fill the gap. A cost-effective way to achieve this would be to have a rural generalist registrar three days a week under the supervision of our specialist, who is a rural generalist GP.

We also have an X-ray machine but no trained staff on site to run it. We have a radiographer coming out for two hours once a fortnight, so we advise our patients to schedule their accidents for that day. Frustratingly, offers of scholarships to train nursing staff have been rebuffed by management. Finally, assuming that the goal is better health outcomes for rural patients, I offer barriers to people accessing health care in rural areas and possible solutions. Many of my customers have had negative experiences when accessing health care in the referral centres

such as Lismore and Casino. Those who have previously waited three to four weeks and travelled for hours for an appointment in Lismore or Casino with no outcome—or who have had a previous bad experience, like being abandoned in Lismore in their pyjamas after an emergency ambulance trip with no way to get home again—are reluctant to seek help or call an ambulance again. It would help if people in these centres were aware of their local geography; perhaps this should be part of job orientation.

Our local roads are terrible, and the road conditions and weather conditions make travel to Casino dangerous, especially when in poor health. Two of my customers have been seriously injured in accidents on the Bruxner Highway in relation to hospital or medical visits over the last five years, and there are regular fatalities on that stretch of road. Thick fog in the mornings and evenings, or driving into the sun in the early morning and late evening, add to the risks. We need appointments in the middle of the day, if possible, and for imaging and other tests to be available on the same trip to town. I commonly hear of elderly people having to leave at the crack of dawn to get to their appointments, or having to go to town three or four times a week, when each round trip is two to four hours and does a lot of damage to their cars. Some private specialists in the city manage to streamline their appointments like this. Perhaps we can learn from them and it should not cost any additional cost to the healthcare department, just a rearrangement and a streamlining of things.

I would also propose a change to the GP Medicare billing to allow an appointment which is long enough to take a full history and physical examination for rural patients. To travel two hours or more for a 15-minute appointment which yields no result is such a deterrent to even trying to make contact with a doctor. I would say perhaps people do not understand our culture, but when rural people, especially farmers, seek help, they have already tried everything they can and put up with terrible symptoms. You may have just one chance to get it right or lose them as patients until it really is too late to diagnose their problem.

The CHAIR: Thank you, Mrs Bird, for your detailed opening statement. Once again, this is a further example of coming with ideas and thoughts genuinely to address matters identified in the local community around the matters this inquiry is considering. We have half an hour for questions. Because I came under some reasonable criticism yesterday about going overtime a little bit with the sessions, we will do it tightly at 10 minutes each.

The Hon. TREVOR KHAN: It was not criticism. It was constructive.

The CHAIR: It was constructive criticism, yes, indeed. I accept that point. But to obviate the problem today, we will keep it 10 minutes tight. Members, please do not ask after the bell, "Can I have that question?"

Ms CATE FAEHRMANN: It is Walt's fault.

The CHAIR: Not dobbing in any particular member. They can identify them. I have not got a problem with that. But I will not identify them. There is 10 minutes each. We will start with the Hon. Walt Secord, whom this was not referred to at all.

The Hon. WALT SECORD: In line with the declaration that Mr Khan made yesterday when we were in Gunnedah, I would like to disclose to the Committee that I worked with Mr Thompson from about 2006 to 2008 in Canberra. I thought it was appropriate, in line with yesterday's declaration by Mr Khan that I would make the same declaration.

The CHAIR: Thank you. That is respected.

The Hon. WALT SECORD: On that note, Mr Thompson, Coraki has been without a doctor since 2017 in a town of 2,000 people.

Mr THOMPSON: No, longer than that. The last visiting medical officer [VMO] at the hospital stayed on for about a year and then went into Lismore and we were left without a doctor then in 2012. After some effort, we managed to encourage a practice in Casino to establish an outreach clinic in Coraki. We had a doctor there for one or two days a week, but it was really insufficient to build up a client base and after about six months they withdrew that to Casino. So I would say since the end of 2012 or 2013 we have been without a GP.

The Hon. WALT SECORD: Since 2013—it has been eight or nine years. What are local residents doing to get health care?

Mr THOMPSON: We go to doctors in Evans Head or Lismore or Casino or sometimes Ballina and the Gold Coast.

The Hon. WALT SECORD: Is it frustrating to see a HealthOne facility constructed and built there and not have a doctor? I have heard it said in the past that having a doctor is like having a heart in the centre of one of those facilities.

Mr THOMPSON: It is, and it is frustrating. We are very grateful for the HealthOne. It is a terrific facility. It should be very attractive infrastructure-wise for a GP, but it has not been enough to attract one.

The Hon. WALT SECORD: Are people neglecting health problems or reluctant to pursue concerns about their health because of a lack of a doctor in the community?

Mr THOMPSON: I would say so. We have, I think, 12 per cent Aboriginal population in Coraki. Many of those do not have their own transport. The effort of finding transport to get to a doctor—and often you have to wait at least a week to get an appointment with a doctor. That effort is simply too much. So I am sure many of them leave their health concerns unattended because of the difficulty of seeing a doctor.

The Hon. WALT SECORD: Mrs Grundy, do you find a similar situation in your community?

Mrs GRUNDY: Yes.

The Hon. WALT SECORD: I understand you are quite pleased that the doctor comes four days a week, but what happens on the other three days a week?

Mrs GRUNDY: We suck it up.

The Hon. WALT SECORD: How large is your community?

Mrs GRUNDY: It is about 3,000 people in the whole district.

The Hon. WALT SECORD: You laughed when you said, "We suck it up."

Mrs GRUNDY: We do use our ambulance service and we get deposited in either Casino or Lismore if there is a real problem.

The Hon. WALT SECORD: What do you mean "use" the ambulance service?

Mrs GRUNDY: The ambulance service is called if there is a problem. But if you are just going for a routine appointment or something, there is a wait of at least two weeks to get into the local doctor. I do not know what wait times are like now in Lismore or Casino. I think it would be similar.

The Hon. WALT SECORD: Back to your doctor, he is there for—is it a male?

Mrs GRUNDY: Yes.

The Hon. WALT SECORD: What is the wait to get to see the doctor in your community?

Mrs GRUNDY: About two weeks.

The Hon. WALT SECORD: If you actually had to make your own way to a hospital or to a medical facility outside your community, how long would a trip like that take?

Mrs GRUNDY: From 1½ hours to three or four hours depending on where you reside in the area. On a rural property or something it could take quite a while. Our roads are quite rough. A lot of people do not like to travel at night because of stray cattle, kangaroos, wallabies and all sorts of things on the road.

The Hon. WALT SECORD: If you take an ambulance—what is the closest major hospital? Is it Lismore?

Mrs GRUNDY: Casino would probably be the first but they usually take us to Lismore.

The Hon. WALT SECORD: Why do they take you to Lismore rather than Casino?

Mrs GRUNDY: It is the only 24-hour hospital service.

The Hon. WALT SECORD: What would a resident do in your community if they are discharged from Lismore hospital? How would they get home?

Mrs GRUNDY: That is one of our huge problems. Like Mrs Bird has just told you, it is a big problem. We get shuffled out and there is the transit area and you have to wait outside because they have no room in the transit area and no room in the hospital for you so you are outside. You have to call somebody to come and get you. Some people just do not have somebody else to come and get them.

The Hon. WALT SECORD: What do they do?

Mrs GRUNDY: To be honest, I do not know. I suppose somebody will eventually come and get them.

The Hon. WALT SECORD: Eventually.

Mrs GRUNDY: Yes. This used to happen to my son-in-law. We used to—my daughter, actually, used to work out that she had to follow the ambulance. He would get put out at about two o'clock or three o'clock in the morning and either one of us had to run in and get him or, like I said, she went in. She used to follow the ambulance and go in and pick him up after some time.

The Hon. WALT SECORD: Lismore hospital is discharging patients in the middle of the night.

Mrs GRUNDY: Yes. I concur with everything Mrs Bird has said. Our people are left there. We have got no means of getting back. There is no public transport, the ambulance has gone back to Bonalbo or wherever to another case, there is no—what do you call them now—inter-hospital transfer services—

The Hon. TREVOR KHAN: Patient transport services.

Mrs GRUNDY: —between Lismore and Bonalbo. There is just nothing. You have really got to rely on family, friends, neighbours or whoever is coming to town to pick you up.

The Hon. WALT SECORD: That is extraordinary.

Mrs GRUNDY: If you had gone into town without your wallet or the ambulance has picked you up in a comatose state or whatever, you really are in a lot of trouble.

The Hon. WALT SECORD: I will ask a question of Mrs Bird on the telephone. Can you hear me, Mrs Bird?

Mrs BIRD: Barely.

The Hon. WALT SECORD: I will move closer. Do you find yourself, as the pharmacist in the community, providing de facto health care to the community?

Mrs BIRD: Absolutely. And that is a free service because we do not have any funding to cover my time with that. The demand is much greater when the doctor is not here, of course.

The Hon. WALT SECORD: Do you find that you assume a lot of responsibility and a lot of pressure? I am sure you take it on willingly, but do you find yourself under a lot of pressure and under an obligation to the community?

Mrs BIRD: Yes, but it is something that we are trained to do as pharmacists, but there is still a line that we cannot cross. There is a new initiative by the Federal Government called Continued Dispensing. When somebody runs out of prescriptions, if they cannot see a doctor in time we are allowed to do a repeat of their chronic medication.

The Hon. WALT SECORD: Do you find that because of the remoteness and a lack of health care in your area and lack of a doctor, you are called upon to use this service or this mechanism much more often?

Mrs BIRD: Yes, definitely, quite frequently. But it has been a real blessing. We are allowed to do that once a year for each medication. I used it to help some people—no, I did not. I needed it during the bushfires. I remember a couple that had lost everything, but I rang their doctor and I said, "Do you mind if I just give them one of everything?" And he backed me up with some prescriptions later on. But if that happened again, it would cover us in that sort of emergency situation too. So, even though that is a Federal program, I would encourage you to talk to your colleagues to make sure that that continues once the COVID threat—you know, do not let them stop that.

The Hon. WALT SECORD: What do you do when you have someone appear in your pharmacy with a major health problem with no doctor on duty and no hospital? What do you do in those situations?

Mrs BIRD: I had a lady have what looked like a stroke. We just gave supportive care and called an ambulance for her. The ambulance took about 45 minutes to get there, so it was a really long time. Sometimes you will refer people and they just look at me and say, "I'm not going to call an ambulance because they'll send me into Lismore and then I'll get stuck there." Or I might say, "Look, this is really serious. You need to see somebody." And they just look at me sadly and say, "It's just too hard."

The Hon. WALT SECORD: The lady who had the stroke—were you able to provide the assistance for her and get her to hospital?

Mrs BIRD: Yes, we were able to give her some aspirin. We were able to just be with her and encourage her and just hold her head up and all those sorts of things. We would have physically taken her up around the corner to the hospital, but she could not walk. We needed an ambulance to transport her, so we just waited until the ambulance got there.

The Hon. WALT SECORD: Thank you, Mrs Bird. That is the end of my time.

The Hon. EMMA HURST: Mr Thompson, we have just been hearing from Mrs Grundy and others about ambulance services. In your submission you said that there is no ambulance service in Coraki. Is that correct?

Mr THOMPSON: There is no ambulance in Coraki, but we do, of course, have access to the ambulance service.

The Hon. EMMA HURST: But how long would that take?

Mr THOMPSON: It takes 30 minutes for an ambulance to get to Coraki from either Lismore, Casino or Evans Head, which are the nearest stations. Then, of course, it will take another 30 minutes to get to either Casino rural hospital or to Lismore Base, which is the normal destination.

The Hon. EMMA HURST: What does that delay mean in a practical sense?

Mr THOMPSON: I can tell you from personal experience. My wife suffered a stroke in 2012 at home and I called the ambulance. The ambulance took 25 minutes to get there, which I thought was pretty good, but by the time the paramedics consulted with the hospital to make a diagnosis of what ailed my wife, it took another 40 minutes to get her into Lismore Base. So well over more than an hour had passed since the onset of the stroke, and the window of opportunity to administer thrombolysis to try and break the clot in her brain was closing when we got to the hospital. There was no neurologist there and there was no stroke unit, so the doctor on duty consulted by phone with John Hunter Hospital and we spent probably an hour or two toing and froing about whether thrombolysis was appropriate in her case. The decision was eventually reached that it was, so she was injected, but regrettably it was not successful and my wife suffered a couple of haemorrhagic strokes as a result of the thrombolysis. Then, because she could not be put onto blood thinners because of the haemorrhagic strokes, she suffered another couple of ischaemic strokes as a result of her atrial fibrillation, and she ended up in quite a mess and she has never walked since. The ambulance service could have saved vital time in her case.

The Hon. EMMA HURST: Do you think also having access to specialists in the stroke area would have helped as well?

Mr THOMPSON: Most definitely, most definitely. I know a stroke unit was subsequently established at Lismore Base, which was a great improvement, and there is now a Telestroke virtual health service, which I believe is achieving quite a lot in rural areas.

The Hon. EMMA HURST: Another thing you said when you were talking to my colleague from the Labor Party was that the new HealthOne facility was a good facility but it was not enough on its own to attract a GP into the area. What is needed to attract a GP into the area? Is it just extra financial benefits, or are there other things that are needed as well?

Mr THOMPSON: I think it is a combination of factors that affect lots of rural communities. First of all, perhaps it is the lack of financial reward. There would be fewer services than metropolitan doctors would get. That is one factor: The client base perhaps is not big enough. Another factor is the lack of professional support for single rural GPs. That is gradually being overcome by telehealth, because the GP can consult professionals elsewhere and specialists elsewhere for advice and mentoring, but that is another factor. Another factor is the lack of employment opportunities—relative lack of employment opportunities for the spouses and perhaps lack of education opportunities for children. These are all factors that influence a GP when they are considering whether to go to a rural community.

The Hon. EMMA HURST: We have talked a lot about telehealth, and while I think there has been an agreement that it can be an essential service, there are a lot of concerns in different places that there is an over-reliance on that because of the difficulties of getting GPs and specialists into areas. This is probably for anybody: Is anyone nervous that there will be an over-reliance on this system in their local areas?

Mr THOMPSON: I think, yes. I think there is a fear in communities that telehealth will be a substitute for face-to-face services and we do not want that. As an addition to those services or for filling gaps when those gaps are unavoidable, yes, it has great advantages. But in Coraki, for example, one-third of households—this is going back to the 2016 census—did not have internet, and they are probably the people that most need access to health services. Telehealth, in their case, is not much use.

The CHAIR: Can I just jump in with a question? I will not cut into Ms Cate Faehrmann's time. If you do not mind, Ms Fletcher, in regard to the provision of palliative care services, would you like to comment on those?

Ms FLETCHER: Palliative care services?

The CHAIR: Yes. Obviously you are dealing specifically with cancer through your work. At the end of life the need for people to transition into palliative care to deal with the lead-up to their death—are you able to make any comment about your observations with respect to what is available to help people at the very end stage of life?

Ms FLETCHER: I am not prepared on that answer. What I do know is that Ballina has a palliative care unit that works well for it. It is something that has improved in the last bit but there is always a gap. I have heard some good reports. I think it is a changing space. What I am more aware of is the trauma that people have when they first hear of it and their mental health of their diagnosis, and palliative is further down. So it is a long journey, because there is a diagnosis, there is your treatment, and then it is living life. One of the great concerns is when people get secondaries come back, and that is another great trauma. Palliative to me is a separate issue, but I can find out more.

The CHAIR: That is okay, but it is part of what is a series of stages people will go through.

Ms FLETCHER: It is a long journey.

Ms CATE FAEHRMANN: I am listening to all your evidence, hearing about the lack of GPs and the lack of ambulance services. We are also hearing about more and more people moving to the Northern Rivers, particularly from Sydney. A lot of these people when they do fall ill or get injured are in for a bit of a shock, aren't they, in terms of the lack of health services available? Mr Thompson?

Mr THOMPSON: They are, but most of them tend to settle in the coastal areas where there are more services. Evans Head, for example, is well served by doctors. It has got a population of only 3,000.

Ms CATE FAEHRMANN: I feel like every second person I talk to talks about moving into the hinterland, to be honest, including around places like this.

The Hon. TREVOR KHAN: Yes, but that is a subgroup of people.

The CHAIR: Order!

Ms CATE FAEHRMANN: The situation here has got surely worse. It sounds like it has got a lot worse over the past five or 10 years. Is that your view as well, Mrs Grundy?

Mrs GRUNDY: Yes. Our services have been getting less, especially our allied health professionals are not being replaced and are not coming in regularly.

Ms CATE FAEHRMANN: I am thinking with the particular situation of the Lismore Base Hospital at night and having people going to the emergency department sick and then being booted out at a certain time in the middle of the night with no transport available. Do you think that is a result of key performance indicators [KPIs] set by the Government to ensure that people are discharged within four hours? Have you heard anything in relation to that? Mrs Bird, I might go to you first.

The CHAIR: She may not have heard that, Cate.

Ms CATE FAEHRMANN: Okay. I will go to Mr Thompson then and then I will repeat it.

Mr THOMPSON: I do not know the answer to that question but I would guess it is due to the demand for beds. There is a huge demand on beds in the hospital. So when people are ready for release, I would imagine the hospital takes the opportunity to release them and free up a bed for a more urgent case.

Ms CATE FAEHRMANN: You are aware that there is a KPI set by the Government which is a four-hour discharge for people going into emergency departments?

Mr THOMPSON: Yes.

Ms CATE FAEHRMANN: I wondered whether people locally were talking about that?

Mr THOMPSON: I know that benchmark is there. I cannot remember the extent to which the northern New South Wales LHD meets it, but I think they go close.

Ms CATE FAEHRMANN: It sounds like it, if they are booting people out in the middle of the night. Shall I ask Mrs Bird that question? Mrs Bird, I have a question in relation to the people who are being left on the side of the road, it seems, after being ejected from the Lismore Base Hospital in the middle of the night. Some of the witnesses and submissions have mentioned that this is happening more than once, as you have said.

Mrs BIRD: Yes.

Ms CATE FAEHRMANN: Do you think this is in any way due to the fact that there is a KPI that has been set in recent years for people to be discharged, if possible, within four hours after entering an emergency department? Are you aware of that KPI?

Mrs BIRD: No, I was not, but it certainly makes sense because we could not understand as a community. I have been part of the chambers of commerce committee in town here as well, and it was raised as an issue some time ago in that committee as well. Now I understand a bit more why that would happen. Often if it is an emergency and it is the middle of the night. I have a friend who was a single man, had not been in Bonalbo long, had a pulmonary embolism, rang the ambulance and I think that he managed to stagger outside. He had left his wallet behind on the floor. He was wearing his pyjamas. He dropped his mobile phone on the way. He dropped the house keys outside by the car. The ambulance got there, picked him up, put him in the ambulance and took him off to the hospital. He called me later that day from his hospital bed and luckily he had us as friends—he was renting my house at the time. I went there, collected the keys, collected the mobile phone, put his wallet somewhere safe, collected some clothes and we were able to drop them off to him. But that is just another example; it happens often.

Ms CATE FAEHRMANN: To clarify, after he was discharged from the hospital he was ultimately collected by the ambulance to go back to the hospital?

The Hon. TREVOR KHAN: No, that is not what she said.

Mrs BIRD: No.

Ms CATE FAEHRMANN: That is what I am clarifying, Trevor.

Mrs BIRD: No. He was not completely bereft, like some people might be, but he could potentially have been left in that situation. Other people I have tried to encourage to call an ambulance just look at me and go, "No, I might just be stuck there and I won't have a way to get home." They would prefer to drive themselves in to the hospital so they have got their car there for transport to get home, but that is not always wise either.

The Hon. WES FANG: Thank you very much for all appearing today. I wanted to touch on the Coraki hospital to start with, Mr Thompson, if you would not mind. Are you able to talk about the hospital before it suffered the storm damage and the like? What services were provided at the hospital? Did it have an emergency department [ED] that was 24 hours or was it partly staffed during business hours and then on-call afterwards? Do you have those details?

Mr THOMPSON: It was a fully staffed small rural hospital. It did have an ED capacity and there was 24-hour on-call ED attention there. There was only one VMO, I think, at that stage, so that service would have been pretty thin. Most of the beds towards the end of the hospital's life would have been used more for rehab than acute care.

The Hon. WES FANG: Was the doctor who provided the on-call service there also a GP in town?

Mr THOMPSON: Yes.

The Hon. WES FANG: How many GPs did you have in town back when the hospital was—

Mr THOMPSON: Back in 1996 there were three. I think when the hospital was closed in 2011, there were probably—there was the resident GP in Coraki who was also the VMO. There may have been one other doctor on call as well.

The Hon. WES FANG: So they did share the on-call? It was not one doctor doing the on-call the whole time and the other two GPs just being GPs in town? It was a shared service.

Mr THOMPSON: That was a way back. That was when I first visited Coraki before I became a resident.

The Hon. WES FANG: I am just trying to establish a baseline of what occurred in Coraki before.

Mr THOMPSON: In its heyday, yes, it was a fully staffed hospital running acute care and all sorts of care.

The Hon. TREVOR KHAN: I take it, Mr Thompson, that what you are describing is what has occurred really throughout regional Australia over the past 30 or 40 years, and that has been the gradual drawdown of GPs who are available to small communities.

Mr THOMPSON: Yes, definitely.

The Hon. TREVOR KHAN: Do you think in regards to that that this situation has been exacerbated by, for instance, the cap that was placed on increases in Medicare rebates for some years by, I think, governments of both persuasions that has made general practice less economically viable?

Mr THOMPSON: Yes, but those caps probably apply equally to rural and metropolitan practitioners.

The Hon. TREVOR KHAN: That is true, but you have also pointed out that really the patient base for general practice in small communities in particular is much smaller than what you can get in a large city practice.

Mr THOMPSON: That is true. The Government's recent decision to increase Medicare rebates for rural hospitals should help. Whether it solves the problem or not remains to be seen.

The Hon. TREVOR KHAN: Would a more available loading for Medicare rebates in rural and regional, particularly small towns, also potentially help in attracting general practice back into these small towns?

Mr THOMPSON: I am sure that will help.

The Hon. WALT SECORD: Trevor, you are trying to argue—this community has been without a doctor since 2013.

The Hon. TREVOR KHAN: Come on, Walt. Just behave yourself for a change.

The CHAIR: Not "for a change". Let's continue the line of questioning. Trevor has the call.

The Hon. TREVOR KHAN: Thank you. You have identified that what we have now received into this inquiry are submissions from across the State—and I am sure, if we were in the Senate, across Australia—that show there has been a gradual drawdown, a gradual loss of that general practice skill base.

Mr THOMPSON: Yes.

The Hon. TREVOR KHAN: And, really, there needs to be some substantive response to that basic criterion or that basic problem that exists in our communities.

Mr THOMPSON: Absolutely.

The Hon. TREVOR KHAN: Have you got any other suggestions as to what may—and obviously, for instance, you have seen some of these submissions like Dr Holliday's that we got yesterday in Manning. I direct this to the three of you. Have you got any suggestions as to what you think might attract general practice back into these towns?

Mr THOMPSON: There are a range of initiatives that have been taken by different local councils all across the State to assist with rental of premises, provision of a house for the GP and assistance with transport. But even those initiatives do not seem to have been able to completely address the problem. I would also argue that it is not a responsibility of local councils to be providing ongoing funding for GPs.

The Hon. TREVOR KHAN: Let me just say, Mr Thompson, you have got me on board on that. There is a division of responsibility in these matters.

The CHAIR: I think Mrs Bird might want to respond to that question.

Mrs BIRD: Yes, please. I think you have really got to look to the whole family. One of the biggest cultural changes in the last 50 years has been women entering the workforce en masse. You are really looking for jobs for not only your GP but also his wife, who is most likely a professional, and there just may not be anything available for her. If that is the case and you are looking at a family man, then he is looking at educational opportunities for his children, which may or may not be appropriate in a really small town. Unless you can make their families happy, they are not going to be likely to come and live and work in a rural area. Having said that, why would you not be able to get somebody in Coraki? It is lovely, it is quite close to the coast and it is close to bigger centres. If we cannot find somebody for places like Bonalbo and Coraki, we have got no chance of finding somebody to go and work in Gunnedah.

The Hon. TREVOR KHAN: As I live near Gunnedah, I think that is a bit unkind on Gunnedah.

Mrs BIRD: My son has just spent five years in Gunnedah.

The Hon. TREVOR KHAN: Mrs Bird, seeing as I have got you there, in terms of the restrictions on what you do at your pharmacy, are there any changes that either the State or Commonwealth governments could make that would broaden what I could call the allied health services that you are capable of providing to your community that you are currently restricted from doing?

Mrs BIRD: Yes, definitely. There is no reason at all why pharmacists could not be given a Medicare billing number or capability for consultations on minor health conditions. Sometimes the best management is not necessarily a product; it is more advice. That would help greatly. I think there are a number of areas we could help in. One that has been suggested is helping in the case of urinary tract infections because if a person gets prompt antibiotic treatment there they can avoid a kidney infection and subsequent hospitalisation. Another one that would be very helpful I think would be in cases of vertigo or gastro bugs and things like that. If we had some limited prescribing capabilities there, it might help—so sort of the role that a nurse practitioner who has got a right to prescribe. That might be very helpful. I have the pharmacy open from 9.00 a.m. to 5.00 p.m. each day. We are very busy in the mornings, but it would be possible to change the practice so that you were doing more consultation-based work in the afternoon. That would be a way that you have got a trained person who could fill in some of the gaps when the need arose.

The Hon. TREVOR KHAN: Mrs Bird, it was indeed the nurse practitioner concept that interested me in terms of what pharmacists do. Would there be a need for some form of additional training to be available to you to fulfil that role?

Mrs BIRD: A lot of that would have been covered already at university, especially in the modern courses as well. I would say it would be fairly minimal training—maybe an examination to make sure that that person's clinical skills were up to scratch. Just to have the opportunity to do minimal prescribing and maybe being able to do some increased examinations of the patient or history taking, that kind of thing would help a lot I think.

The Hon. TREVOR KHAN: My time has expired, Mrs Bird, but I am most appreciative of your comments. I thank the other witnesses as well. I am sorry I have taken my friends' time. No, I am not. I lied!

The CHAIR: Thanks very much. It is all good banter amongst members here. We are all good friends. That draws that session to a conclusion. On behalf of the Committee, I thank all present and Mrs Bird over the telephone for the frankness and the clarity in which you have been able to answer specific questions and particularly inject some very interesting and valuable ideas to supplement what was said in both your submissions and opening statements.

(The witnesses withdrew.)

CHRISTINE ROBERTSON, Private Citizen, affirmed and examined

CHRIS HOARE, Private Citizen, affirmed and examined

FLORIAN ROEBER, Private Citizen, affirmed and examined

ANDRE OTHENIN-GIRARD, Private Citizen, affirmed and examined

The CHAIR: On behalf of the Committee, thank you for making yourselves available to come along to provide us with the opportunity to supplement the content of what were some very good submissions. Before we go any further, I take the liberty of welcoming Mrs Robertson, who many of you would know, and if you do not I want to acknowledge this: Mrs Robertson had a distinguished period of service in the Legislative Council as a member of the Labor Party. Over the years I spent with her in the council, which were a number, if there was one area that would have to be identified as her policy area of not just interest but declared advocacy over, it is the matter of health and health outside the margin of metropolitan areas. I know it is being a bit political, but I want to say that Christine was a warrior, in her own way, inside the Labor Party but also in the House about drawing attention to the needs of the citizens of New South Wales outside the major metropolitan areas and in drawing to the attention of whoever the Minister of the day was—and in those days it was Labor government Ministers—the need to give proper attention to the needs of people outside those metropolitan areas. I just want to acknowledge that.

Mrs ROBERTSON: Thank you, Mr Chair.

The CHAIR: I invite each one of you to make an opening statement. Please keep them reasonably concise to enable the maximum time for questioning—so three or four minutes.

Mr OTHENIN-GIRARD: Thank you. My name is Andre Othenin-Girard. My submission was No. 206. I want to talk about my own experience and draw your attention to the high costs to the State and individuals associated with waiting times and submit that underfunding rural and regional health is an illusory comparative economic advantage. You will understand why. I want to inform the inquiry about additional troubling information received since lodging my submission. I also want to talk about the unrealistic workloads of nurses and doctors in hospitals and the security issues that they face. Since I have been invited to witness, I have read other submissions. A couple of them reminded me of something I experienced unrelated to my own submission and if the Chair will allow me I would like to touch on this as well.

The CHAIR: Please.

Mr OTHENIN-GIRARD: Thank you. That is my introduction.

The CHAIR: Thank you very much. Forgive me, I should have declared at the start, with respect to all your submissions, they have been received and processed by the secretariat and stand as submissions to the inquiry. You are quite correct; yours is submission 206. Dr Roeber's is submission 218, Mr Hoare's is submission 426 and Mrs Robertson's two submissions are 432 and 432A. They have all been processed and uploaded on the inquiry's webpage. Dr Roeber, would you like make an opening submission?

Dr ROEBER: Thank you. My name is Dr Florian Roeber. I am, by training, a veterinarian with specialist skills and post-graduate qualifications in infectious animal diseases. I work for a local veterinary contract research organisation that conducts contract research for the animal health industry and therefore requires quite specialist personnel with specialised skills. I moved from metropolitan Melbourne to the Northern Rivers region in early 2019 to commence this position but unfortunately became unwell with a neurological condition within the first six months of my arrival. My neurological condition had an acute onset in August 2019 and resulted in a marked weakness of my right hand and the inability to fully extend my fingers, as well as chronic pain in my right arm and shoulder. Not only has this condition seriously impacted on my ability to work and my quality of life overall, but I also had to experience significant lack of certain medical professionals with the required expertise to accurately diagnose and treat my condition.

Basically, the end of the story was that I had to travel to the Gold Coast to find specialist neurologists and neurosurgeons and this has resulted in significant expense for travel as well as time off work. Therefore, I am grateful to be given the opportunity today to share my story with the Committee and hope that this will increase the awareness of the medical needs of the Northern Rivers community and people residing in rural and regional New South Wales altogether. I guess the key message I want to communicate today is that the lack of specialist medical professionals in rural and regional New South Wales means that patients residing in these areas are disadvantaged to those that live in major metropolitan cities. Also, often patients have to travel long distances—

The CHAIR: Sorry to interrupt. That was a quite nice opening statement that you have just given. Do you mind if we just get to the other opening statements and we will come back to you?

Dr ROEBER: Of course.

The CHAIR: Sorry to cut you off, but we will certainly return once we get through the opening statements. Mr Hoare, do you have an opening statement?

Mr HOARE: Yes. I might ramble on a bit before I get to my submission.

The CHAIR: If you concentrate on what you would like to draw to our attention, I am sure the questioning that comes from the members will draw out the specifics you want.

Mr HOARE: Not specifics; just a few other things. This affirmation I do not mind taking, but on your first page here of being a witness you are talking about opinions and perspectives. I am not, to paraphrase a previous prime minister, a repository of facts and figures but I have got opinions and perspectives.

The CHAIR: We are more than happy to hear opinions and thoughts.

Mr HOARE: Another thing: There were 708 submissions; 273 had their names suppressed and 87 were confidential. That adds up to 50.8 per cent of all the submissions—so that is over half. I suggest that that is due to fear, because a lot of the submissions were from staff, nurses and doctors and some mentioned repercussions and backlash from health departments or the community. The other thing I will briefly touch on, because the NSW Farmers Association has brought it up nicely, is about dental health. There is very little being talked about that, but they suggest it should be in Medicare and bulk-billed. There is a lot of expense in that. The other little point is our choice is to live in the rural area for health. It might be a problem sometimes when injury or sickness happens, but we feel advantaged and privileged to live in the bush. We live two hours away from here and half an hour from Bonalbo, which is our local chemist and hospital, and sometimes floods and other things get in the way of being able to get anywhere. We are used to travelling, anyway.

The CHAIR: Sorry, where do you specifically live?

Mr HOARE: It is called Lower Duck Creek.

The CHAIR: It sounds like a beautiful place.

Mr HOARE: It is a great place, on the eastern fall of the Great Dividing Range. Our place was completely burnt out by a huge bushfire in late 2019, which makes things a little bit difficult.

The CHAIR: Yes, no doubt.

Mr HOARE: In my submission, one of the main things that happened to me personally was presenting at the emergency department [ED] at Bonalbo to get stitched up. On that occasion, as I have mentioned in the submission, there were three nurses in Bonalbo and none of them could stitch me up. So they contacted Urbenville shadow on-call doctor and Urbenville suggested they send me to Casino, but the nurses told me to just present at the ED and they probably would not turn me away. So that was one experience. That was a half-an-hour drive to Bonalbo, another half-an-hour drive to Urbenville and between I had to knock up the local petrol station because I was low on fuel—it was after hours, of course.

The other thing—probably the main thing—was talking about medications. I have got a long-term, stable or finite condition that does not change, and no history of abusing the medications I need to take. Twenty-five years ago I had a brain tumour—pituitary adenoma—and I take thyroxine, cortisone and testosterone and a couple of other things to sort that out. What I suggest there is—and this might be a detail—that there is established a hotline; that someone can identify me on the other end; I say, "I need this, I need that"; they post the medications to me. We pay in the normal way you would pay for any transaction on the phone, and the next day I see I have got some medication. Sharon Bird has been very helpful with that; she is our local pharmacy.

The CHAIR: Yes, we have heard from her.

Mr HOARE: I have got nothing against Mark the doctor there, who is a great doctor, but he is only there four days a week and there can be considerable waiting times. I have got other things, but that will do.

The CHAIR: No, that sets it up very nicely. There is a lot of detailed information there from a personal point of view. Thank you for being so honest. It is not easy to come and sort of lay out, dare I say, parts of your life so openly as you have done in a public fashion, but it does enable to us to look at some fine detail around those issues you have raised. We thank you for that. Mrs Robertson?

Mrs ROBERTSON: Thank you, Mr Chair. I recognise the traditional owners of this land and their Elders past, present and emerging. Thank you for inviting me to participate in this inquiry. As already has been

stated, I personally know some of the Committee members. I came here not to speak—I do beg your pardon, my main issue relates to planning processes in rural health care. I am concerned there has been no update of the hospital role delineation in this local health district since 2016. The role delineation document, obviously from the Health submission that is on the end of this day, is an incredibly important component of rural health and if it is not taken any notice of—I really have come not to speak. Role delineation is the way you tell at what level a hospital can deliver service and when people should be moved on to a higher-level facility, a function which used to belong to the area planning departments using the health ministry's specialist-led role delineation guidelines. The guidelines are constantly updated, despite the fact the submission at the end of this day says it was last done in 2016. When you go to the net, you can see that there are new dates on the bottom of the role delineation document. It is constantly updated.

The data collection is absorbed by patient satisfaction surveys, it would appear to me, occasions of service and waiting times, and are used as political tools by both sides of Parliament. They always have been. They are not useful data collection tools for health outcomes. There is a local health district strategic plan which mirrors the board's contract with the ministry. There is no current service plan that I can find for this local health district. Operational staff are responsible for maintaining budgets, implementing the central statewide silos, managing equipment failures, managing the community advisory groups, managing the constant staff shortages currently compounded by our accommodation crisis—like everywhere on the eastern seaboard, rents and housing have gone through the roof—and, it would appear from our experience in Maclean, organising major hospital changes. The mothballing of an acute ward in Maclean was stopped by community outcry. It is not good enough that community outcry stopped it and not good enough it was to be mothballed without proper planning processes.

It appears that health planning is now totally covered by contractual consultants. The current process at Grafton-Maclean does seem to be comprehensive and should result in a clinical services plan for the future of health services for the Clarence—that is the low bit of this local health district—which is a perfect example of an underfunded rural health service. Nothing like an election to get a promise—too bad. We got the planning because there was an election on. Health services need to be right and happen at the right place at the right time We need assessment, referral and transport, and the ability to look after the people who fit into our service delineation. We do not need brain surgery, cardiac surgery, inpatient mental health, midwifery and paediatrics in every town. We need the funds, staff and resources to deliver what we actually need. The rest is in my submission. Thank you.

The CHAIR: Thank you very much, Mrs Robertson. As usual, you were very pointed and very clear.

Mrs ROBERTSON: I am so sorry, I am out of practice. It is my voice; see, I don't use it now.

The CHAIR: I could hear the adjournment speech ringing in my ears from years gone by. Thank you so much.

The Hon. WALT SECORD: Mr Othenin-Girard, can you tell me a bit about the difficulties that you faced? Where do you currently reside?

Mr OTHENIN-GIRARD: I live in Lismore.

The Hon. WALT SECORD: You actually had to seek services in Brisbane and the Gold Coast because—

Mr OTHENIN-GIRARD: Yes. I was diagnosed with atrial fibrillation in 2006.

The Hon. WALT SECORD: I am sorry, can you explain that in simple terms? What does that mean?

Mr OTHENIN-GIRARD: It is a heart that does not beat properly. I had to wait 14 months for my first appointment with a cardiologist.

The Hon. WALT SECORD: Fourteen months?

Mr OTHENIN-GIRARD: Fourteen months.

The Hon. WALT SECORD: In New South Wales?

Mr OTHENIN-GIRARD: In Lismore.

The Hon. WALT SECORD: And then what happened at the end of the 14 months?

Mr OTHENIN-GIRARD: I met the cardiologist. I had a stress test, an ultrasound, a blood test and whatever, and he put me on some medication. That worked well for a number of years—in fact, for a long time—but I had a heart attack in 2016 and the medication I was on he had to withdraw because it was not appropriate after my heart attack. He put me on another medication, which I was allergic to. He recommended that I have an

ablation, which is a procedure where they burn a part of the heart that closes the fibrillation. He recommended me to the Princess Alexandra Hospital—

The Hon. WALT SECORD: In Brisbane.

Mr OTHENIN-GIRARD: In Brisbane. I had to wait a long time—I cannot remember how long but a very long time, more than a year—to see the cardiologist at Princess Alexandra. There we discussed the case and everything and he thought that I could have an ablation but he thought that I could go on a drug called amiodarone and that would keep my heart in sinus so I went on amiodarone but after a year it affected my thyroid. They had to take it away and they did not have any more medication to regulate my heart anymore because I was allergic or the drugs caused side effects.

The Hon. WALT SECORD: In the meantime, you are driving from Lismore to the Gold Coast to Brisbane.

Mr OTHENIN-GIRARD: What happened is that—let me try to get the sequence right—after a year, they had to take me off amiodarone. My cardiologist in Lismore decided that he would recommend the ablation again. He said, "My staff will advise the hospital and so forth." After six months, I had another appointment with him and I asked him about where I stood in the line. He said he does not know yet. He asked his staff and the next day the staff called me and they said they called the hospital and there was a stuff-up and I was not on the waiting list. They put me on the waiting list and I was again in the queue. Then two years ago, I got a call from the Princess Alexandra Hospital and they advised me that they were transferring my case to the Gold Coast University Hospital because of COVID and I could not travel to Brisbane. The Gold Coast Hospital let me know that they received all the papers and so forth and that I was in line, you know, in the queue.

The Hon. WALT SECORD: Did your cardiologist explain why you could not be treated in Lismore? Is it a rare—

Mr OTHENIN-GIRARD: They do not do this procedure here. This is something that I want to question as well, because Lismore Base Hospital has a state-of-the-art operating theatre suite and an intensive care cardiac unit but they cannot perform an ablation. It seems like an aberration to me. But, anyway, that is how it is.

The Hon. WALT SECORD: My questions are actually getting to that point. There are, I understand, state-of-the-art facilities here and they are not being used or maximised. How did that make you feel when you discovered that you were travelling to the Gold Coast?

Mr OTHENIN-GIRARD: It is very inconvenient. But I am very lucky because I am mobile and I have support from my wife and my children. But I am thinking if I was alone and if I had a pet or something like that, you know, it would cause a lot of stress in my life.

The Hon. WALT SECORD: What did you do during COVID?

Mr OTHENIN-GIRARD: Pardon?

The Hon. WALT SECORD: During COVID, when the border closed, what happened? Were you able to get through?

Mr OTHENIN-GIRARD: No. So, what happened is, I had to wait until January of this year before I could see the cardiologist from the Gold Coast Hospital and that is only because, having no drug to care for my fibrillation, I was hospitalised five times for cardioversion.

The Hon. WALT SECORD: Here in Lismore?

Mr OTHENIN-GIRARD: In Lismore—cardioversion TOE, which is a trans-oesophageal echocardiogram. This is done under anaesthesia and it costs a lot of money, obviously. I have been hospitalised eight times in Lismore. Not counting tests carried out when I was hospitalised, I had numerous stress tests, Holter monitor surveillance, an inordinate number of ECGs, X-rays and blood tests, echocardiograms, ultrasounds, electrosounds, nuclear medicine perfusions, sleep apnoea tests, CT scans and probably more than 50 GP visits during those four or five years after my heart attack.

The Hon. WALT SECORD: But no procedures here?

Mr OTHENIN-GIRARD: No procedures, just the angiograms. In hospital I also had two angiograms, five cardioversions and trans-oesophageal echocardiograms. Every time I go to the hospital they do all the normal blood tests, X-rays and sometimes a CT scan and more. So that is an awful lot of cost just for waiting in line, right?

The Hon. WALT SECORD: I understand.

Mr OTHENIN-GIRARD: The cost of the operating theatre, the cardiologist, the anaesthetist and assistants, nursing staff in the theatre, in the reception bay, in the recovery bay and add to this the cost of ancillary services like orderlies, meals and deliveries, cleaners, administration and rehabilitation staff and so forth, you know, it goes on and on—it is a very expensive thing just to be waiting.

The Hon. WALT SECORD: Dr Roeber, is your experience similar on a lack of specialists at Lismore Base Hospital? Do you have similar experiences to Mr Othenin-Girard?

Dr ROEBER: Yes, I think it is similar. In my case there was a complete absence of neurologists in Lismore at that time. When I first saw the GP the only neurologist he was aware of was up at the Gold Coast. So he referred me to a total of four different neurologists at the time to see which one I could see first. The first appointment happened after six to eight weeks of waiting.

The Hon. WALT SECORD: Six to eight weeks?

Dr ROEBER: It was six to eight weeks before I could have my initial consult with the first neurologist, who also then, after half an hour talking to her, dismissed me saying that she does not have the skill and the expert knowledge to diagnose and treat my condition. To explain a little bit more, I basically woke up one morning and could not move my right hand anymore all of a sudden. So far it has never really conclusively been diagnosed. It has been called an idiopathic neuropathy—"idiopathic" meaning "of unknown cause". I had to basically run to the GP here, who said, "Well, I can only refer you to the Gold Coast". I saw the neurologist there, after six to eight weeks, who told me then, "I don't know what to do with you" and then it took another three to four weeks until I was referred to the director of neurology at the Gold Coast, who then started kind of investigating my case.

The Hon. WALT SECORD: Did you have to drive yourself from here to the Gold Coast, back and forth?

Dr ROEBER: A total of 15 times or so.

The Hon. WALT SECORD: How many times?

Dr ROEBER: Fifteen, at least.

The Hon. WALT SECORD: What about working and supporting yourself? How were you able to do that?

Dr ROEBER: Fortunately, my workplace has been very accommodating and kind of adjusted my position to a way that still allows me to work. So rather than being more hands-on with the animals, which is kind of what I do, I have been provided with more office duties and have a more managerial role rather than hands-on researcher.

The Hon. WALT SECORD: Mr Hoare, can you tell me about your experience? You live in a place called Lower Duck Creek.

Mr HOARE: Yes.

The Hon. WALT SECORD: What happened when you went to the multipurpose service [MPS]—I think it is Bonalbo MPS—and they said they could not stitch you? Were you surprised that you showed up to an emergency department and they could not stitch you?

Mr HOARE: Well, yes. I am just trying to think if it was the MPS then or the old hospital.

The Hon. WALT SECORD: Okay, well, even a hospital then?

Mr HOARE: One or the other. So I had rung them up previously and I knew there was not a doctor there. They said, "Come in and we'll have a look. It might not need stitching." I was pretty sure it did. There was a big gouge in my leg.

The Hon. WALT SECORD: Was it a cut in your leg?

Mr HOARE: Yes. I was just finishing up for the day and clambering over a trailer and I slipped off. I do not know what I hit, but a bit of steel sort of made a bit of a—

The CHAIR: Gash.

Mr HOARE: I had half a runner full of blood and I thought, "Oh, that doesn't look too good", when you see all the white bits and that. So I wrapped it up and I gave them a ring. They said, "Come in", so I did. So that is about half an hour. Anyway, there were three nurses there and they had a look. They said, "Oh, yeah, that needs stitches." But they cleaned it up, wrapped it up and rang up Urbenville which had, at that stage, a doctor. Like

I said, I knocked up the petrol man and then took off to Urbenville and just had a short wait there and got stitched up.

The Hon. WALT SECORD: How long was it from the accident to getting stitched up?

Mr HOARE: An hour and a half, two hours.

The Hon. EMMA HURST: I would just like to ask Mrs Robertson, based on the introduction that was given by the Chair and I understand that you have been involved in this space for a long time, what do you think are some of the essential recommendations that should come from this inquiry? What should be some of those top-line things that have been going on for so long that need fixing?

Mrs ROBERTSON: I think one of the biggest issues is that it is very difficult for the community to get a handle on what is happening in Health and why. I am not sure, but there needs to be someone to attack the health department and all health services with a plain English mallet so that it is explained what health services can happen where and why they happen there. In this area, our tertiary services are mostly offered by Queensland. Some persons go down to Newcastle or Sydney, but mostly by Queensland. So mostly we accept that we have to go to Queensland for our tertiary services. There is just no other way around it. We just do not have the numbers of humans or the numbers of disease processes or specialists to have otherwise.

If people could really understand what the role delineation meant then maybe it would be much easier for the services to provide what they need rather than be pushed around by political processes nonstop, so I think that would make a difference. The problem with the lack of GPs is incredibly difficult. Someone hit the nail on the head here earlier when they said, "There's no admitting rights, so we're not going to get a GP." The GPs used to come to the country, to the small towns, because they got really rich at it. They would come and save up the money for the private school for high school and move on. That is gone. That has changed with the smaller hospitals coming. That is an incredibly important incentive for country visiting medical officer [VMO] GPs that is going away. There are a hundred things. They are some of the big ones. The staff shortages are phenomenal. It is about too many of our trained persons wanting to become posh and specialists and earn more money, and moving off out of the GP cycles and not recognising the value of community GPs to our communities and to themselves. Is that enough?

The Hon. EMMA HURST: Yes, that was great, thank you. Mr Othenin-Girard, are you still waiting for your ablation surgery?

Mr OTHENIN-GIRARD: No. What happened is a cardiologist in Lismore, after my five cardioversions, contacted the Gold Coast hospital, and I was finally able to meet the surgeon. That was in mid-January. The first thing he said is that there is a very long waiting list and fibrillation is not an emergency. The Queensland Government is also starving them of funds, and one of the directors of the Gold Coast hospital suggested that no more patients from New South Wales were processed there. He said that the doctors would fight this but at the moment that was the situation.

The Hon. EMMA HURST: Are you worried that that is going to come into play? What would that mean for—

Mr OTHENIN-GIRARD: I do not know if it has come into place. It would be very difficult for the New South Wales Government because it would have a whole lot of patients to redirect to Sydney.

The Hon. EMMA HURST: You guys are relying on the Gold Coast, are you not?

Mr OTHENIN-GIRARD: Yes. Then he said if I can be ready at short notice if there is a cancellation, he would be able to maybe slot me in because he recognises that my case was a little bit different. Then he read more about my background and so forth, and he said he had a "brainwave", he called it. The hospital was retained to—he said if I want to be a guinea pig for testing an American invention then he could do that test on 17 February and since I would be in the theatre under anaesthesia he would be able to perform the ablation. The test would last one hour. He had explained to me that it is no big deal, it is safe and so forth, and on this basis I accepted. I said, "Well, yes, I want to go and do it."

The Hon. EMMA HURST: Can I just interrupt you? Would you have agreed to this alternative test treatment if you had not had to wait for three years already?

Mr OTHENIN-GIRARD: I do not know; it is a hypothetical, but probably I would have because I was very incapacitated by my condition. So, anyway, what happened is I went on 17 February. I had the test and the ablation. I was under anaesthetics for 5½ hours, I think. Now I feel like a new man; I walk 10 kilometres a day—just wonderful. I had to wait all that time—

The Hon. EMMA HURST: Not feeling that well.

Mr OTHENIN-GIRARD: —for something that could have changed my life and saved the State a lot of money. So this is where I have to question, you know.

The Hon. EMMA HURST: Yes, it is that limbo.

Mr OTHENIN-GIRARD: Yes.

Ms CATE FAEHRMANN: Thank you all for coming today and for giving your evidence. Sometimes you hear people say that because people move to the regions or to remote New South Wales they therefore have to expect health services that are not as good as in Sydney; people choose to move to the regions and therefore health services are just a trade-off, if you like. What do you have to say to that, Mr Hoare? You live quite remotely.

Mr HOARE: Not compared with some of the people I read about in the submissions.

Ms CATE FAEHRMANN: You are right, yes.

Mr HOARE: We live a bit away, put it that way. What was the question again? A trade-off?

Ms CATE FAEHRMANN: This is not my view by any means, but I am just putting a view that some people say, "You choose to live in the country, you choose to live in these places, therefore is it not to be expected that you will not have fantastic health services?" What do you have to say to that?

Mr HOARE: I suppose if you do not expect everything that you would walk down the street to get in any large city or even a town like Lismore, but basic health things are all I really expect to get there. We were spoiled in a way; 15 years ago we had a doctor who was a local fellow—Trevor Tierney, if I can say his name.

The CHAIR: Yes.

Mr HOARE: He was there forever, and he was on call seven days a week, 24/7. He looked after the hospital and his own general practice, looked after the aged-care facility, which was separate at that stage, and he was just there. His parents lived close. His kids, I think, went to the local high school for a while. So, we had that experience of a very good doctor who was there all the time.

Ms CATE FAEHRMANN: That is not too much to ask for, though, is it—a good doctor who you can see in regional New South Wales when you need one?

Mr HOARE: When we moved there 30-odd years ago, that was the norm. There was the hospital and there was Trevor, and it was terrific. So I thought, "This is alright." Something happened there with me and I had to go quickly to Brisbane, but I did not expect it to work any other way. Any help after that was done by Trevor locally or visits to Brisbane to see the—what do you call it?

The CHAIR: The specialist.

Ms CATE FAEHRMANN: Mrs Robertson, you are nodding. Can I get your point of view on that question?

Mrs ROBERTSON: I agree very much with what Mr Hoare is saying in relation to having a stable person who understood how to operate the services in town and look after the people and also refer when required, which is what is required. He is going to the place where he needs the extra care. That is why I was nodding; I was listening to his story.

Ms CATE FAEHRMANN: Dr Roeber? You moved from Melbourne.

Dr ROEBER: Yes, I would very much like to comment on your query. The business I work for requires quite specialised skills and heavily relies on people with such skills, which is not necessarily readily available in regional Australia. I was attracted to take this job because of the good package they offered me, and at the time I accepted that job I was not ill. I was, at that time, unaware of the potential, as you call it, trade-off I might have to accept of moving out here. I was just looking at the change of lifestyle, and it was all appealing to me. But then when I fell ill I kind of had to learn the hard way, this trade-off, coming from a metropolitan city like Melbourne where the neurologist services would have been available at the doorstep for me. I kind of regretted my decision to move to regional New South Wales because, yes, it led to a potentially worse health outcome for me. If that is the case, then it is not only me who suffers from that but also the business that employs me which has serious economic impacts, not only on the business, myself, but on the State of New South Wales altogether in that specialised businesses cannot attract the required employees to work there.

Ms CATE FAEHRMANN: The New South Wales Government does say that it wants people to move to the regions and actively encourages people to move to the regions.

Dr ROEBER: That is my understanding.

Ms CATE FAEHRMANN: New South Wales is a rich State, and Australia is a rich country. There should not be such a trade-off, should there?

Dr ROEBER: No, I agree with you. It should not.

Ms CATE FAEHRMANN: Does anybody else wish to make a comment along those lines? I will proceed to more questions.

The Hon. WES FANG: You can only lead the witnesses so far, Cate.

The CHAIR: Order! You can ask the questions in the way you wish to ask your questions.

The Hon. WES FANG: I don't lead them.

Ms CATE FAEHRMANN: Mrs Robertson, you talk about health service planning. In your additional submission you provided the fact that the last services plan for the northern New South Wales district finished in 2008. That is the clinical services plan, is it?

Mrs ROBERTSON: Yes.

Ms CATE FAEHRMANN: Is it unusual, do you think, for a clinical services plan to have expired for so long?

Mrs ROBERTSON: I don't think 2008 is right.

Ms CATE FAEHRMANN: Sorry, 2018—my fault. Is it a lack of transparency around that clinical services plan or is it just not there?

Mrs ROBERTSON: No, it is not there. I am not exactly sure what has happened to the planning department within the area health services that used to actually be responsible for reproducing when something was run out. Obviously there is a Rural Health Plan for the State—I found it eventually—but it is not very precise about individual services and providers, so it is very difficult to interpret back onto your own area health service.

Ms CATE FAEHRMANN: Do you think there needs to be more transparency? Would you like to comment on the transparency around these plans for health services delivery?

Mrs ROBERTSON: I think we actually need one.

Ms CATE FAEHRMANN: That is a good start.

Mrs ROBERTSON: It says so in their strategic deal with the ministry that they were responsible for doing health service planning, and then it seems to have gone elsewhere. It is now done—I don't know this for a fact, but it now seems to be done piecemeal. The funding came for Lismore hospital—big State funding for the planning, big State planning for Lismore hospital. The funding has come for Grafton, and so Maclean is included in that. It is big State funding. It is different; it is not a comprehensive local health district plan. Probably the Tweed had the same thing—a health service plan up there. Am I making sense? A consultant is drawn in for the development proposal, rather than health planning for the community. It is not healthy.

The Hon. WES FANG: Thank you very much for coming and appearing today. It is fantastic to get your insights. Mrs Robertson, I was taken by your opening statement, in particular the bit where you talked about not having, say, neurosurgery on every corner, or paediatrics, but appropriate health care for the area at the time. Can you expand a little bit more on that? I think that has been part of the conflicting themes we have had. Some people have insisted that they want every single health service on every doorstep, but people like yourself have said, "We just need appropriate health care in the regions and then access to other stuff." Can you provide a little bit more clarity around that?

Mrs ROBERTSON: In the olden days in small hospitals and district hospitals anywhere, you could have babies, you could chop things out, you could do all sorts of amazing things. The outcomes were not always that good but everyone loved the doctor anyway, so it worked okay. Gradually times changed and people started to demand quality of care, and so people started to demand that they wanted their babies born where somebody was a posh person, or whatever. In the area I used to work in, where he comes from, they were still—I am not supposed to talk like that. Where the Hon. Mr Trevor Khan comes from—

The Hon. WES FANG: "He" is just fine, Mrs Robertson.

Mrs ROBERTSON: —there were hospitals that still had some maternity that were being hung onto by the skin of their teeth, that only the poor could use or would go to because all the others left town to go across the border to actually get the treatment. That sort of stuff gradually changed, and then the delineation process and the "right place at the right time" philosophies came in. Both governments have used both of these, so I am not making

a political statement here. That is what made a lot of difference to the changes to rural health care. But it still does not mean that you can stick a camera in every single doctor's office and say, "This is what you've got," without a doctor at the thing to help the person with the camera. It does not mean you replace stuff, which is what seems to be being forced to happen because people's budgets are being squashed down. It is complicated, but it has changed.

The Hon. WES FANG: I think that is the balance that we need to find because obviously we want appropriate health care in the regions. I live in Wagga Wagga, so I want to make sure that the people west of the Great Dividing Range have that. But there is also that law of diminishing returns where if you do not get the exposure to, say, things like neurosurgery—if you have a neurosurgeon in a small town and they get a case once a year they are not getting that exposure, they are not keeping their skills. That is the balance, isn't it? We used to have a lot of services that were done periodically but the mastery of that skill requires constant training, doesn't it? Is that where that philosophy has come from now, do you think?

Mrs ROBERTSON: Yes, and a long history of incredibly disastrous results for some persons when these things were tried where they did not have the skill base. If you are doing maternity, you have got to have an obstetrician and an anaesthetist. GPs used to do that. Now their insurance is so incredibly high, hardly any of them can do it, so that goes away. That goes out of that town. So those things changed. That has changed but this inquiry is more about knowing you have the transport when somebody needs to get somewhere to go and have a CAT scan to see if they have actually got a clot in their head for their stroke. It is more about knowing there are services to back up for the referral. There is no use having a system, which talks about—there is no use having a hospital where there are three nurses on and you cannot get a stitch in your leg.

The Hon. WES FANG: You raise an interesting point. I think for many people this inquiry means different things, and that is something that we are looking at throughout the inquiry. For some it means that, like I said, they want to be able to have every single service on their doorstep, but other people have provided testimony to us that differs to that. That is why I thought your opening statement was interesting, because it went to the heart of what rural and regional communities may need into the future. Thanks for that. I know that the Hon. Trevor Khan has some questions that he might want to ask as well.

The Hon. TREVOR KHAN: Mrs Robertson, thanks for being here. I know you had a great deal of experience with the hospital system in your time when you were in Parliament.

Mrs ROBERTSON: Injured.

The Hon. TREVOR KHAN: Yes. Good to see you looking so well. Taking into account your history, we took evidence yesterday in Taree. I am interested in essentially the shape of the health districts and whether you would have a view—and I will ask particularly in regards to that Taree area—about whether our delineation of, for instance, Manning Base Hospital being in Hunter New England is appropriate, or whether it is more appropriate that that be aligned, say, with the Mid North Coast health district. Do you have a view, from back then particularly, as to whether we got the delineations right?

Mrs ROBERTSON: Taree used to be in New England years ago.

The Hon. TREVOR KHAN: And it is now. That did not seem to—

Mrs ROBERTSON: Taree wanted brain surgery. They all walked out of a meeting I was in because I laughed. I have not got an answer. The people of Taree might find it difficult, but that is—Newcastle. Newcastle is their community of interest; it is very close. I think it is probably appropriate that Taree remains with Hunter New England because Hunter New England is now such a huge region and Taree's community of interest would be Newcastle. I think so. I think there are enough problems on the mid North Coast with things that the Government is trying to do there.

The Hon. TREVOR KHAN: Indeed. I will just ask, seeing that you were a resident of Tamworth with me—

Mrs ROBERTSON: Not quite with you.

The Hon. TREVOR KHAN: Well, sort of. Duri, if I remember correctly, sort of Tamworth. We received a small amount of evidence yesterday in Gunnedah from a specialist from Tamworth who was positing a view that there should be a breakup of Hunter New England into what I assume to be a New England and a Hunter health district.

Mrs ROBERTSON: Go back again.

The Hon. TREVOR KHAN: Sorry? You will go back again?

Mrs ROBERTSON: Go back again. No, do they want—I wouldn't. They would not have me. I am too old.

The Hon. TREVOR KHAN: I assumed that specialist was of the view that that was the case. I have a contrary view, I have to say, but I might be alone. Have you got a thought?

Mrs ROBERTSON: I think the original decision about putting Hunter and New England together was about knowing that the Hunter and particularly Tamworth base, which is a very high-level hospital, can share resources and share resources successfully. So some of the specialty teams from the Hunter are the backups for the Tamworth people and some of the Tamworth specialists did not like that. I do not know if I am supposed to say that, politically or otherwise, but that is my recollection of the history of that issue.

The Hon. TREVOR KHAN: I don't think it has changed, to be frank.

Mrs ROBERTSON: "Don't tread on my toes."

The Hon. NATASHA MACLAREN-JONES: I have only got one question. Have any of you had any dealings with nurse practitioners?

Mr OTHENIN-GIRARD: No.

Mrs ROBERTSON: I have. It is often very difficult to get them to want to work in that kind of environment for the same reason that we cannot get the GPs. There are nurse practitioners in specialty areas who love it and who go to the base hospitals or whatever they are called these days, but getting them to actually go out and work by themselves at an MPS where they could do your stitch, that is another issue.

The CHAIR: We are just about to go to time. I thank you all sincerely on behalf of the Committee. It has been very enlightening to have, in effect, case studies for us to look at in some detail—not just broad comments about your circumstances but some details behind that. As I said, coming forward in a public situation like this and going into your own personal stories is not always easy, but it is those case studies which help inform us and give us some clarity as to what the actual issues are in the particular parts of the State as we travel. I express our thanks on behalf of the Committee.

(The witnesses withdrew.)

(Luncheon adjournment)

WAYNE JONES, Chief Executive, Northern NSW Local Health District, sworn and examined

DAVID HUTTON, Director of Clinical Governance, Northern NSW Local Health District, sworn and examined

KATHARINE DUFFY, Director of Nursing and Midwifery and Aboriginal Health, Northern NSW Local Health District, affirmed and examined

The CHAIR: Good afternoon and welcome to our final panel for this afternoon visit to Lismore. We welcome very much the persons this afternoon—some very senior people. As I am sure you know, the Government—NSW Health—have their omnibus submission, which stands as submission No. 630 to the inquiry. It can be taken as read. All the members are familiar with its content and detail. We have members from the Government, the Opposition and the crossbench, so there is a good reflection. We will provide you with the opportunity for an opening statement and then, if you are agreeable, we will open up for questions. We will share it around between ourselves and work through whatever questions may arise from your particular opening statement but more likely, in addition to that, other matters that have been raised. Are you comfortable with that?

Mr JONES: Very comfortable.

The CHAIR: Once again, we know you are extremely busy in your role at this time with the matters going on over the last 12½ months, so thank you very much. We know your time is very precious.

Mr JONES: Before I start I would like to acknowledge the traditional custodians of the land on which we meet today, the Widjabul Wia-bal people of the Bundjalung nation, and pay my respects to Elders past, present and emerging. Whilst I am here I would like to pay my respects and extend that acknowledgement to the other Aboriginal nations on which the land of our organisation is—that is, the Yaegl, Gumbaynggirr and Githabul people. It is a privilege to live on the North Coast and to work on the North Coast. It is a very diverse community and it is a community that uses that term frequently. We are very proud of the service which we provide as an organisation. We have seen it grow exponentially, particularly over the last five to six years.

We service a population of around 300,000 people and that population is growing. For us to service that people, we need to continue the planning that we have been doing over a long period of time. We need to ensure that our planning is nimble and flexible for the demographics and changes in the aging that we are starting to see. There is a need to be on the forefront of delivering innovative and sustainable models of care, but we cannot do that alone; we need to work with our partners. We work very hard to develop services that reflect the community needs with our partners. To name several of those, they are the primary health network Healthy North Coast, our local general practitioners, Aboriginal medical services and a range of non-government organisations.

Our partners include our community, very much so. We have gone to great lengths in the last few years to revamp our community engagement plan framework that has been put in place to support and proactively engage in meaningful engagement with the community so we understand the issues that matter to them, not just the issues that we think matter to them. We have worked with them over a number of years now in co-designing services that meet their needs. This includes the development of the Bonalbo multipurpose service [MPS], the Coraki HealthOne and we are in the process now of developing the Clarence Valley health services plan and the Ballina regional health services plan. It is recognised that we have roughly 220 hospitals in New South Wales. We cannot provide all services to all people. We need to network services. We are no different to any of the colleagues you have heard in the south and west of this State so far. We have internal networking where from the smallest hospital and MPS up to our large facilities at Lismore and Tweed our role is to ensure we understand and recognise the conditions that they present to. There is an escalation process to allow them to receive the right care at the right place.

In addition to our internal networking service, we have a very good relationship with Queensland Health and Queensland hospitals, particularly the Gold Coast university health campus where we have a cross-border committee arrangement with them and we meet regularly to discuss issues and concerns. Our goal is to ensure that our networks provide the right care, at the right place, at the right time. At times that means transferring them to another facility. I want to assure the Committee that any decision to transfer a patient from any facility is not taken lightly, because we are taking them away from their home. We take those decisions based on clinical advice. The only advice we listen to in transfer is the clinical advice. It is to ensure the betterment of care and the betterment of treatment for that patient.

One of the challenges we have, like all health services around the world, is the recruitment and retention of highly skilled workforce. As you have already heard, geography plays a large part. As a district we are committed to boosting our workforce. I am sure throughout questioning we will be able to give evidence where we have done that considerably over the last few years, but we need innovative models to recruit and attract. Several that we have worked with is with the University Centre for Rural Health and the partnership with them

and our regional training hubs, which link medical students across the region here from their undergraduate years through to their intern years and ongoing. They remain here ongoing and have a career path within our organisation.

In our workforce growth we have seen over 1,000 new staff since 2012. We have seen 170 additional doctors, 360 nurses and 120 additional allied health staff. To support our growth and recognise the demands we have as an organisation, we have had a capital development boom over the last few years. We have had over a billion dollars invested in development of capital within our footprint. At Lismore Base we are in the final stages, thank goodness, of the redevelopment there—$320 million. If you saw Tweed, the Tweed Valley Hospital is fast coming out of the ground. It is a $670 million investment, not only to replace the Tweed Hospital, which is a tired, fatigued building—it is to provide additional services: cardiac catheterisation services, radiation oncology services from the get-go. This is all about reversing flows that we have seen go to Queensland.

I want to take this opportunity to acknowledge the staff who work in our organisation: our clinicians, our non-clinicians, our support staff, our wardsmen, everybody. They all come to work to do a good day's work and to do the best they can. Without their compassion and without their dedication we would not hold the standing that we have within our communities, but also against the key performance indicators we see in quality and safety and others. Our staff are our backbone and we go out of our way to acknowledge that with them and to support them as much as we can. As the Chair has pointed out, the last 18 months in particular have been incredibly challenging for all our staff. As chief executive and on behalf of the district I welcome this inquiry and the opportunity it presents for our communities and staff to have a voice and share their experience. I am hopeful that the inquiry delivers recommendations which are meaningful and actionable and can support the ongoing positive changes that we have seen developed in our organisation. Thank you.

The CHAIR: Thank you, Mr Jones, for that comprehensive opening statement. In terms of the time allocation, can I suggest three tranches of 15 minutes, which gets us to three o'clock, then three lots of 10, which gets us to 3.30 p.m.? Obviously, if we need to adjust the last lot because there has been a bit of slippage, we can do that. Does that work for people, or would you rather do 10-minute blocks?

The Hon. TREVOR KHAN: No, I am happy with 15. Could I suggest—not so much for us, because I do not think our questioning will be that hard—that the crossbench and the Opposition have an opportunity of an extra five minutes, which can then be adjusted at the end? If the Hon. Walt Secord gets a sense of blood, then he can follow through for the extra five minutes.

The CHAIR: Can we handle up to 20 minutes?

The Hon. WALT SECORD: Yes.

The CHAIR: Ten each? Does that work for you?

Ms CATE FAEHRMANN: Yes.

The CHAIR: We will do that. Thank you for that deference. We will assume 20 minutes, then we will make an adjustment to provide opportunity for the Government members to deal with any matters they wish to do so. Thank you, Deputy President.

The Hon. WALT SECORD: Thank you, Mr Chair. In the spirit of the suggestion from the Hon. Trevor Khan, Mr Jones, why is Lismore Base Hospital booting out patients in the middle of the night without transport, without any means to get home and, in cases, without a wallet and without a telephone? Why are you guys doing that?

Mr JONES: Let me start the answer, Mr Secord, by saying that is not our normal practice. Our clear direction to services and staff is that when you are transferring someone, whether you are discharging someone—and the people you are talking about here are the people who are discharged from the emergency department, not from the ward areas—when you are sending someone home, no matter what day or night, it is important that you factor in a whole range of requirements. Transport home, particularly in isolated regions, is one of those. Unfortunately, we have failed on several of those occasions. But I can tell you, it is not the standard of what we try to achieve, and we failed those individuals that presented that information. We have put memos out to staff reminding them. We have increased our in-service about transport. We have increased our own patient transport vehicles locally. We have community transport contracts, and we have a clear position that particularly after 8.00 p.m., if people cannot get home then we are to find accommodation for them, or transport. Unfortunately, as I said, we need to acknowledge that we failed a small number of people.

The Hon. WALT SECORD: You said in your answer that that refers to the practice in the emergency department.

Mr JONES: No, it is primarily the patients in reference that the witnesses have given so far reflect emergency departments.

The Hon. WALT SECORD: It has also been put that, in fact, discharging people, or getting them out of the emergency department or the hospital quickly, is about the lack of beds in the hospital; in fact, it is a way of freeing up beds to get other patients in.

Mr JONES: That should not be the case. There is no disputing emergency departments are busy. The last quarter results from the Bureau of Health Information show that the number of emergency department [ED] patients coming through our facilities is second highest on record. So we are busy, there is no disputing that, and Lismore is one of those facilities. We do not discharge people because of bed pressures per se. Patient discharge and admission is a clinical decision. What has occurred in these circumstances, a decision has been made to discharge a person home, and unfortunately, due to lack of complete preparation, they have been discharged out without transport home. But I emphasise again—sorry, I just need to really repeat—these are rare occasions in our service. But we take them on board. We should never have failed anyone in this circumstance.

The Hon. WALT SECORD: Mr Jones, what is Code Black?

Mr JONES: Code Black is an escalation of an emergency situation. A perfect example I can give you is recently we had a bomb scare, a phone call into Byron Central Hospital, only a number of days ago. A Code Black is triggered and that requires an escalation of concern. The executive need to take control and the response varies depending on what it is. In this case the relevant support services, police and fire, were called and the facility was put into lockdown.

The Hon. WALT SECORD: Are there other circumstances when a hospital goes into Code Black? I am not talking about dangerous circumstances—maybe dangerous circumstances, but not external threats to the hospital. What are other occasions when a hospital would go into Code Black?

Mr JONES: When you have risk of incendiary devices, not just bomb threats but malfunction of equipment. You can have situations where there is an escalation when there is absolute gridlock with beds. I think that is what you are leading to.

The Hon. WALT SECORD: That is what I was leading to.

Mr JONES: There are situations which then escalate the need to engage the executive team to actually get engaged in what is happening with patient flow. They should be at that point in time anyway, because it has escalated up. And then there is a range of actions that trigger that with the Director of Medical Services going around, working with the consultants to see about discharging to create additional bed flow.

The Hon. WALT SECORD: When you are talking about bed flow, when a hospital gets into Code Black involving beds, what is the figure? I think it is 140 per cent capacity; is that correct?

Mr JONES: No, there is no real figure set there, Mr Secord. It is just when you are at capacity, when there are no other beds you can identify and it has created a situation of exit block out of your emergency department, which then has a flow-on effect of delays in ambulance offload, as an example. Once those figures reach—and we do not have a key line in the sand here because there are a number of variables there, if there are resuscitation patients coming forward, a whole range of different—what is the type of patient waiting for admission from the emergency department? We do not have a set-in-stone set of occupancy or criteria. It is when there is effectively inability to transfer patients out of the emergency department for an extended period of time.

The Hon. WALT SECORD: Does this happen very often at Lismore hospital?

Mr JONES: No. It happens infrequently, but it does occur.

The Hon. WALT SECORD: What happens when you reach Code Black and the hospital is at capacity and there are no beds? What do you do when that happens? Is that when you turf people out, kick them out of the hospital? Is that when that occurs?

Mr JONES: No, we never turf people out, kick them out of the hospital. We work with the consultants, the admitting specialist of each of those patients. Are there patients who are ready for care elsewhere? Are they reaching a level where we can put them to a district hospital, as opposed to our base hospitals? Are there patients who are ready for discharge? Are there patients who could be transferred into our Hospital in the Home program, so they continue the delivery of care but in their hospital in a community setting?

The Hon. WALT SECORD: Does it happen very often when Lismore goes into Code Black, when you reach capacity and there are no beds left?

Mr JONES: There certainly are occasions where we identify patients, an inability to address all the pressures in the emergency department, but I—

The Hon. WALT SECORD: Has it happened this year?

Mr JONES: I have not had a situation where we have not been able to ease that pressure—maybe not completely relinquish it.

The Hon. WALT SECORD: But that was not my question. My question was does it happen very often at Lismore hospital when you reach capacity, meaning that all the beds are full?

Mr JONES: No, because most of the time you are pre-planning, you are seeing that the patients are filling up in ED, you are seeing that your elective surgical activity is coming through, so you are already preparing for what comes through. We know on average how many patients come through our emergency department on any day. We know how many elective surgical patients are booked. So if we see there is a clash there, there are times where we need to cancel elective surgery because we need those beds. There are times when we need to look at facilitating discharges, so it varies.

The Hon. WALT SECORD: How many times since the beginning of this year—you would know as CEO—has Lismore hospital gone into Code Black, where you have reached capacity in beds?

Mr JONES: No, I don't know that number. I can tell you it is a small number but I am not sure of the exact number.

The Hon. WALT SECORD: Can you take it on notice for this year and for 2020 the number of times you have reached Code Black in relation to capacity of beds?

Mr JONES: We can certainly take that on notice and provide that.

The Hon. WALT SECORD: You mentioned in your answer previous to my question about cancelling elective surgery when you reach that point. What happens when that occurs and how many times has it occurred this year?

Mr JONES: Again, the exact number is not something that as the chief executive I need to be aware of.

The Hon. WALT SECORD: It must come to your attention when it occurs.

Mr JONES: No, it does not. We look at the figures on a trending basis because a lot of times these patients are re-booked. It is when they go overdue that it comes to our attention.

The Hon. WALT SECORD: What is overdue?

Mr JONES: When you are booking someone for elective surgery, the clinicians book, they determine the clinical status. If it is category one, then they need to be done within 30 days; if it is category two, within 90 days; category three, within 365 days. So if they breach those category timelines, then they are overdue. I get a report on a monthly basis of where we are sitting with that activity. Sorry, I apologise, I cannot remember your question.

The Hon. WALT SECORD: It was about the cancellation of elective surgery.

Mr JONES: I don't know the exact number. What we do know is that we are continuing to work on—if we are looking at cancelling, then it is a clinical decision on prioritising what that is. So we contact our operating theatre management team and with the anaesthetist and the surgeons we go from the lowest clinical risk to the highest clinical risk and it is managed in that way. There are some cases, for example, that you just do not cancel no matter how bad your bed block is. They need that operation today.

The Hon. WALT SECORD: We had evidence earlier in Sydney at one of our very first hearings. There was a doctor, Dr Evill, who expressed his frustration about the new ICU unit at Lismore hospital. What is the current status of the ICU unit? Is it up and running now?

Mr JONES: No. If I can spend a minute to explain where we were.

The Hon. WALT SECORD: I am going to ask you a few questions about this, so take your time.

Mr JONES: I am sure you will. The new ICU was ready to transfer and it was approximately January of last year. Two days before we were ready to transfer, the NSW Nurses and Midwives' Association put a claim in for additional staff. We were considering that at that point in time and then COVID hit. We pulled together a lot of consultative work with clinicians. We needed an ICU that had more isolation than our current ICUs had because people will remember the beginning information we had was devastating. What we were seeing overseas

was unbelievable. So the clinicians decided the best place to house our COVID positive intensive care patients was Lismore Base in the new ICU because they were self-contained rooms.

The Hon. WALT SECORD: Can I interrupt you there because this is interconnected with COVID and the ICU. Without breaking any confidences, are there any COVID cases in the local health district at the moment?

Mr JONES: We have recovering COVID cases.

The Hon. WALT SECORD: Okay, but are there people in hospital in the ICU?

Mr JONES: No, we have no COVID ICU patients at this time. But, as I said, we need to go back to what people were expecting to come through the door and we needed to prepare for that. Everyone agreed, no-one argued that we needed that new ICU. So that was our COVID ICU and we did end up having a number of patients cared for very well in that ICU. We continued then. The new ICU was split into two zones. We could close off one zone because we needed to progress our vaccination program, and the agreement was to start our vaccination program in one of those zones pending resolution of COVID ICU and also the industrial action. In the last month we have brokered an agreement with the NSW Nurses and Midwives' Association on resourcing for that unit. The Nurses and Midwives' Association, the clinicians and management have set a date as 22 July to move the old unit into the new unit. Part of that delay is to allow us time to then set up a new public vaccination clinic at Lismore Square, which we have done, and to relocate the staff clinic into another facility. There have been many dominoes and issues we have needed to work through. It has been very complex.

The Hon. WALT SECORD: So there are no active COVID cases in Lismore Base Hospital at the moment but the ICU unit was originally set up in case you needed it for COVID?

Mr JONES: Correct.

The Hon. WALT SECORD: We are probably about 15 or 16 months into COVID now. What are your plans to open up the ICU unit?

Mr JONES: It is planned. We have negotiated. We have been working with the staff and people transition to the new ICU on 22 July.

The Hon. WALT SECORD: So 22 July is when it will be open?

Mr JONES: Yes, pending any major issues that come up between now and then. The agreement with the association and the staff is the date of the twenty-second.

The CHAIR: Mr Jones, this is our eighth hearing and as we have been travelling around the State hearing evidence. The phrase that has been used from individuals and stakeholders is that as a general statement it costs more to treat a patient outside large metropolitan areas and it costs more to treat a patient in a hospital. It is a general statement. I don't know whether that is true or not. As a matter of a fact, I just do not have the knowledge and the information to be able to establish that one way or the other. We understand that the way in which NSW Health operates in terms of its funding is that it purchases services. That is the way it operates; that is its fundamental underpinning and modus operandi.

If you don't know the answer, simply say so but with respect to the purchase of the services that are undertaken—and if we look at it in a local health district sense now and your response for a local health district—are you aware that the calculus that is used, the formula that is used, to purchase the service contains an assumption or a condition of its calculation that because this is outside a major metropolitan area there is going to be an extra cost associated with the treating of that individual because they live outside a major population centre?

Mr JONES: There are some components to the funding called "residual operating cost", and I will come back to those in a second. But I will say that since the implementation of activity-based management, activity-based funding, we now have a national efficient price, which has a national weighted activity unit, down to a State efficient price. It is my understanding and my experience, particularly over the last six or seven years, that there has been incredible equity in the allocation of funding to rural in regard to running a hospital service. I get the same national weighted activity unit value as my equivalent metropolitan local health districts [LHDs]. It is recognised through the funding process that some rural, for example locum agency—we are talking about the ongoing difficulty in recruiting doctors.

We are all reliant on locum agencies to fill those gaps at times. Some of us have locum agency rates. We have been sitting on about 22 per cent of our visiting medical officer [VMO] numbers have been locum agencies for a number of years now. That is slowly but surely dropping as we are getting some traction now in recruitment in places like Grafton. But it is recognised that that locum cost is more than employing a VMO. So there is recognition in the funding cycle that you have some residual operating costs you cannot fix, but we need to support you going through that. So it does accompany a few of those. You have got the locum rates and there are a couple

of others in there. I do not understand them that much purely because in a sense it does not apply to us. There is a component in recognising reality in the funding cycle.

The CHAIR: This amount that you have described, does that sit effectively as a pool that you can access in your capacity as the CEO, that you are able to utilise to provide you with some flexibility perhaps to deal with what could be contingencies or changing patterns within your area of responsibility, your LHD?

Mr JONES: I think it is more recognition of cost, not so much allocation of budget. How it is actually managed I cannot tell you because it is not something that we apply too often in our LHD because of the way we have managed our budget. We have had considerable growth in budget over the years. In the last five years we have seen a 32 per cent increase in budget. Last year alone we saw just under a 4.5 per cent—or $39 million—increase in budget. That is reflecting an increase in activity. We have been able to manage our activity and our budget over the last few years. We have not availed ourselves through the necessary detail of going through that so, I apologise, I cannot answer that question.

The CHAIR: No, that is fine. With the activity that you have just described, in looking at the forecasts for the following year are you assuming an extension of an activity in the future that is likely to be the same or different? In other words, are forecasts built into looking forward as opposed to looking in the rear-view mirror?

Mr JONES: Without a doubt. There is a lot of negotiation with the ministry that takes many months leading up to the allocation of the budget. It is based on your population, your growth in population, your trend in activity and a range of other variables. For example, if you are building a new service or if you are building a new hospital, what are the costs in going for that? So there is quite a strategic view. It is not just looking out the rear-view mirror, "This is what we did last year." There is also an activity and an opportunity for us to negotiate what we can do or need to do next year. It is both.

The Hon. WALT SECORD: Mr Jones, how many hospitals and MPSs are in the local health district?

Mr JONES: We have eight hospitals and four MPSs. Sorry, just for completeness, we have three health ones and 19 community health centres.

The Hon. WALT SECORD: How many health centres?

Mr JONES: Nineteen.

The Hon. TREVOR KHAN: That trick only works once, Walt.

The Hon. WALT SECORD: No, I am going somewhere else with this intro. We have had previous inquiries in Deniliquin and Cobar and there is consternation in the community about the use of telehealth. How many of the health MPSs and the 19 smaller health operations are reliant on telehealth?

Mr JONES: Reliant, I would say—

The Hon. WALT SECORD: Or use telehealth.

Mr JONES: The majority of them. The MPSs do because we put in what we call critical care cameras. It allows them, if they get a patient coming through, even with a GP—GPs have a scope of practice. Sometimes patients can present beyond that scope of practice. When you do not have a GP, you have nurses there who are trained in first-line emergency care, or FLEC nurses—you might have heard that term already—providing that. It allows visualisation back into a base—Lismore Base, for example. We will use Bonalbo as the example. Bonalbo gets a patient, they want that and the critical care camera goes through in that regard. We are fairly fledgling on our telehealth and virtual health programs in our footprint. It is not something we have invested in heavily historically. It is something we are certainly moving on in developing, but we certainly see it as an adjunct, not a replacement of services.

The Hon. WALT SECORD: I will ask you one quick question as I am aware that my time is running out. In southern and western New South Wales, a number of hospitals indicated that they were without doctors on weekends. How many of the hospitals within the local health district this year had weekends without a doctor physically present and on duty and had to rely on telehealth?

Mr JONES: Can I just ask for clarification?

The Hon. WALT SECORD: Yes.

Mr JONES: Do you want to include MPSs in that or are you just referring to hospitals?

The Hon. WALT SECORD: No, MPSs as well as all health facilities under your purview.

Mr JONES: If I can talk hospitals first, we work to staff all our emergency departments and hospitals seven days a week. There are occasions where due to illness and last minute unavailability of a locum, no matter what we try, there might be a shift where it is not covered despite our best intentions. But they are very rare and getting rarer because of the change in model we have implemented in our district hospitals in particular. The MPSs tend not to have a doctor rostered over the weekend, but they have access to the critical care camera and they have access to further supports.

The Hon. WALT SECORD: So MPSs on the North Coast here generally do not have doctors on weekends?

Mr JONES: Correct.

The Hon. EMMA HURST: I want to ask a couple of follow-up questions to the questions that were just put to you. You mentioned that people should not be discharged in the middle of the night without accommodation or transport available. Who pays for that accommodation or transport?

Mr JONES: There is a range of ways we do that. There was a presentation earlier with Sharon Bird and so forth. We are a small community and we know each other. We encourage people, if they have family and friends to transport them, to do so because of the reliability and they are more timely in that regard. I need to state that up-front. We do rely on family and friends supporting at times. If we are organising transport, then the cost would be borne with us.

The Hon. EMMA HURST: The entire cost?

Mr JONES: Yes. If we needed to transport someone back because they had an inability to get back, we use things—not so much with Bonalbo—like taxi vouchers and so forth. But in those circumstances where people cannot get back and they have no transport, the normal process is that we will organise transport primarily through our patient transport vehicles. Ambulances do not do that sort of work, understandably. It is not clinically required. So we enhanced our patient transport vehicles. We would bear that cost.

The Hon. EMMA HURST: And what about accommodation? What if someone was discharged in the middle of the night and maybe a transport vehicle is not easily available?

Mr JONES: In those sorts of circumstances, if they negotiate with us and talk to us in ED and so forth and they cannot get home, we invariably bear the cost of that accommodation.

The Hon. EMMA HURST: You said that they have to negotiate with you.

Mr JONES: Sorry, I think "negotiate" was a poor choice of words—to raise that concern with us.

The Hon. EMMA HURST: I imagine some people might be embarrassed or afraid to bring it up and not realise that there would be a potential service available. They might be the people who are falling through the cracks and just walking out the front of a hospital and saying, "Well, now what do I do?" You did say that you wanted these services to be available to everyone and that you were concerned about the people who had fallen through the cracks. What is being done now that you have heard that people are experiencing this? What is being done to correct it?

Mr JONES: The emergency departments have been reminded that no-one should be discharged after hours—after 8.00 p.m. is roughly the time we use—and that staff should be talking to you if we are ready to discharge you and not rely on you raising the issue with me but, "How are you getting home? Do you have a way of getting home?" That should come from us, where the person can then comfortably say, "Well, I do have a challenge." We should not be discharging them out the door until we are comfortable they have a way home. If the nurse, for example, says, "I can't," then we need to escalate that up either to the clerk on shift or up through the assistant director of nursing at the hospital at that time to organise something different. There have been occasions where this has worked well, where we have organised transport or we have organised accommodation. But as I said—I think you have summed it up quite well. It is my take that the staff have not asked and therefore people have been too proud or embarrassed to raise the concern directly.

The Hon. EMMA HURST: Has there been some training or staff communication to try to change that?

Mr JONES: Yes, there has—both.

The Hon. EMMA HURST: And you said that nobody should be discharged after 8.00 p.m.

Mr JONES: Can I add to that? Sorry. Part of the things we have implemented, we have been very fortunate to be one of the pilot sites of the emergency department concierge model—people understand what a concierge is—which put someone in the waiting room of the emergency department, and to see how that worked in not only easing the tensions in the waiting room but also supporting people. It has been an absolute

overwhelming success. We have got that about 14 hours per day in our bigger hospitals. We have got it at Grafton, Lismore, Tweed and Ballina. That person, when you walk in the door—we are finding it particularly useful for elderly people—a reassuring smile. It used to be a reassuring handshake but with COVID it is just more a reassuring smile now. And that person works with them, not only in the waiting room to ease their concerns and tensions, but if there is an issue on transport when they are on shift, the concierge work greatly in supporting that. I apologise, I had forgotten that.

The Hon. EMMA HURST: You did mention that nobody should be discharged after 8.00 p.m. If you did get to one of these situations where you were over capacity and that happened late at night, what happens then if you are not to discharge people?

Mr JONES: It was not my intent to say no-one is discharged. No-one should be discharged without a plan of getting home. Obviously in an emergency department you can be discharged or released at any time of the day or night, depending on your condition. What we emphasise with people is you need to take in the holistic care of that person and make sure that they have a way of getting home and that there is somewhere for them to go home.

The Hon. EMMA HURST: What is the difference between before 8.00 p.m. and after 8.00 p.m.? Are you saying that if someone is discharged before 8.00 p.m. that there does not need to be that emphasis on making sure they have a way to get home?

Mr JONES: We tend to find that up until then there are more services available and problems are less. It is after 8.00 p.m. when there is less staff that we tend to find that. No, what I am emphasising, and this is 24/7, but we emphasise in particular after those hours that should be something people should have in the front of their mind.

The Hon. EMMA HURST: A lot of the submissions referenced the fact that a lot of people are being forced to drive many hours over the border into Queensland to access medical care. Is this a concern that has been brought to the LHD?

Mr JONES: Cross-border flow, as you can imagine—we sit on the Queensland border. We represent about 48 per cent of the State cross-border activity, and on a raw volume of headcount more Queenslanders come into our footprint for care than New South Welshmen go across the border. Queensland take up about 20 per cent of our elective surgery work and about 25 per cent of our ED activity in Tweed, so we do that. There is a network of services with Queensland, as I said earlier, that works very, very robustly and we are aware of that transport and that difference. So over the years we have set up a number of services—radiation oncology services at Lismore to stop people travelling; cardiac catheterisation services at Lismore to stop people travelling; Tweed Valley, both services will be implemented there within two years. All of this development is to meet the needs of the local community, but part of the offset to that is to reduce flows. We anticipate that we will see about 5,000 people return back and get their services locally once we complete the development of Tweed Valley Hospital.

The Hon. EMMA HURST: We heard evidence today from a patient who was regularly travelling to the Gold Coast and he had heard from, I believe, one of the practitioners working in Queensland that Queensland was actually considering making some kind of decision to stop people that live on the border into New South Wales from coming up to Queensland to be treated. Is that something that you have heard, because obviously it is causing a lot of stress to the people who rely on the Gold Coast?

Mr JONES: It is one of those stories that come up every now and then and we respond to it immediately. I can give you a recent example. A cardiologist at The Tweed Hospital called me about eight o'clock one evening—this goes back about three or four weeks, maybe a little bit longer—and expressed his concern that he is hearing the Gold Coast will not accept our acute cardiac patients. He obviously is very concerned about that. I contacted the chief executive at the Gold Coast—this is part of our communication relationships; we have got each other's mobile—I have raised it with him and following that discussion he sent me formal advice that killed that completely. So that is not the case.

Every now and then this comes up, but it is important we recognise the level of activity in south-east Queensland, and we do not want our patients denied care. We have a cross-border committee that looks at flow; we have developed pathways—trauma and stroke are just two examples—and the deal is if we cannot manage those patients because of acuity and they need to go to super-specialty services, then they accept them. The quid pro quo is that as soon as they are ready for discharge we take them back.

The Hon. EMMA HURST: There was also, obviously, a lot of stress for people who were relying on services in Queensland during COVID border lockdowns, and obviously a lot of people were unprepared for a major outbreak like that, but what is being done now for people who are relying on Queensland services, given

we are still not really out of the woods as far as COVID is concerned or future issues where we have further border closures?

Mr JONES: It is a very timely question. I understand that there has been a further border restriction implemented today.

The Hon. WALT SECORD: I live in North Bondi. What is going on?

The Hon. EMMA HURST: You are not allowed back.

The Hon. WALT SECORD: Can I go home?

The Hon. EMMA HURST: Bondi has been closed.

Mr JONES: In all seriousness, the border closure was a very unfortunate situation to have to manage. It did create a lot of emotion and frustration, I can tell you from me alone, let alone the poor patients who needed to get across the border; it created a degree of confusion. But over a matter of several days we negotiated with the Queensland Government—we have contracts with them—and with Queensland health services that there would be no delay in emergency transports. The hard border block, there would be access for emergencies to go through. That was not stopped. Where we had challenges were those non-emergency transfers. Those patients who had visits there, we negotiated on an individual basis. If you had an urgent need to go and see a consultant because of a range of services we do not provide here, we negotiated exemptions and so forth. But it did create a degree of confusion and anxiety that was unfortunate.

The Hon. EMMA HURST: And going forward, is there anything now in place for some of that non-emergency stuff and for family and friends if somebody is put up into Queensland?

Mr JONES: We had to be fairly selective in what we can do in that regard. One of the clear increases we have done is our cardiac catheterisation service at Lismore. It was about four days a week it was operating on. What we saw with the hard border lockdown was it created a clinical risk, so we have expanded that to five days a week. I remember the cardiologist and the nursing staff saying to me last month that we are training more but the great limiting factor in increasing it even more has been nursing staff. We could not recruit experienced cardiology nurses, cardiac cath nurses, so we are in the process of training our own and by the next roster we will have five days a week and on-call for the weekend. It is that sort of services that we deliberately increased based on the border closures. Other services we are going to have to manage case by case as we did before but, as I have publicly stated, I would encourage anyone not to close the border to health services if there is a need we can support.

There was a negotiated agreement that we are hoping, I understand—and I apologise, I have not heard the details about today's announcements—but I believe there is what we call our border bubble, and that is all services and populations down to just north of Grafton have free access across the border. We negotiated that with the Queensland Government following the last border lockdown. But it does not stop that delay going through traffic and so forth. I emphasise it is very unfortunate.

Ms CATE FAEHRMANN: I just wanted to go back to the issue of transport out of Lismore Base Hospital of the evening. You mentioned in response to questions that there have been some changes made in relation to people not being booted out in the middle of the night. When were those changes made? When was the instruction given to Lismore Base Hospital staff to not do that?

Mr JONES: There were not changes made; it has always been our position not to do that. We reminded people that that should not occur. And I emphasise again, it is unfortunate those errors did occur and people paid a price for it and we have apologised to those people where we could, where we knew who they were, and we have reminded people that that should not be the practice.

Ms CATE FAEHRMANN: There was Mrs Bird's evidence earlier, however—in the submission from the Old Bonalbo CWA, they refer to the fact that there seems to be an overwhelming issue with the hospital releasing patients at all hours. It states:

> Many of us have experienced the call at night to say, 'they have let me go home and said I cannot stay inside until someone comes to get me' …
>
> I know that this is NOT an uncommon complaint and has happened to so many people.

This was repeated today. We did not hear from the earlier witnesses today, with respect, Mr Jones, that this issue has been resolved. So it is not a hospital policy, you are saying—

Mr JONES: Correct.

Ms CATE FAEHRMANN: —that people cannot be discharged if they do not have transport or somewhere to go to.

Mr JONES: No, there is no policy in this regard. Our practice is to ensure that when we are caring for people in the emergency department we have dealt with their clinical presentation and they are ready to go home. Our practice is that they should be asking "How are you getting home? Are you all right to get home?" If there is an inability to get home, we should be supporting them either in getting home or finding them accommodation until there is an available relative or friend to pick them up.

Ms CATE FAEHRMANN: So it is a value statement, not a protocol.

Mr JONES: Correct.

Ms CATE FAEHRMANN: Does the LHD still have in place then—I understand it was potentially one of the Premier's 2019 priorities around hospital services—key performance indicators [KPIs] around emergency treatment performance?

Mr JONES: Yes, we do.

Ms CATE FAEHRMANN: Could you explain what that is in terms of the four hours?

Mr JONES: Emergency treatment performance [ETP] is an indicator based on research and evidence that shows conclusively that if you keep patients in for too long in the emergency department they are more prone to misadventure, mortality and morbidity. You need to get them out of the emergency department. There is a whole range of factors there: congestion and being cared for by relevant experts. So the decision has been made, and it is relatively consistent, that that period of time is four hours. So I present to the emergency department and the triage, and the clock starts ticking. Once that clock starts ticking I need to be triaged, assessed, diagnosed and treated, and dispatched—either admitted or discharged appropriately within that four-hour period. But I stress that any decision to admit or to discharge is a clinical decision and at no time do we put any pressure on clinicians to make inappropriate decisions on admission and discharge based on ETP.

Ms CATE FAEHRMANN: However, you do have KPIs in that regard to meet the emergency treatment performance? I looked it up before just to make sure I had it right: You do have KPIs in that regard?

Mr JONES: Correct.

Ms CATE FAEHRMANN: So if there are people, say, who come into a particular hospital at nine o'clock at night with something where they are treated, from several hours away. They have made it to hospital, they are treated. It is better for you though, in terms of meeting your KPIs, if they are discharged at 1.00 a.m. than staying the night, even if there are beds available. It sounds like it is more an issue of meeting your performance indicators as opposed to an issue of not enough beds.

Mr JONES: I reject that wholeheartedly. At no point have we raised this with any of our clinicians and, with due respect, I am yet to meet an emergency clinician, be it medical or nursing, who would adhere to that if I gave them that directive. That would be rejected outright by them. I emphasise again that there is no directive, there is no influencing from my office or senior management to convince clinicians to discharge someone based on a KPI. They discharge them based on clinical advice.

Dr HUTTON: Can I just add there that for the past 12 months the KPI has only applied to patients who are admitted to hospital, not for those who are discharged from the emergency department.

Mr JONES: Correct.

Ms CATE FAEHRMANN: But the past 12 months? In terms of transferring them somewhere else, are you saying within the hospital system—

Dr HUTTON: The KPI used to apply to both patients who are discharged from the ED as well as those who are admitted to hospital. But for the past 12 months, it has only applied to those who are admitted to hospital.

Ms CATE FAEHRMANN: That is useful. Do you know whether that is for the whole State or just this LHD?

Dr HUTTON: That is the whole State.

Ms CATE FAEHRMANN: We heard from one of the local cancer network people about what I understand is their advocacy for a dedicated cancer care coordinator in the area. Are you aware of the need for that within the community, Mr Jones? Have you received any request for that position locally?

Mr JONES: I believe you are referring to the Ballina Cancer Advocacy Network. Not specifically from them, but there is always encouragement from our cancer support groups and we work with most of them in this regard to improve cancer services. We have improved cancer services over the past number of years. As I said before, local radiation oncology services. We have increased our cancer care coordination. When we talk about cancer care coordinators, we need to recognise that it is not a singular term. We have multidisciplinary team coordinators who manage cancer. We have nurse practitioners; a part of their role is coordination. We have breast care nurses; a part of their role is to coordinate. We have prostate nurses; a part of their role is to coordinate. And we have social work staff; part of their role is to coordinate. It is not one role that does it, and we have a number of positions on that. But we acknowledge, we review this on a regular basis and there are times when we need to increase those numbers as the number of cancer patients increase. The sentiment expressed by the Ballina Cancer Advocacy Network this morning is one we share. We work with them and when there is a need and a demonstrated need, we respond to that.

Ms CATE FAEHRMANN: There were a number of cases that they presented to us in terms of people not being informed of their options after they have left hospital. That is a concern. It seems it is a reasonably simple thing to solve, if you like, in terms of having a coordinator who is there to assist them like other areas have.

Mr JONES: Correct. As I said, we have a multitude of cancer coordinator roles in different designs. My understanding is—and I am happy to be corrected—the two cases that were put forward were both treated in Queensland and discharged from Queensland. What that demonstrates to me is that we need to improve our communication or remind people to improve our communication with Queensland as they discharge out to our facilities, which is normally the case. You are correct, the situation of the man with the prosthesis as an example, that is publicly provided. If they were referred to us, that is something we would have reminded them of. But that is a gap that has happened in that situation.

Ms CATE FAEHRMANN: You would have heard the earlier evidence that a person has to wait 14 months to see a cardiologist. That is certainly not something you would want to wait 14 months for. Do you agree, Mr Jones?

Mr JONES: I think waiting 14 months to see any specialist is unfortunate. We occasionally get complaint letters or letters of request from local MPs or direct from patients saying, "I have waited this long to see an orthopod. I have waited this long to see so and so." We investigate those and understand why. Invariably, we tell the people that "You have been categorised as X, so you need to go back to your GP and escalate your categorisation back through the consultant." We cannot influence, per se, the access to the consultant. It is a GP to a consultant process. But in our case, I can tell you we have four cardiologists at Lismore Base Hospital and they provide a roster to cover 365 days a year, not only on site but on call. We have a fairly comprehensive cardiology service. I cannot speak of delays in referring from GPs to the consultants themselves, but I would agree with you that 18 months is a long time.

Ms CATE FAEHRMANN: It was 14 months.

Mr JONES: Sorry, 14.

Ms CATE FAEHRMANN: The cardiologists at the hospital provide services to public patients as well, do they?

Mr JONES: They do. They have their private rooms and they provide services in the public hospital. They have appointments at the public hospital.

Ms CATE FAEHRMANN: Does the LHD have a current clinical services plan?

Mr JONES: No. What we have had, as has already been presented by Mrs Robertson earlier this morning, is that our last one ran out in 2018. It was quite a voluminous document and it is not the type of document that I support. I prefer it to be more focused.

Ms CATE FAEHRMANN: At least it was a plan, though, Mr Jones.

Mr JONES: Let me fill in the gaps there. We were actually looking at doing it. We also had that period of time—and this is not an excuse, it is a practical barrier we had. Our director of planning and performance had retired and we were in the process of recruiting a new director of planning and performance. There was a delay there. That delay ended up being a bit longer than we wanted. When we started the process, we did start the process and it was going very well. There was a lot of consultation. Our board chair and another community member were co-chairing the development of the plan, and then COVID hit and we have had a delay.

What we can say is we are not absent of planning. We have a strategic plan that directs the pillars of which we need to develop to complement what we need to do in the absence of a health services plan. We have

developed a service direction statement so that people know where we are going with our service directions. It is a more focused document. We have had very comprehensive clinical services planning for the Tweed-Byron network with the development of the Tweed Valley Hospital. We have had a very detailed clinical services planning process for the development of the Lismore Base Hospital. We are currently going through the process of a clinical services plan for Ballina, which incorporates the surrounds. And we have a clinical services plan in the process of being developed for the Clarence Valley—that is Grafton and Maclean. The only hospitals we do not have a clinical services plan going forward are the MPSs, and we recognise that oversight. Part of our work, when COVID allows, will be a broader health services clinical services plan.

The Hon. NATASHA MACLAREN-JONES: I want to ask a couple of questions in relation to staffing. In your opening remarks you did touch on the number of staff and the increased number of staff in the area. Obviously we have seen that in the past 18 months with COVID there has been a lot of changes, in particular probably this area, where you might have had people wanting to go back to other parts of Queensland or interstate. I just want to get an overview of how many people have resigned in the past 18 months and where the numbers are up to now.

Mr JONES: We have what we call a churn rate. We have about 75 to 80 people resign every month and we recruit an equivalent 75 to 80 people every month. As you can imagine, in any organisation there is movement of people. What we do have is an astounding number of people who have been here for a very long time. We do not have a retention issue, but we do have people who leave because of job promotion, relocation and so forth. You have had that 80; that is 960 people turned over in a 12-month period. COVID has created further challenges. We cannot step away from that. We have had people who have applied for positions from Queensland or from elsewhere in New South Wales and at the last minute have been our preferred applicant, we have offered them the job and they have declined. This is not a large number, but it sends a strong message. They have declined that offer based on the border closures, because their elderly parents live in Queensland or there is someone important in Queensland and they do not want to be locked out.

The border closures have created challenges for us. In the initial border closures that were referred to by the Deputy Chair, we had major concerns over a short period of time in providing medical coverage at some of our facilities because a lot of the locums I was referring to that we use were coming from Queensland. With the hard border lockdown, they could not come through. Every time there is a lockdown, we have a problem because I have got staff who work in my hospitals who live in Queensland and vice versa in Queensland. We have negotiated an agreement with the Queensland Government and Queensland police that when that occurs, there is sort of a secret road map that the staff have so they do not have to queue up in the long lines and they can get through both ways. But it has created a degree of difficulty that is—again, I know I am using this word too much—very unfortunate.

The Hon. NATASHA MACLAREN-JONES: I want to move on to staff training and upskilling. One of the witnesses this morning said that an application had gone in for upskilling and they were declined. Obviously, everybody cannot be given upskilling training. I just wanted you to clarify what the process is for applications for people to be upskilled but also to get support for study and being able to take leave, particularly if they wanted to go on and do—

Mr JONES: Can I answer directly the point? Because that was a Bonalbo issue that was raised.

The Hon. NATASHA MACLAREN-JONES: Yes.

Mr JONES: Then I will ask Ms Duffy to comment more on the education side of it. That request was to upskill some registered nurses in X-ray operation. Having nurses doing plain film imaging—is what it is called—is something that is not fully endorsed by radiologist societies or radiographer societies. We declined that partly because the local GP wants to take more advanced training and for him to do that work. We have not said no completely to the nurses because we do see some benefit in that, but we are going to assess what happens with the GP and then revisit that further down the track. I will ask Ms Duffy to answer the broader question.

Ms DUFFY: In regard to access to study leave and professional development support, there is a range of approaches that are taken. We have across the district a number of clinical nurse educators and nurse educators amounting to 71 full-time equivalent. They work across all of our sites and they support staff with clinically based education and skill development. There are also processes in place where staff can apply for support for study leave to undertake postgraduate studies and also can apply for scholarships through various mechanisms and be released with study time to do that as much as possible.

The Hon. NATASHA MACLAREN-JONES: Just in relation to the 71 clinical nurse educators spread across the region, using Lismore as an example and maybe just a general surgical ward, how many clinical nurse educators would you have at Lismore and how is that structured across different wards?

Ms DUFFY: Generally speaking, in an average 30-bed ward you might be looking at one full-time equivalent of a nurse educator or clinical nurse educator. But it would depend on the need and how the education service was to be structured, what the specialty of that unit was and the other supports that were available, including clinical nurse consultants and nurse practitioners who also support staff development. So it is variable.

The Hon. TREVOR KHAN: I can say it was raised yesterday, so I will put it that way—the availability of outpatient clinics particularly for chronic disease, or the lack thereof. Have you got built into your plans the provision of outpatient clinics for chronic disease?

Mr JONES: We run a number of chronic disease management programs. Because of the nature of chronic disease, we have an outreach chronic disease management program. We work with people with chronic disease—respiratory groups and cardiology groups, just to name two as an example.

The Hon. TREVOR KHAN: What about, for instance, rheumatology?

Mr JONES: We do not run a rheumatology outpatient clinic. To be honest with you, we have never been approached to run a rheumatology outpatient clinic or a rheumatology program specifically. But we work, particularly in the last couple of years, very closely with our general practitioners through the primary health network where our chronic disease management team work with the GP practices who have those known chronic disease patients. We tend to know those people because we deal with them on a frequent basis. So we have implemented a range of programs to maintain their health—as I said, respiratory and cardiology just to name a few—but we also have programs to support chronic disease management through winter. It is what we call our winter plan where we work with the GP practices directly and provide social planning and upskilling of their practice nurses, with our experts going in and providing education and support.

That has been overwhelmingly well received, not only by the GPs and the practice nurses but in the feedback from the individual patients. The one that really got me was—and I had never even looked for it or thought this would be happening—that support has allowed him to have a more broader social life. When I spoke to him directly he said, "I was isolated at home because I didn't feel confident in going out. The program now has given me the confidence to go out." So we do it. We also have a specific Aboriginal chronic disease management program because that needs to be culturally specific and also work with the Aboriginal medical services. With our aging population, chronic disease management is something we are fast becoming experts at.

The Hon. TREVOR KHAN: It seems to me that so much of the increase in population that has occurred in certain areas of the State—the North Coast being one and around Tamworth is another area—is where there has been a large movement of an aging population into the area, essentially a retirement movement. The question that arises from that is are the local health districts [LHDs] sufficiently nimble to take into account what is essentially a changing demographic in the area?

Mr JONES: It comes back to an earlier comment I made about planning. In my view, having a strategic plan that goes for 10 years is not very valuable. You need something that has a shorter period. For me, three or four years would be the most that you would want that plan because it needs to relate to the changing demographics. We know that we have got a certain percentage of people over 65 and we know that we have got a certain percentage over 85, but we do not know how that is going to impact our healthcare delivery over the next two years. We do know that we are planning for it. If I use Tweed as an example—that is the most recent plan—part of the redevelopment for Tweed Valley Hospital is a broader rehabilitation program recognising the aged.

We have enhanced our palliative care services, recognising the aged, and the chronic disease management programs. The value-based care programs that we are implementing are primarily looking at managing conditions of the elderly. So we are responding to that. It depends on a raft of things, so we do not commit ourselves on a path for 10 years. You used the word correctly—we need to be "nimble" and respond because we are seeing a growth in population. I am trying not to be flippant here but it took me six months to meet anyone who actually was born here. Everyone had come from somewhere else. We are starting to see that again. There are a lot of people wanting to come. I hope that answers your question.

The Hon. TREVOR KHAN: Yes, thank you. I will move on to another area because I am mindful of time. How many ear, nose and throat specialists are in the LHD?

Mr JONES: Off the top of my head, I do apologise, I think we have—

The Hon. TREVOR KHAN: You can take it on notice. This is not a guessing competition and it is certainly not a memory test.

Mr JONES: We have a roster at Tweed. They had a difficulty for a number of years in recruiting a complete roster for Lismore Base Hospital, so we are still reliant on locums coming forward. But I can certainly get that detail back to you.

The Hon. TREVOR KHAN: Thank you. Now this is something that is reasonably close to my heart because of my grandson. What provision is there for the availability of ear, nose and throat services for preschool kids?

Mr JONES: The challenge with that is it is what we would term a rooms-based service—accessing an ear, nose and throat [ENT] specialist in their rooms. That has always been a challenge. There were some decisions made a number of years ago—Dr Hutton may recall when—if you were taking tonsils out, which is often a young person's condition, the specialist needs to be around in case of complications for I believe now up to 10 days—

Dr HUTTON: Something like that.

Mr JONES: —post surgery, which makes it difficult in regional environments when you are relying on locums because locums do not want to hang around not operating for 10 days. So our focus is on getting people to stay here and work here. We have had a modicum of success but the market for ENT specialists in Australia is very difficult at this point in time.

The Hon. TREVOR KHAN: I am not going to ask anything more because—

Mr JONES: But, sorry, just to clarify and to answer you, we do have good relationships with Queensland. I keep coming back to that. We work with our GPs. So a lot of the GPs now, through the meetings we have with them on a regular basis, we tell them the supply we have in a number of services—ENT being one—and if there is not enough supply to meet their demand, then they refer up to ENT surgeons in the Gold Coast.

The Hon. TREVOR KHAN: I accept that. My concern was in part the evidence that we received yesterday from a young woman. It is not the experience that my family has had. Things are different in different circumstances. But her story of accessing appropriate services for her daughter involving travelling to Newcastle—a single mother—is very concerning. She coped, but my feeling would be a single mother with other children accessing services two hours away is likely to see that child or many of those children get no services at all. I get the model for adults but it really is a concern to me when you see those stories involving young children whether we are doing enough.

Mr JONES: I agree.

The Hon. NATASHA MACLAREN-JONES: You made a comment that there is a supply and demand issue in relation to ENT surgeons Australia wide. Why is that?

Mr JONES: I could not answer that in too much detail; I am not across it. All I can tell you is that ENT surgeons in regional but also in some metro areas are difficult to attract. It seems to be less difficult to attract them in the private sector than in the public sector. Most of them do work with a foot in both camps in that regard, but all I can say is that we have had difficulty for a number of years in recruiting to permanent positions, either VMO or staff specialist, for ENT surgeons.

The Hon. TREVOR KHAN: The argument in regard to Tamworth was that, whether this is right or wrong, it was the adequacy or inadequacy of access to operating theatre time that was preventing an ENT coming to Tamworth. Is that potentially an issue in your LHD?

Mr JONES: Not at this point. I would have said five years ago potentially because of capacity, not for any other reason. Part of the building of the Tweed Valley Hospital was to do some work at Tweed Hospital to keep it safe and operating for the building period. Part of that included two extra operating theatres. The Lismore Base has got capacity up until, I think, 2028, so we are using, I think at last count, eight of those theatres. So, no, access to operating theatres is not the challenge to us, and we have got operating theatres at a number of our facilities. Again, we network services. We do not want everything to come into Lismore. It defeats the purpose of trying to de-congest it, so where it is clinically appropriate—and we have a number of surgeons; orthopods and general surgeons—who do a lot of their minor work out in our peripheral hospitals.

The CHAIR: Before you go on, I am just looking at the time. It has just gone 3.11 p.m. May I suggest two lots of 10 minutes—that would get us through to 3.30 p.m.—and another five to tidy up if there is a need to do so?

The Hon. TREVOR KHAN: Yes, I am happy with that. I suspect there will not be any tidying up.

The Hon. WALT SECORD: I probably will not need my full 10 minutes.

The CHAIR: I have some questions, so I will jump in.

The Hon. WALT SECORD: Mr Jones, I want to take to you back to some earlier questions about the COVID impact on New South Wales-Queensland border relations. Would you admit or would you recognise that COVID highlighted an over-reliance on sending people across the border to Queensland for specialist treatment that should have occurred here?

Mr JONES: Not so bluntly, I would not, but please let me explain. We do recognise, as I said earlier, four or five years ago elective surgery may have been difficult to access because of capacity. We have dealt with that. So a lot of the planning now—we have a very deep and broad range of medical specialists in our larger hospitals, so it is not so much accessing that; it is more coming back to the quality and safety component of networking services. The border should not be seen as a negative, going across it, because the proximity to supra-specialty services at the Gold Coast that people in the North Coast can access that other regions in New South Wales cannot—it is a difficult time to travel across, but the time is not that great, if I am really direct on that.

So, no, I do not think it is, but I do recognise we will continue to send people up for supra-specialty services because we will not be developing them because there is a risk of having low-volume proceduralists here. We do not want to do that. We have seen the benefit of centralising. Cancer surgery is a classic example. The mortality and morbidity improvements associated with centralising into bigger facilities where people do more surgery is just proven in that regard. But what we will see with the enhancement of both Lismore, Tweed, and Grafton, when it is developed, and Ballina is more capacity for what work we can do. So we will see a return back; as I said earlier, about 5,000 people, we anticipate.

The Hon. WALT SECORD: I will take you back to Lismore Base Hospital. Are you confident that junior doctors are getting the appropriate supervision?

Mr JONES: Yes, I am, and I base that on a number of counts. We get a number of audits that have been done. The Australian Medical Association is an example. It does an audit of training programs, and the service came up very well in that regard. The JMOs themselves felt there was good supervision. In Lismore, in particular, we work with the University Centre for Rural Health and have a training hub through there, so there is a great deal of support for the JMOs there. We have a dedicated group of senior clinicians who take training very seriously, and they pride themselves in moulding the next generation of surgeons and physicians. A longwinded answer. I am very comfortable.

The Hon. WALT SECORD: You would not be aware, but we have had evidence to the Committee that doctors have expressed concerns about working for unrealistic periods. We had evidence that there were doctors who had worked—this is where Trevor and I had an exchange—96 hours continuously. Are you aware of those claims?

Mr JONES: I am aware of the historical comments being made, and I use that term deliberately. There have been a number of systems put in place by NSW Health to prevent that. We do not want our JMOs, who are the backbone of delivery of care in the hospital, fatigued. In the old days—and I think we need to recognise—it was the practice that JMOs worked extended hours. Now we roster them. We audit the rosters. We check because sometimes you could swap your shift, and we would think you are okay, but then all of a sudden you have swapped, you have not told anyone, and you could have worked extended periods. We work with the JMOs not to do that, so there has been incredible improvement in ensuring that JMOs are not fatigued by overworking them.

The Hon. WALT SECORD: This morning we heard evidence from George Thompson of Coraki and the residents' association there about the HealthOne facility. Is the local health district taking any steps to help secure a doctor for the HealthOne facility there?

Mr JONES: We have taken a number of recruitment rounds. There has been limited response. When we have had response, we try to make the package exceptionally attractive. We pay the outgoings, we pay for the administrative staff, we put a lot of financial incentives in there to attract GPs. I think George Thompson mentioned this morning that the volume of activity does not meet the business model that anyone has come to. We even went to one of the corporates, which is against my DNA to do. They came and had a look, and they could not see any benefit in doing so. We have approached the GPs in surrounding areas, such as Casino, which is about 22 minutes or 23 minutes away to see if they would support. There is no support. We will continue to work with the local community but also with the primary health network [PHN]. I do recognise that general practice is a Commonwealth priority, but the reality is this is part of our community, so we work with the agencies, including the Commonwealth PHN, to try to get a GP. We will continue to try, but we are struggling in getting someone into Coraki.

The Hon. WALT SECORD: I will end on this question: Taking you back to some questions that I asked earlier about the MPSs, in the four MPSs that have several nurses working on the weekends do you have security

staff to assist? We have had evidence in other MPSs in rural and regional areas that there was concern from nurses about their security.

Mr JONES: No, we do not. When the opportunity arises, we employ health security assistants. We have one or two of those in Kyogle. The tenure of those positions in the MPSs does not allow us to do that, but we do, when we replace them, look at those as an option. What we do in lieu of that is modify the buildings to create security. We will say five o'clock is a point in time when the staffing numbers reduce. What the process then is, the MPS is locked down. Someone goes around and checks that all the access points bar one—and that is the main entry—are locked. Even then, that main entry is locked under a—you press a button to open the doors, and that allows the visualisation of someone walking up to the MPS. They decide that person looks a bit—"I do not know that person, what risks they are going to provide"—and they can intercom them in that regard. A longwinded answer. No, we do not have security staff, so we operate through processes and systems.

The CHAIR: Mr Jones, I will ask you this question in the third person, if I can describe it that way. It is a vicarious way of asking you to imagine this: Assume in a few weeks' time there is a gathering of the LHD CEOs all around New South Wales as part of an annual gathering. You have had a busy day and got through all the business on the business paper, and you had had dinner and then broke to the bar for a few drinks. You have had a couple of drinks and are sharing things. Someone says, "Listen, what could we do to really improve palliative care in New South Wales? We are the CEOs of the LHDs, we have a pretty good knowledge through that, directly and indirectly, about matters to do with palliative care."

That is not reflecting on any LHD or any CEO, just the history of how we got to where we are with respect to the understanding and delivery of palliative care. I want to talk about the very end stage. I know palliative care can have a long tail depending on individuals, but I am saying literally hours or a day or days before death. What would that CEO who was reflecting on all that say about what could be done to take a step up not overnight but moving towards a better way in which we can deliver palliative care to the citizens of this State? It is inviting you in a cheeky way to be frank. It is not reflecting on you personally, I do not want you to take it that way, but rather what could be done holistically by NSW Health to step up the way in which we deal with end-of-life care in New South Wales?

Mr JONES: I cannot recall which Minister instigated this, whether it was the current Minister Hazzard or his predecessor, Minister Skinner, but there was a focus on workshops for palliative care in regional communities, bringing the community, the non-government providers and government providers together. That certainly identified varying deficits. Everyone had a deficit, it just varied on what it was. There has been a strong injection of resources and thinking about palliative care. I can only comment on my patch at this point in time. We worked very closely with an agency called Silver Chain, which was doing the home-based palliative care program. That model has shifted.

They provided excellent care; let me make that clear on record. They were very, very professional and very capable, but there was always a degree of disconnect with our services. So the decision was made where we had the opportunity to look at bringing that service in house, which we have done. We have increased the number of specialists. We have three palliative care specialists now. We have a range of community services. I think the improvement we have had—we now communicate well with those providers. We support through financial funding the only hospice we have in our footprint, Wedgetail. We work a lot more with our general practitioners. So I believe the system has improved dramatically. We have got palliative care nurse practitioners and so forth.

Where can it improve? I think to continue to work with people and families who are going through that journey and give them the choice of where they wish to die. We do that and we do it quite well, but I think if there can be improvement it is ensuring that communication is there so that people do not feel anything other than it is their wish where they wish to die—in a hospice, in a hospital or in their home. I think that is the next quantum leap. Because at the moment we talk to people and we believe that whilst there is greater choice there for people to select where and how they die, then we need to make sure it is even more. We do get some feedback that "Mum died in hospital, but wouldn't it have been great if she died at home?" And then we ask why did that occur.

We are creating environments in most of our facilities. Recent funding has allowed us to refurbish and develop palliative care rooms in a number of our hospitals, so it does not look—if you want to die in a hospital because you do not want to leave that challenge of managing the body at home, then it is as homely a place as possible. There has been a lot of investment and a lot energy into palliative care. I think the next step is recognising end of life and giving people the choice about end of life, but that goes into a political sphere that I will refrain from commenting on.

The Hon. TREVOR KHAN: I think the Chair and I have a different view on it.

The CHAIR: Perhaps for another day. Thank you.

The Hon. EMMA HURST: To follow up on the questions about Coraki. You mentioned that you were going to continue to try to recruit a GP in the area. Where do we go from that if that continues on and on and on? Obviously there have been a lot of witnesses who have come here today saying that just trying to recruit somebody leads to nothing and something else needs to be added to that to incentivise them. What are the next steps if that continuing recruitment process leads nowhere?

Mr JONES: I apologise if I am mishearing your question but I think you are leaning towards Coraki looking at an MPS model.

The Hon. EMMA HURST: It was more of an open question to say, "Where do we go?"

Mr JONES: Let me talk about why it is not an MPS. When the planning phases, the options with the community fell down when—no pun intended—the hospital was damaged, it was HealthOne or an MPS. An MPS is a combination of Federal funding for aged care and State funding for acute community-based care. The aged-care facility at Coraki did not wish to change. They did not wish to segregate from their current organisation and join an MPS. Bonalbo UnitingCare, which was behind the old Bonalbo Hospital, was comfortable to relinquish the licences back to us. That allowed an MPS model. So that is why it is a HealthOne as opposed to an MPS.

I wish I had an answer that would satisfy people like Mr Thompson and the people of Coraki, who we meet with on occasions to talk through it. We will continue to work with the PHN. I think there need to be some changes to the remuneration models, and that involves Commonwealth changes as well as State changes. It needs to be attractive. It needs to recognise that it is not a business based on volume. Some of the communities, and Coraki is the only one I can speak to, will not generate a great deal of income for a GP based on volume. So there has to be some further incentivisation. I think the next step is to sit down with the Commonwealth agent through the PHN, Healthy North Coast. They are very committed to this; I want to put that on record. They have supported and tried to get a GP as well. Is there something between us that we can do that is novel? Because there is a need there. I am not stepping away from the fact. GP services are only 22 or 23 minutes away from Casino, Lismore and Evans Head. The reality is it is an aging community and a local GP would be an outstanding outcome.

The Hon. EMMA HURST: Yes, definitely. Do you think the main incentivisation would be financial?

Mr JONES: There are a lot of studies—and I am sure you learned people are across these—that say remuneration is not the primary driver of why people take a job, but you need to earn a living. So it needs to be a whole range of benefits. I will not bore you going through them—I am sure you have read them—but we need to ensure there is an adequate income for those individuals to maintain a quality of life. What we do know is having a single GP in small towns is a model that is dying. It is not something that lends to a quality of life, hence people are stopping it. There is a challenge in getting multiple GPs with the workforce to go and provide that roster that is required. But we are going to have to look at something because in places like Coraki, it is a challenge for us dealing with the community. What we do recognise in regional and rural, despite the fact that when you sit down with communities and say GPs are funded by the Commonwealth—"Yeah, but what are you doing about it?" We are the face of Health. We can put our hands up and say it is a Commonwealth problem, but at the end of the day they are residents in our footprint.

The Hon. EMMA HURST: We also heard from a number of witnesses who had different health issues and who were considering leaving the area because of their concerns around the health issues. Is that feedback that you have also received, that people are now moving out of the area? Are you concerned that that is going to continue to happen with the current state of play within the healthcare system?

Mr JONES: I do not want to dismiss the concerns. The gentleman is talking specifically about neurology and neurosurgery.

The Hon. EMMA HURST: There were others as well. There were quite a lot.

Mr JONES: But I am just saying in this case, neurosurgery will not be provided here because of volume and quality and safety concerns. Neurology—we have had challenges. We have neurologists at Tweed, we have got a neurologist in Ballina, we have had trouble in Lismore—we have someone starting in the middle of July, which helps. What we are seeing is more people coming to us than leaving us. It is our job as an organisation to recognise that we cannot provide everything in your own backyard, but it is our job to ensure that when you need it, we can escalate and transfer you to get that care that is required.

Ms CATE FAEHRMANN: I wanted to touch on the Aboriginal Health Unit, if I can, Ms Duffy. I have the Aboriginal Health Unit page unit in front of me. How many Aboriginal workers within the LHD are there?

Ms DUFFY: I do not think I can answer that off the top of my head. We would have to take that on notice, unless Mr Jones has that figure to hand.

The CHAIR: Sure.

Mr JONES: It fluctuates. At this point in time we have a very low number. It is about 18. But that does fluctuate. We are happy to get the actual figure and bring it back to you and take it on notice.

Ms CATE FAEHRMANN: That would be great—the positions, if you like, and then the filled positions. I understand there are probably potentially some vacancies, like there seem to be in a lot of different areas.

Ms DUFFY: Only a very small number at the moment. We do have some movement from time to time, but there is not much in the way of vacancy at this moment in time.

Mr JONES: Can I add what we are doing about that, because it is a piece of work that we have been working on for a number of years. We were very fortunate to recruit an Indigenous woman by the name of Kirsty Glanville, who is our associate director of Aboriginal health. When she came to me, her previous employer contacted me and said, "Well, be careful because she will hold you to account," and she does that very much so. We have commenced an Aboriginal employment recruitment and retention officer. We have an Aboriginal employment plan. We are about to be the only LHD in Australia that works with the ACCO, the Aboriginal Community Controlled Organisation, to work also with the Indigenous allied health association and have Aboriginal cadetships for allied health—permanent positions going forward.

We are looking at culturally sensitive ways in which we can retain workers. We have tried in certain circumstances, and the one that comes to mind is having an Indigenous sexual assault worker. That failed because having a single Indigenous sexual assault worker provides them no cultural protection. We need to look at if we are going to employ one in an area such as that, we need to employ two. There is a lot of work going on. We are very confident that we meet the number target that we try to achieve, but we want to have 5 per cent. There are 4.2 per cent of people in our LHD who are Indigenous. We want an employment target of 5 per cent. We are very committed to the fact that one of the best ways to deal with adversity and disadvantage is employment.

Ms CATE FAEHRMANN: I was going to ask about the workforce target, that 5 per cent, which is great to hear. Is that by a particular year?

Mr JONES: We are trying to do that within 12 months.

Ms CATE FAEHRMANN: That is ambitious.

Mr JONES: It is ambitious based on where we are at this point in time, but we think there is a range of service. We are not just saying low-level roles, we just do not want Indigenous people coming into—there needs to be a career path. Coming back to the comment earlier about how do you attract and retain people, the clear evidence is have a pathway so they do not see it as, "I'm not just going to be the cleaner, I'm not just going to be the allied health technician, I can be a whole range of services." We are very committed to that. We are very fortunate that all the MPs of all colours, Federal and State, are supporting us in this. We work with our other major employers. We have invested in a position to work outside of Health to develop an Aboriginal employment and recruitment and retention program for some of our other major employers in the area. The meatworks is one example. We are very committed to this. We have invested in it.

Ms CATE FAEHRMANN: Thank you, Mr Jones. That is good to hear. Ms Duffy, can I ask about Aboriginal birthing units and/or midwives and what that looks like within the LHD? We have heard, I think, at Wellington about the Aboriginal midwife there who was talking to us, firstly, of the fear sometimes of, for obvious reasons, the hospital environment, but then the important and essential role she was playing for pregnant Aboriginal women in that area. Is that the case here? Do you have Aboriginal midwives in the LHD?

Ms DUFFY: Yes, we do. That does fluctuate. We work closely with our maternity services in ensuring that there are culturally safe and sensitive services provided to these women. It continues to be an ongoing piece of work. Certainly Kirsty, from the Aboriginal Health Unit perspective, is involved in that in terms of how we work with the community to provide those services.

Ms CATE FAEHRMANN: If that could also be provided within, I assume, the positions as to whether they are full-time, whether they are permanent and what that looks like as well, that would be great.

Ms DUFFY: Yes.

The CHAIR: That brings us to a conclusion. Thank you all very much for coming along. We know your responsibilities are high and your time is precious, but you have made available an hour and a half-plus this afternoon. We appreciate that very much. Thank you on behalf of the Committee for all the astounding work you do for the citizens of Lismore. The doctor, obviously as a medical practitioner, no doubt is on the tools, so to

speak. Of course, that work is greatly appreciated and the administration is vitally important. Mr Jones and Ms Duffy, thank you very much. That concludes our hearing this afternoon.

(The witnesses withdrew.)

The Committee adjourned at 15:35.