REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY SELECT COMMITTEE ON REMOTE, RURAL AND REGIONAL HEALTH

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

At Jubilee Room, Parliament House, Sydney, on Friday 13 December 2024

The Committee met at 9:00.

PRESENT

Dr Joe McGirr (Chair)
Ms Trish Doyle

PRESENT VIA VIDEOCONFERENCE

Mr Clayton Barr
Ms Liza Butler
Mrs Tanya Thompson
Mrs Leslie Williams

The CHAIR: Welcome to today's public hearing of the Legislative Assembly Select Committee on Remote, Rural and Regional Health. Today's hearing is part of our inquiry into the implementation of Portfolio Committee No. 2 – Health recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities. My name is Dr Joe McGirr. I am the member for Wagga Wagga and Chair of the Committee. Joining me today in the room is Ms Trish Doyle, the member for Blue Mountains, and online are Mr Clayton Barr, the member for Cessnock; Ms Liza Butler, the member for South Coast; Mrs Tanya Thompson, the member for Myall Lakes; and Mrs Leslie Williams, the member for Port Macquarie. Our fellow Committee member and Deputy Chair, Ms Janelle Saffin, the member for Lismore, is an apology for today's hearing.

The hearing is being broadcast to the public via the Parliament's website. We have a combination of witnesses appearing in person and via videoconference. Before we commence, I acknowledge the Gadigal people, who are the traditional custodians of the lands we meet on here at New South Wakes Parliament. I also pay my respects to Elders past and present of the Eora nation and extend that respect to other Aboriginal and Torres Strait Islander people who are present today or watching the proceedings on New South Wales Parliament website. I thank everyone who is appearing before the Committee today. I declare the hearing open.

Mayor DARRELL TIEMENS, Narrabri Shire Council, sworn and examined

Ms DONNA AUSLING, Director, Planning and Sustainability, Narrabri Shire Council, affirmed and examined

Mayor JULIA CORNWELL McKEAN, Berrigan Shire Council, before the Committee via videoconference, affirmed and examined

Mrs KARINA EWER, Chief Executive Officer, Berrigan Shire Council, before the Committee via videoconference, affirmed and examined

Councillor LOUISE O'LEARY, Parkes Shire Council, before the Committee via videoconference, affirmed and examined

Deputy Mayor STEVEN RING, Lithgow City Council, affirmed and examined

Mr SHAUN ELWOOD, Director, Lithgow City Council, affirmed and examined

Mayor NEIL WESTCOTT, Parkes Shire Council, before the Committee via videoconference, sworn and examined

The CHAIR: Good morning, everyone. For those of you who are here in person, please be aware that staff will be taking photographs throughout the hearing. If you have concerns, please let us know. Can everyone confirm that you have been issued with the Committee's terms of reference and information about the standing orders relating to the examination of witnesses? Everyone is nodding. Councillor Louise O'Leary and Mayor Neil Westcott are appearing online, but their video isn't working. I'll assume that they have received that information. We'll commence by giving each council the opportunity to make a brief, two-minute opening presentation, if you would like, and then we'll proceed to questions. Narrabri, would you like to make a brief opening statement?

DARRELL TIEMENS: Yes, thank you very much, Mr Chair. I'd also like to acknowledge the local Aboriginal people and all their Elders past, present and future. Honourable members, I rise today to call out some of the glaring inequities faced by residents of Narrabri Shire under the Hunter New England Local Health District. Let me make it very clear that we're not second-class citizens—emotional words, I know, but I have patterns of evidence to show that we're being treated as second-class citizens.

Narrabri Shire is the second most productive agricultural district in all of Australia. We pay huge amounts of tax and yet we've got three very suboptimal hospitals. One hospital has an emergency department. It's the only emergency department in the region that closes at 5.30 p.m. every night. It has no doctor, and there are no patients in any of the beds in any of the wards of that hospital. Another critical hospital, Narrabri hospital, has missed out on crucial life-giving services like telehealth, dialysis machines and decent oncology services, yet earlier this year we almost had our pathology lab closed based on poor evidence given by that health district. If it wasn't for the hard work of the community and the hard work of our local member, we would not have this lab.

The lives of our rural Australians matter just as much as those in the city. We just feel like the system constantly lets us down, forcing our community to shoulder risks and burdens that would be unthinkable anywhere. As we speak, we've got farmers working 24 hours a day. Some of them are two or three hours away from the nearest major hospital, yet we've got an emergency department that closes at 5.30 p.m. at night and basically shuts its doors. I've got case after case after case of patients who have turned up at, say, Wee Waa Hospital, only to be moved on to Narrabri Hospital and then moved on to, potentially, Tamworth Hospital. I've got videos and cases that I have here that I'm very happy to offer and show about some of the inequities that we've been facing as an area.

Our local government area has a lower life expectancy than any of the local government areas around our area, yet our economy is twice the size of any of the other local government areas around our area. We pay massive amounts of tax. We pay the same rate of tax as everyone here in this room, yet we receive what can only be described as almost Third World hospital situations. We have a situation where the local health district has a hospital committee for Wee Waa Hospital and our deputy mayor is on that committee. That committee has not met for four years. I'm the representative on the Narrabri Hospital committee. The local health district proposed to shut down the pathology lab without any consultation with the other community members on this particular hospital committee.

We've got case after case after case of failure by our local health district, Hunter New England Health. The local member, our community and myself and are 100 per cent united in our criticism of the local health district that it is not fit for purpose. It is an opaque organisation that does not communicate properly to its community members. It says it does; it has all these absolutely wonderful press releases and bureaucratic statements. The community has had enough. We were in a situation recently where we had a number of community rallies. The

bubbling and boiling anger directed at that health district is just palpable, and the community has had enough. Being polite country people, our politeness has found a limit.

The CHAIR: We'll have an opportunity to explore those serious issues, but we'll give the other councils an opportunity to make a brief opening presentation. We might go to Berrigan Shire Council, who are online. Would you like to make a brief opening statement?

JULIA CORNWELL McKEAN: Yes, please. Berrigan Shire Council thanks the Committee for inviting us to attend this morning. My name is Dr Julia Cornwell McKean. I am not a medical doctor, but I am a doctor nonetheless. As I mentioned, I'm Mayor of Berrigan Shire Council. I'm also a director of Goulburn Valley Health. I'm not here today speaking on behalf of Goulburn Valley Health, but I wish to make the point that Goulburn Valley Health is a health service in Victoria. We in Berrigan Shire Council are largely serviced by the Victorian health system, though we are part of Murrumbidgee Local Health District and they do provide a limited service to us. We do rely heavily on Victoria. That's why I put my hand up, when the time came, to be a director for Goulburn Valley Health. What that means to us is that, other than myself being on that board, we largely do not have a say in the health services that are delivered to our community.

I am heartened, however, that at Goulburn Valley and across Victoria, they have expanded the quadruple aims of health care from quadruple aims to quintuplet aims to encompass also health equity. It is far from inaccurate to say that we do not get equal care in rural and regional areas. Indeed, if you live in Melbourne and you have a stroke, you will get the appropriate care within one hour. If you live in Barooga, it won't happen. It won't happen. There are a few things that are particularly concerning to us. We have no dialysis chairs among a population of 9,000, with an average age of 55 in Berrigan Shire. Our partner community in Victoria in Moria Shire have 30,000 people and they have two chairs.

People travel to Shepparton, Wagga and Deniliquin and they have a waiting list. If you need dialysis care today, you can't get it if you live in Berrigan Shire. We also have issues in relation to ambulances. For our biggest town, Tocumwal, which has a population of nearly 3,000, the average time for priority one and two is 40 minutes for an ambulance. Frankly, that's not good enough. While we are grateful for an upgrade of Finley Hospital and the $25 million put towards that, it still fails to provide us with CT and dialysis. We are grateful for health near the home and developments in that area and in digital health. We think that will assist in approaching health equity—I say "approaching", and not "achieving" health equity. There is a lot to do in relation to the actual physical care that we need to have in our rural and regional areas.

The CHAIR: Thank you, Councillor McKean. Does Parkes Shire Council wish to make an opening statement?

LOUISE O'LEARY: I am not quite sure whether Mayor Westcott has been able to dial in. I have some notes. I'll just read through those. One of the most pressing issues in rural and regional New South Wales is the severe shortage of doctors. This shortage has led to long waiting times for medical appointments, reduced access to specialist care and increased pressure on existing healthcare services. The lack of medical professionals in these areas not only affects the immediate health of residents but also contributes to the overall decline in health outcomes for our rural populations. Local hospital emergency departments are rapidly becoming pseudo primary healthcare service providers. It may be time in many communities to embrace the need to provide primary health facilities from local hospitals and provide multiple roles, such as trainee doctors and allied health professionals, servicing the needs of our EDs and inpatients and providing primary care to the community.

The pathway to developing health professionals needs to be built in a much more robust way, including the funding of placements for trainee doctors. Just in summary, the lack of access to doctors in our region is becoming critical. Experienced fellow doctors cannot work harder to solve the problem. They can, however, supervise and train mobile student doctors, which must be part of our long-term solution. All tiers of government, industry and universities need to work together. Parkes has a new $80 million state-of-the-art hospital with a modern birthing suite and twin operating theatres which are grossly underutilised. We have not had maternity services in Parkes since 2019. The outlying towns are then impacting on the bigger facilities, and they also have to drive. The outcomes for the people in the region are in serious decline. Ambulance staff are caught up with patient transports.

Universities have existing relationships with regional hospitals to train young doctors. These relationships need to be fostered. Western New South Wales Local Health District and Parkes Shire Council have developed a health precinct master plan, which provides significant opportunities for health clusters around the Parkes Hospital. The way we are working is not working. New models must be trialled. Parkes is actually proposing to develop a training pipeline for doctors and allied health professionals whilst supporting the primary healthcare needs of our hospital. Thank you.

The CHAIR: Thank you. I understand Mayor Neil Westcott is online now.

NEIL WESTCOTT: Yes, I am.

The CHAIR: Thank you very much, Councillor Westcott. I will now go to Lithgow council. Would you like to make a brief opening statement?

STEVEN RING: Yes, I would. The proximity of Lithgow to Sydney is seen as an advantage, but in terms of our health services it really is a significant disadvantage. Lithgow sits at the end of two health districts: Western NSW and Nepean Blue Mountains. The level of health issues in our community is highest within the Nepean Blue Mountains and within the Central NSW joint organisations. Our hospital, although rebuilt a number of years ago, has turned into a triage centre for Nepean Hospital. Patients are transferred to Nepean. This causes a disconnect for our community members in being able to visit relatives or friends that are in hospital. Although it's only an hour-and-a-half drive, you have to be able to drive. You have to have the train service. If you live in Glen Davis, you're looking at a two and a half hour drive to go to Nepean.

The facilities that we have are limited. The equipment is limited in Lithgow Hospital. I'll give an example. In terms of vein lights, that equipment doesn't exist in Lithgow. In fact, if you have serious issues with your veins—and I'm talking from personal experience, with a daughter who has multiple health conditions and serious chronic illnesses—not having that technology can cause serious longer term issues with the loss of veins, them being destroyed, particularly when you need to find deeper veins. We have significant mental health issues in our community, yet anyone who needs services is sent to Katoomba. Yet again, for anyone that is living there without transport, that is a burden on them getting up. There is a disconnect between the people going to those other hospitals and their family. That causes stress for both the patient and the family, which does not help in the recovery moving forward.

We do get specialists at the hospital, but we need greater incentives to get a better variety and a better quality of specialists. Once again, if there is a rheumatologist, for example, at Lithgow Hospital and you're not satisfied with that person or they're not capable of dealing with complex issues, you have to travel. Yet, because there is a specialist in that field at Lithgow, there is no support in travel costs to go to Sydney. As I said, I'm speaking from personal experience. I have to take my daughter to Eastwood probably every couple of months and the San Clinic at Wahroonga every three months. Because some of those specialists are available, there is no support. We do have a number of GPs, but maintaining and retaining those GPs in the area is difficult. We're basically getting GPs coming up who are doing their training, either new to the country or just to get their experience up, and then going back to Sydney. They don't have the experience or knowledge to deal with complex health issues, chronic illnesses and, in some cases, even an ageing population. We need to have doctors that are there and can be supported.

Being within range of two health districts is a problem. If there are no beds at Nepean, there is no attempt by the local hospital to send someone to Bathurst; it's not their health district. This does not give our community a good health outcome. We need to be able to get our people to hospitals where they can get service, and we need a hospital that has a trauma unit and an intensive care unit. We have two major highways and a major arterial road coming through our community. We have rail, we have mines, we have manufacturing, and not to have a trauma unit and an intensive care unit, I find amazing.

I've had doctors refer patients to Bathurst rather than the Lithgow Hospital. I will commend Lithgow Hospital; there has been significant improvement in the past few months. But in the past, the standard of service in the intensive care unit has been subpar. I will give a personal example. About 10 years ago, my daughter was sent there with a referral from a GP for a lumbar puncture to assess for Legionnaires. She was sent home with two Panadols. We went to Bathurst Hospital the next day. They performed tests and diagnosed my daughter with intracranial hypertension. These are the areas where we're failing our community and that we need support on. Thank you.

The CHAIR: Thanks, Councillor Ring. Opening up to questions, I might first go to Mr Barr, who is online.

Mr CLAYTON BARR: Thank you all for helping us out with our inquiries at the moment. We really appreciate your time and your connection to community as local government councillors. Given this is a New South Wales inquiry, this first question might seem quite strange, but it's going to help with the fabric. How do councils interact directly with the Australian Federal Government in terms of providing health services and trying to fill gaps? What opportunities are there for local councils to deal directly with the Australian Federal Government about health?

DONNA AUSLING: There are some great opportunities for more holistic cooperation between all the tiers of government, particularly around the strategic planning piece that's referred to in council's submission, and

getting some real conversations and discussions between community and those various tiers of government, and those strategic plans, to ensure that our services are fit for purpose—and also engaging with the various stakeholders that are involved. As we've alluded to in our submission, our community in particular is very socially disadvantaged, so there are some great opportunities to connect with the local Aboriginal community and make sure there are some clear discussions happening with the Federal Government. But there's certainly a great need for improvement of engagement and communication between all the tiers.

Mr CLAYTON BARR: What about down in Berrigan?

JULIA CORNWELL McKEAN: I have to say that the Federal Government is conspicuously absent. Our cross-border situation is something they are silent on. We have requested meetings with Minister Butler and have not even received a response.

Mr CLAYTON BARR: And what about Lithgow?

STEVEN RING: The only direct contact we've had is through the grant process or through the local health districts. As a council moving forward, next year we'll be setting up a working party on health and working towards having a whole summit with our local community with the practitioners, basically to find out what we're lacking and what we need, so then we can move forward and approach both Federal and State government.

Mr CLAYTON BARR: And Parkes?

NEIL WESTCOTT: Put bluntly, the further west you go, the separation of primary health care and the State system is untenable. East of the mountains, it works quite happily to have your specialists and GPs and everything operating quite remotely from the hospital system but, as some of the speakers I've heard already say, more often than not our emergency departments end up as pseudo—they just get smashed with triage and things that should be happening at the primary care level.

As the council, we end up having to spend a lot of our ratepayers' money attracting general practitioners to our town and to our shire. That's money that we're not spending on other things that are supposed to be the remit of local council. For Parkes, it's been quite difficult, and we were at a very low spot eight to 10 months ago around being able to provide the most basic of health care. As far as Federal funding goes, we would like to see—as per the report that I went down and spoke about in Orange back in May at the Federal inquiry, one of your suggestions was a pilot program of bringing together State and Federal as a trial for both educating practitioners and for bringing closer together the whole range of specialist services within one area, in our rural areas.

Mrs LESLIE WILLIAMS: Firstly, thank you to all of the witnesses for giving us your time and supporting us today with our inquiry, particularly those who have travelled down to Parliament House. We really appreciate it. Since the PC No. 2 report and the recommendations from some two years ago, obviously, one of the things that was highlighted was communication and consultation with councils and LHDs. I have to say that the first two presentations by Darrell and Mayor Julia—wow, your anger and frustration was absolutely palpable. I'd be interested to hear from the other councils. Do you think anything has changed in the last two years, since the report, in relation to the manner in which your LHDs communicate with you and consult with you or has it gone backwards? We can start with Darrell.

The CHAIR: Yes, we might start with Narrabri.

DARRELL TIEMENS: Yes, thank you very much for that very considered question. I think at the heart of this issue, and at the heart of the issue of a lot of communities, is communication. The very fact that I, as mayor, had to find out that our pathology service was being closed down—even though I'm on that hospital committee, I had to find out through my gardener at my farm. That's how I found out, and it just blew up from there. If it wasn't for the fact that we had found out early, we had 500 people turn up to the RSL at our local Narrabri RSL with 48 hours notice. The anger—the nurses turned up in overnight uniforms. They have re-formed the nurses union as a result of this. The doctors have never been so cross and angry.

It was largely because of lack of communication and lack of commitment. The opacity is the thing that I would describe. That's the way that Hunter New England Health operates. It's seriously like an episode of *Yes Minister* where they will make a case for the closing of Narrabri's pathology lab when we have identical needs states. We've got the numbers; we've got the figures—identical needs state as Moree and they were going to close it down and move everything up to Moree, which is 75 minutes up the road. Our community was absolutely furious. I have Aboriginal Elders on video—I have a wonderful video—that spent eight years having to travel multiple times a week to get dialysis done in Moree simply because there were no dialysis services in Narrabri.

We have communicated these needs over time, and they will never tell us why we've been denied these services. Fair's fair. If there's evidence that we have a lower needs state, then we're more than happy to cop that. But the needs state is really high and we feel like the bureaucrats—I have had multiple conversations, long before

I was even Mayor of Narrabri, with these bureaucrats and it is opaque. You cannot get to the evidence—how they're making their decisions. Our local committees—the Wee Waa hospital committee hasn't met for three and a half or four years. The local member is almost tearing his hair out in this and he's passionate about getting that hospital up and running again.

We're all united as a community. This is a communication issue and it's a resourcing issue. I have had multiple meetings down in Newcastle where we have travelled six hours down to Newcastle—multiple councillors—to speak to Hunter New England Health, the CEO, and other bureaucrats and we just get this polite shrugging the way bureaucrats do. They're lovely people, but we get no action. Our community has got a gun to my head and to our local members' heads saying, "What are you doing about this?" We pay our taxes. We pay the same rate of tax as everyone in this room and yet we do not get anything like the services. We don't want Royal North Shore Hospital; we just want an emergency department that opens after 5.30 at night. We want at least one or two nurses that are happy to be able to perform stitches if a farm worker at midnight falls off his tractor. It's just fundamental basic human rights we're talking about. Our Aboriginal community doesn't want to travel to Moree to get dialysis performed, and no-one will tell us why we can't have dialysis at our local hospital.

Mrs LESLIE WILLIAMS: Thank you, Darrell. It sounds like it's not just about no communication and no consultation; it's also about no transparency.

DARRELL TIEMENS: Correct.

JULIA CORNWELL McKEAN: I'll focus in on communication, if you'd allow me to share an anecdote. Twelve months ago we had Health Infrastructure NSW and Murrumbidgee Local Health District ostensibly attend our council meeting to provide an update on the Finley Hospital refurbishment. We had six people online and three people in person. They put up a little diagram, "How to build a hospital". I found it the most patronising diagram I've seen in my life. They think we are uneducated country hicks. They think we don't know what we're talking about. The discussion went crazy. They didn't know what they were talking about. At one point, someone online asked, "Is this meeting about Finley Hospital?" They were focusing in on I don't know what. They were not even talking about patients. I had to pull them up and say, "Hang on, what about the patients?" They kept talking about clinicians and not the actual people they're treating.

It was so horrendous and embarrassing that I wrote a letter to Minister Park saying that he should be embarrassed, and that if these are the people providing us with health care and building a hospital, we have a serious problem. Twelve months on, remarkably, we now have—and the CEO will step in if I'm incorrect—quarterly personal meetings with the CEO of Murrumbidgee Local Health District and their chair. They've somehow found and located Tocumwal and Finley and had board meetings in both locations in the last 12 months. I'm going to keep cage-rattling to get these people to understand that we're here and we're going to speak loudly, and that they need to seriously stop sharing that diagram, "How to build a hospital".

KARINA EWER: We do have to continuously remind them that Barooga is in fact part of the world and it is in their MLHD. Honestly, they do forget which towns are even in their system.

The CHAIR: I do want to hear from Parkes and from Lithgow, but I am just going to interject here with a further follow-up question. We have heard that the Murrumbidgee Local Health District has an extensive network of local health advisory councils. Berrigan, you're in the Murrumbidgee Local Health District. Do you have a local health advisory council in that region? What's your relationship with that local health advisory council? Were they involved in those discussions you've just had? Can you provide us with some information on that?

JULIA CORNWELL McKEAN: Yes, I certainly can. There are local health advisory committees in Finley, Berrigan and Tocumwal—three small committees. Our town of Barooga does not have a committee and, as the CEO mentioned, frequently is forgotten. Essentially, we're part of Cobram in Victoria. That's the story there. We do have a very active committee in Finley. Syd Dudley, who is the chair, was, I believe, Volunteer of the Year in 2023. He runs a tight committee, which is why there's $25 million in the refurbishment for Finley. But even Syd is deeply disappointed on the absence of CT and dialysis in that refurb. The problem is, of course, that $25 million, when you picture it five years ago, isn't the same as $25 million today. The committees in Berrigan and Tocumwal, albeit small, are reasonably active, but these are very small hospitals. In terms of the broader health care, they achieve the aims of a small hospital; the broader health care goals, not so much. As I say, Finley is the most active of all.

The CHAIR: That's a very good point about local government. We have to hear from Lithgow and Parkes. Perhaps Lithgow next?

STEVEN RING: I'll defer to Mr Elwood if you don't mind, Chair.

SHAUN ELWOOD: Our observations with communications are that we have a range of GP providers throughout the community. We have a local community hospital, Lithgow community hospital, and it's those providers that directly connect with and are proactive to engage with council. What we find is that to engage with the LHD, council has to be the proactive party. That's our main concern.

STEVEN RING: Chair, if I could just add to that, the Nepean Blue Mountains health district does have a local committee, but their sole purpose is to collate good news stories. I attended once during my first term on council. They didn't like hearing a complaint. You had staff there. I'm sorry, but any organisation or bureaucracy needs to be able to hear that they have good and bad. We cannot improve our services unless we have open and frank discussions. That is what's missing in our health community.

NEIL WESTCOTT: I would just concur with the previous speaker that communication comes from our end, and not from the other, in regards to the LHD. To take an example, in a shire of 15,000 or 16,000, we haven't had a baby born in our two brand-new maternity units for six years. Our local member, Phil Donato, has spoken on the floor of Parliament about this three times. We've made many, many representations. We've gone down to Parliament and spoken to Minister Park's staff and Minister Park himself in regard to this issue.

Each time we do it there is a response from the LHD. Usually the opening sentence is, "We have no money." That's the opening sentence statement all the time. As Councillor O'Leary offered up to you there, we do come with positive and proactive ideas on how to overcome this current situation. The problems are diverse and we understand they're not easy to fix. But with the communication side of it, I always tend to feel that I will get a message back from the LHD two days after I've actually talked to Minister Park's staffers or something like that. It is a little bit disappointing, but we do have a relationship with them that I think is open and reasonably positive. How we move forward to actually make a difference in a rural community of, as I say, 15,000 or 16,000, is something we are working on.

Mrs TANYA THOMPSON: Thank you to all of you for giving up your time today and speaking so passionately and honestly about your regions. It's scary to hear that health isn't improving at all across our regional areas. Sticking with the conversations we are having around the conversations between councils and the local health districts, I am interested to hear if you have any solutions for how you think communication could improve? Do you have some strategies, perhaps, that would improve communication between local health districts and local councils, and the Local Health Advisory Committees (LHACs) and councils, perhaps? I am opening the floor to some strategies and solutions.

DARRELL TIEMENS: Thank you very much. I'll let you in on one of the solutions that I've found. It's probably something that is required across our health district. It is actually having community groups that are close to the community. I've got multiple WhatsApp groups made up of nurses, doctors, community members, Aboriginal elders and staff members from the hospitals—multiple WhatsApp groups. They know they can trust me to not breach. They've had multiple warnings that they're not allowed to talk to their elected representatives on council. We've been able to get together as working parties to work through solid need states and also come up with very, very strong clinical solutions. We've presented some of those solutions to Hunter New England Local Health District. We're still yet to get any response from them.

It's about having on-the-ground, honest dialogue. We know we're not going to get a Royal North Shore Hospital. We know we are going to get a basic fundamental emergency hospital. But actually having those open dialogues between elements of the community, where we can share the data, understand what the needs are and understand where to move forward, is what's required—having real committees. For instance, on the Narrabri hospital consultative committee we have a wonderful staff member who is from Community Health. We have no-one there who is actually involved in the acute side of the hospital, at all, meeting with us. We get no clinical data. We get no sharing of any of the information. We have been getting that information, as a shire, through the back door. I think it's grossly unfortunate. Open dialogue, I think, is what's required.

DONNA AUSLING: I'd like to add to what Mayor Tiemens said. The committees that have been lying static and stagnant need to be urgently reactivated. They need to be appropriately resourced and there needs to be a cultural change to that of true engagement rather than the tokenism that we've seen for a number of years. They're tokenistic committees that have no real purpose other than ticking a box. There needs to be a real change to the attitude and the role of these committees in that whole framework.

NEIL WESTCOTT: I'd like to add to that, and I might get Councillor O'Leary just to quickly finish on a positive note in regard to telehealth. Parkes Shire Council is really looking for support for the Western NSW Local Health District to activate our precinct marketing, particularly to support the training of student doctors through Charles Sturt University. We need a dedicated recruitment strategy to ensure that Parkes Hospital is functioning optimally to include the emergency department, maternity and the theatres themselves. We believe

we're a community at a size where that is a very basic requirement. Councillor O'Leary is a registered nurse (RN) at Peak Hill, a smaller community within the shire. I might get her to quickly talk about telehealth.

LOUISE O'LEARY: Thanks, Mr Mayor. I'll just reclassify that I'm an enrolled nurse, and I do actually work for NSW Health and work for Western NSW in a very small rural hospital. I'll just quickly put one little point forward, before my really positive point, about the aged-care system. We have had multiple aged-care facilities close in rural and regional areas. Particularly here in Peak Hill, we had a very much community-funded aged-care facility that had 10 initially low-care beds. That facility, sadly, had to close a number of years ago, which has put a huge strain on our MPS service here at Peak Hill, but also other areas. Aged-care beds are closing. Where do these people go? They actually end up in hospitals and they sit in acute beds, waiting for placement. So I do think there needs to be more consultation between the State and Federal governments in terms of how this is going to be fixed or how it could be potentially improved.

On a positive note, working within NSW Health, we have a doctor but our doctor is not here from time to time. We strongly advocate the virtual telehealth service, or the Virtual Rural Generalist Service (VRGS) as we call them. Peak Hill was actually a pilot many years ago, when we didn't have a doctor for three years, and this service has actually improved immensely. It provides proficient services via telehealth. Our nurses, yes, have to be more upskilled which, again, is where Health does work. But this provides specialised services. Within our small facilities, yes, it's not face to face; however, it does provide an input and it works well for staff. As a staff member, I know it works really well. That helps take the burden off people that come through our back door for our emergency services. Thank you.

STEVEN RING: We need to have a more formalised group—be it a stakeholders group or providers—that is able to facilitate and share information, including members from the Nepean Blue Mountains Local Health District, but also for planning for our future needs on what we are missing. That group could also advocate on the part of the Nepean Blue Mountains Local Health District, as well as our community, to improve either resourcing or alternative solutions. But we also need formalisation of communications between the local health district, council and the local providers so that we're made aware of decisions that were issues rather than hearing from staff that management at the hospital's going to be changed or they're going to be based at Katoomba. We've had this happen in the past. We need to know issues before they happen so we can help work solutions. There has to be an open and transparent communication system in place.

JULIA CORNWELL McKEAN: In relation to the Finley Hospital, there was a lot of concern that the refurb was, effectively, cosmetic. One of the things I suggested to Murrumbidgee, which they subsequently took up, is that they should map the clinical services plan to what they were actually delivering in terms of service for Finley Hospital and indicate what was in and out. It was a two-pager. It was for the community—clear, targeted communication. It's actually pretty simple. I actually don't want it directed to me as a council; I want it directed to the community that they service.

Ms LIZA BUTLER: Continuing the theme of communication, there were two recommendations in the report that we are looking at: Recommendation 5 was improving communication between communities and health services, and recommendation 43 was developing place-based health needs assessments. What I'm hearing is that there has been no improvement. I'd really like you to elaborate on those two particular recommendations.

DARRELL TIEMENS: I'll give the example of Wee Waa Hospital, for instance. It's gotten worse. Earlier this year, the local health district instigated a 5.30 p.m. close-down. That's not an improvement. We are the only hospital in a two-hour radius that has an emergency department that doesn't operate 24 hours a day. We have very disadvantaged communities that feed into it well beyond Wee Waa—that come from the Western NSW Local Health District to use that hospital. I've got case after case after case of dysfunctional service. By the way, the staff are wonderful there, but at 5.30 at night they've got to shut their door and people have to move on.

I've got elderly patients who are—I've got a situation of a young 10-month-old daughter who was choking on a leaf and was turned away from Wee Waa hospital because the staff weren't available after hours. I've got situations where farm contractors have had strokes and they've had to move hundreds of kilometres to Moree simply because they couldn't get proper emergency services at Wee Waa Hospital. This is not improving; this has gotten worse. We have had promise after promise after promise for years now about Wee Waa Hospital, and the community has quite frankly had enough.

Ms LIZA BUTLER: But can you tell me, since the last report and since you've been raising this, has the Government come to you and developed a place-based needs assessment for Wee Waa Hospital?

DARRELL TIEMENS: Absolutely not, no. We've had what's called a collaborative care model, which is an interesting model. I think it's a good word. It's a nice, trendy term. The community sees right through that.

If you don't have the health system in a local community built on the solid foundations of a solid hospital with real doctors and 24-hour care, then it's a house of cards. It has genuinely gotten worse in Wee Waa.

Ms LIZA BUTLER: Do you have locum doctors at the hospital or just no doctors at all?

DARRELL TIEMENS: No, there are no doctors at all in Wee Waa. There are three doctors in the hospital in the actual town. Hunter New England Health just hasn't been able to formulate any Visting Medical Officer (VMO) rights. I don't know; I'm not paid the big bucks. But they have not been able to get their act together to organise a contract with the local doctors there. I don't know what the politics is. I don't understand any of that stuff, but we do not have a doctor. We have a couple of nurses. We just had the acting hospital manager resign about a week ago. That was a trigger for a big rally on the lawns of the hospital about a week ago. The community was triggered by the fact that they lost an experienced RN. She quit in frustration at that local hospital. The gates have gone up. There is a lovely helipad there, there's a lovely nurses' quarters, but there are wards with empty beds and not a single patient in those beds. It is a ghost hospital and it's an embarrassment. It's something that that health district ought to be ashamed of.

The CHAIR: Any other comments from other councils? I am keen for one more question, but just in relation to Ms Butler's question about a place-based needs assessment taking place. Berrigan?

JULIA CORNWELL McKEAN: We haven't had a place-based health needs assessment, but I will say that we have an anticipated growth in population of up to 32 per cent, the majority being retirees, over the next five to 10 years. Our average age is 55, and in one of our towns, indeed, it is 70. There has been no planning for what we have now and no planning for what we anticipate, and I think it's getting into quite dangerous territory.

The CHAIR: Parkes?

NEIL WESTCOTT: I'd only add that Parkes is unique in that there has been State Government funding towards our special activation precinct and the promise of growth and jobs over the next decade, but it's a little bit like the house of cards that the previous speaker was talking about there. Unless we have the services, how do we attract people? Health is obviously right at the top of the list. It's no good having a shiny factory if you can't have people wanting to come and be part of a community, with services like maternity and others.

Ms TRISH DOYLE: First of all, thank you all for speaking your truth to power and being brutally honest with how the situation is in your local council areas. Before I throw a quick question to you, for the record, I note that there is intense pressure on the hospital system and healthcare system, and it has been our understanding over the last couple of years in this Committee that that's particularly felt more in regional, rural and remote areas across the State. I want to acknowledge that. But it didn't just start yesterday and it didn't just start in the last couple of years; it's more than a decade of systemic failures and problems. I acknowledge that the availability or lack of availability of GPs in most areas puts extra pressure on our EDs, so we need all tiers of government to work together. That's the reality. I wonder, if you could pick the two areas of health care in your region that most urgently require that collaboration over the three tiers of government, what would they be? Let's start with you, Lithgow.

STEVEN RING: We definitely need better services in mental health in aged-care facilities.

Ms TRISH DOYLE: Narrabri?

DARRELL TIEMENS: Yes, that's fairly simple. I've got a list of about 10, but I'll give you the top two. For the Indigenous community particularly at Narrabri hospital, in-hospital dialysis machines, for which we've been begging for years. The second one is an actual doctor at Wee Waa hospital—an actual, real doctor, not a telehealth machine.

Ms TRISH DOYLE: Berrigan?

JULIA CORNWELL McKEAN: Given the age of our population, I would have to say kidney health, stroke care and heart care.

Ms TRISH DOYLE: Parkes?

NEIL WESTCOTT: Our top priorities are around aged care, maternity and especially the availability of general practitioners.

The CHAIR: I would just like to thank everybody for appearing today, as we bring this session to a close. Parkes Shire Council, you mentioned your precinct plan. Can I just have a question on notice about that?

NEIL WESTCOTT: Yes, absolutely.

The CHAIR: You have briefly outlined some of it in your report, but I suspect you have a much better-developed document. I would be interested to see that and how you are proposing to tackle this issue of basically having what sounds like a hospital without patients—no obstetrics, the theatre is not used and so on. It sounds like you have a plan, and I would be very interested to see some more detail on that. I hope that is okay.

NEIL WESTCOTT: You probably have it there, but certainly it has been part of our presentation. Mark Spittal, our local director has certainly—we have been working with him on it. But the precinct plan is well advanced as a part of—what we are trying to do is bring in education, so it's a regional thing, because there is a lot of country west of Parkes. You've got all of these Parkes people going to Orange, but it is a long way from Orange to Condobolin and further west of there, and Parkes is essential to that.

The CHAIR: In your submission there is some reference to it; I just thought there might be a bit more detail. We will follow up with a question.

NEIL WESTCOTT: We do have a precinct plan. Yes, I can get that to you.

The CHAIR: Thank you. Excellent. I thank everyone for appearing before the Committee today. You will be provided with a copy of the transcript of your evidence for corrections and any questions that have been taken on notice today. We may also send you some further questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions? I think everyone is nodding, and Parkes would be okay with that. Once again I thank all witnesses for their contribution. Thank you.

(The witnesses withdrew.)

(Short adjournment)

Mr LUKE SLOANE, Deputy Secretary, Rural and Regional Health, NSW Health, affirmed and examined

Mr GREG WESTENBERG, Executive Director, Government Relations, Strategy and Violence Prevention, NSW Health, sworn and examined

Ms JILL LUDFORD, Chief Executive, Murrumbidgee Local Health District, NSW Health, before the Committee via videoconference, sworn and examined

Ms TRACEY MAISEY, Chief Executive, Northern NSW Local Health District, NSW Health, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome the witnesses from NSW Health. We have some appearing by videoconference and in person. For those appearing in person, please be aware that staff will be taking photos throughout the hearing. If you have any concerns, could you please let us know? My name is Joe McGirr; I'm the Chair of the Committee. I have with me Trish Doyle, the member for Blue Mountains, and other members of the Committee are online, including the members representing the electorates of Port Macquarie, Myall Lakes, Cessnock and South Coast. Can each of the witnesses please confirm you've been issued with the Committee's terms of reference and information about the standing orders in relation to the examination of witnesses?

LUKE SLOANE: Yes.

GREG WESTENBERG: Yes.

JILL LUDFORD: Yes.

TRACEY MAISEY: Yes.

The CHAIR: Ms Maisey, I can hear you but it is quite faint. So when you answer questions—I'm not sure where your microphone is? Perhaps you could speak again or check your sound?

TRACEY MAISEY: Is that better?

The CHAIR: Not really. Perhaps sit closer to the microphone. While you're adjusting that, I'm interested to know, Mr Sloane, whether you or your representatives wish to make any brief opening statement.

LUKE SLOANE: No, other than to say thank you for welcoming us back to hear our evidence. We're happy to progress through the questions across all four of us today. Hopefully we've assembled the right people to answer those questions for the Select Committee.

Mrs LESLIE WILLIAMS: Thank you to all of you for coming to speak with us today. We appreciate your time. It's a very busy time of year, I know, for everyone. I'm going to get straight into some of the recommendations from the PC No. 2 report. This is our second day of hearings in this particular tranche. What we've been hearing this morning and yesterday were issues relating to the recommendations about communication and consultation, particularly between LHDs and councils. It was made pretty clear to us this morning that not only has nothing really improved in this space but, in fact, it has got worse in some cases. I would like you to comment on that. I'm not going to talk about specific cases and specific LHDs, but what we want to hear, in general terms, is what steps have been taken to respond to the recommendations about communications with community and councils and so on, through LHDs, for example, and the ministry?

LUKE SLOANE: Thank you for your question, Mrs Williams. There is a fair bit of work being done in this space. We can always improve. As communication evolves, we're always open to satisfying needs, as positions change in local government or communities or otherwise. The things that I'd highlight, since the formation of the regional health division and working with the rural chief executives, is that we have partnered to do a large piece of work on strengthening local health committees. I know the Select Committee heard from local health committees or connected community committees. It doesn't matter what shape their name takes. We released a document. We have follow-up work happening on strengthening that partnership.

We know, since the division commenced, there was varying capability, capacity and engagement with local health committees right across New South Wales Regional Health. We understand and acknowledge the importance of those committees, as the knowledge and understanding aspect of how the local health centre, service or hospital works with local committees, not only in what's happening at the hospitals themselves but also in how the community strive for health and wellbeing. We have those two documents and, if we haven't already supplied them—I think we have—we are more than happy to supply them to the Committee so that you can read through. We have five principal recommendations for all local health districts with regard to establishing or strengthening their local health committees and keeping them fresh regarding that engagement with the community proper. I'll park that there because that's just one part of the component of engagement.

Mrs LESLIE WILLIAMS: Can I quickly ask for clarification about local health committees? Am I correct that the aim is that every hospital would have a local health committee connected to it?

LUKE SLOANE: I think in a perfect world, but there's no policy or rule around that. We know that there are very effective ways to communicate with local communities, who are always very invested in what's happening from a health service point of view in regional, rural and remote communities. I don't think there's any edict to it, but we recognise that the patient and human experience for anyone interacting with NSW Health and our health services needs to be done in a very co-designed and collaborative way. I know they're corporate speak words, but we do, with the very best of intention, work towards engaging with communities.

Again, it's not just for what's happening with regard to services planned or changes to services in local community hospitals and local community health scenes—I know that Berrigan Shire presented this morning—but it's also working with them so that they can better understand what are the key factors affecting them from a Health point of view and to be able to respond and work with them to be able to deliver on things like mental health and wellbeing, preventative health conditions and health promotions, vaccination, support groups, active healthy eating and living and/or transport. As I said, there's no edict for everybody to have one connected to each local hospital. We want to make sure that there is strong communication otherwise. There are some local health districts that are testing more regionally based consultation and engagement groups rather than having a local health advisory committee that's connected to a specific facility. Are you happy if I go on with the other engagement bits?

Mrs LESLIE WILLIAMS: You can, but can you just note that we did hear that there is, for example, a local health committee that is established but hasn't met for three and a half years. Anyway, I will park that.

LUKE SLOANE: I will just make the point that local health committees are volunteer groups. Many of the districts—and Ms Ludford might like to talk about this—have worked exceedingly hard to make sure that the membership is fresh. Sometimes the membership does not like to change or rotate and they like to be involved for a very long time. In order to make sure that they are engaged and meeting, there is an amount of energy that goes into doing that from both sides, from the community point of view and from the Health point of view, and we very much acknowledge our responsibility in making those happen. Thus we concentrated on looking at what does make a really strong local health committee, how can we engage them and what are the five principles for why that works. There is a myriad of local health committees right across the State. We're continually working through, making sure that they are up, running, working and at critical mass for communication and consultation with the community.

Further to that, I would say that—and, again, listening to some of the evidence that was supplied to the Committee this morning—at the Regional Health division in NSW Health we have had a very strong connection with the local country mayors and we have done since the get-go, interfacing with the deputy chair and Mr Rick Firman, who was in charge of the Health portfolio, and also Ken Keith, who was the Mayor for Parkes previous to Rick Firman holding the Health portfolio. Not only that, we have been to several Country Mayors Association events, and we've also been to several Country Mayors executive committees to not only consult with them across a wide variety of projects that we're doing, but also to keep them up to date with what we're doing from a very high level on a strategic point of view and be able to be that connection between NSW Health and them, also working with the districts from wherever that mayor may or may not be.

I have made several visits, more than I can count, to different local communities to meet with the local mayor themselves and/or the local general manager to discuss what's happening from a Health point of view, to listen and then to be able to work with the local health district or other partners outside of NSW Health—from a primary, preventative and promotion point of view for health—to understand exactly what the needs are, trying to organise and close the gap for those services in that town and then talk around what the community is offering from a liveability point of view, because we know that's very important, from a recruitment and retention strategy, to be able to deliver on the ground. We really have engaged quite heavily in the last two years with the Country Mayors Association and with the Country Mayors executive—I would say more than what has been done in Health before from the centre—and we will continue to do that as well.

Further to that, our team is also leading, not only for the Regional Health Strategy but for Future Health Strategic Outcome No. 2, around access and equity. Our team is leading a large-scale shared understanding project that's currently looking at three metro and three regional local health districts to understand exactly how we can bring the subject matter expertise, which is relied upon in NSW Health for healthcare delivery, and be able to meet that with community needs and expectation and have a really good, equally balanced conversation for consultation, for communication and engagement. Noting some of the comments made around Health Infrastructure NSW, they are very engaged in this project as well.

We're going through a second stage of validation with that piece of work at the moment, and it sounds like people are being consulted to death; however, as part of that, it's us talking, listening and engaging. The three local health districts that we're doing that for in the rural and regional areas see that as important, and we know that will then go into advising statewide planning, infrastructure planning, clinical care and service planning. We know, through not only the Select Committee here but also a special commission of inquiry that is examining this as well, that we need to do better to have a system-wide oversight with regard to how that happens, and link it all up with that community and be able to feed it back properly in a really meaningful way.

Mrs LESLIE WILLIAMS: Did you want to add anything, Jill or Tracey?

JILL LUDFORD: I would like to add something about councils. I think it's really important that local health districts engage with all three tiers of government. We have a number of ways of doing that. In fact, I was sitting down with the Lockhart Shire Council just this time yesterday. I undertake site visits across all my 47 services, across 126,000 square kilometres, which equates to about one a week. It's not only to meet the staff and find out the good things that are going on in each service or hospital; it's also to meet with the local visiting medical officers and also to meet with council and to meet with the local advisory committee. We do have a local advisory committee attached to each of our hospitals. We have 31 LHACs altogether.

Meeting with council is particularly important. We talk about a whole range of things around what they see as priorities in their council local government area. Lately we've been talking a lot about key health worker accommodation, which is a very topical issue. Councils are partnering with us around helping find accommodation for some of our professionals as they come to town. And, of course, we talk about health service planning and some of the workforce strategies that we are undertaking. It's really beneficial. I've probably got a speed dial of most of the mayors and GMs. If there's a local issue, they know. I also have a quarterly meeting with all of the mayors and GMs online. We come together. We just had one last week—really great attendance. They just dial in. It's quick. It's an hour. I go through key priorities for the first 20 minutes and then there's an open "ask me anything" session. It's incredibly valuable for developing relationships.

I appreciate not everything that communities may think they need, we are able to provide. But I think we need to be open and transparent about what we can do and how we can network services. It's sometimes hard for communities to understand there's a service that might be somewhere else and it might come in as part of a network service model. That's a little bit challenging for people, sometimes, to understand. We just need to keep talking about it. That helped enormously with virtual care, getting that over the line. They now see it as a service, and they see technology as our friend. I will leave it there. We do have council representatives on each of our LHACs as well. I'll stop talking because Tracey might want to say something.

The CHAIR: Sorry, I think your microphone is not working, Ms Maisey.

TRACEY MAISEY: Can you hear me now?

The CHAIR: Yes, quite faintly.

TRACEY MAISEY: I've tried putting the headset in. I've tried the volume, so I'll just have to sit closer [inaudible].

The CHAIR: Just proceed. Do you wish to make a comment now?

TRACEY MAISEY: I'll try to speak up. I'll just make some comments around community advisory groups and the Community Partnership Advisory Committee. We do have the advisory groups associated with each of our facilities. They meet generally two or three times in a quarter. I attend at least one of those annually. There's representatives from each of our community advisory groups on our district-wide Community Partnership Advisory Committee. I meet with that group once a month. They escalate issues. We address areas of common concern. There's been a range of advocacy from those groups which we have implemented and it's affected how we've gone about our planning. They have been most recently actively involved in looking at our draft vision and objectives for the next three to five years.

Each of those Community Partnership Advisory Committee members have this year been invited to attend our leadership summits, one which was in person and one which was virtual. And those have senior members of our district—clinicians, managers—at an equal footing with members of our community from those advisory committees. In terms of our engagement with councils, I've already spoken to Jill about maybe adopting what she's doing in terms of those quarterly meetings. I think that's a great way to make sure that we have our councils involved. We don't have anything like that in place at the moment but it's certainly my intention to put that in place in the next 12 months. Thank you. I am trying to sort the sound out.

LUKE SLOANE: Chair, can I make just one more addition? It probably might benefit Ms Williams as well. All of those parts of the consultation and engagement that we've covered off there—I just wanted to also

add in that we've also done significant work around consultation in many areas around charity and not-for-profit groups as well, understanding that they also invariably make up members of the community and parts of the community or are coming in to service communities. We have spoken at length with the Rural Doctors Network about some of the work that their CEO, Richard Colbran, has done in this space previously, but also around smaller communities and the myriad of services flowing into there and for the health district, the PHN and everybody in the community to understand and be connected to those as well. We have a project reference group that continues to work on that information.

But our goal, from a NSW Health point of view and working with the chief executives, the local health districts and the PHNs, is to bring all of that work together so that we can continue to engage. But we also need to very really understand what people expect from engagement. There are varying capabilities through all levels of not only Health but the people that we are engaging with, their understanding, and I think we constantly just need to be aware of what that means for someone, whether it be regards to data, what's happening in their community or just to ensure, like we've heard this morning, who might be the local health manager that has just been put in post for a week and how the local government or councils, mayors and community can support them.

Mr CLAYTON BARR: Luke, I reckon you've got one of the hardest jobs in Health. I think that the recommendations that have been put out are really ambitious. But in truth, as a committee, what we're reading in things like the NSW Health Progress Report or the Ernst and Young report, compared to what we're hearing directly from people out there—they're miles apart. I want to ask about the small hospital funding models in particular—so recommendation 1. If we jump in a time machine and go back to a time before the upper House inquiry and the recommendations came out, was it normal practice at that time to regularly review hospital funding models and to try to identify gaps in services and then to pitch a plan to get extra additional or change the funding model to fill the gaps? Was that how it used to work prior to the report and recommendations?

LUKE SLOANE: Yes, the process around annual service level agreements discussions, the rollout and annual budgeting process and working with districts in order to establish that—I will just add for the record we're talking about NSW Health facilities and clinical services. Then, yes, that has continued. Has it changed ever so slightly with regard to what the focus is or what some of the risk adjusters were? Yes. Has the varying different levels of growth depending on the budget handed down changed? Yes. We've come from a period where we had a significant period of time prior to COVID where there was pretty consistent growth, not only in line with indexation but otherwise. That growth and those discussions every year were a bit more flexible with what we were able to work with regarding clinical services, planning, expansion of services and targeting services. That's both with and without efficiency processes and factoring in revenue cycle. Fast-forward to now and it's a little bit different.

There are some financial constraints after coming out of COVID, because we had a significant spend during that period, with a no-regrets approach to how we were working and delivering probably one of the best global responses to COVID-19 in the world. We now have to be a little bit more austere. The growth across all aspects—cost of living, government, non-government, private business and organisations—has changed ever so slightly, so the amount of growth that we're working with or that we can move flexibly around to target different programs of work has changed significantly. We will continue to do that. Yes, we have still got that service level agreement in process. That's being examined pretty significantly by the special commission of inquiry. It's also reliant on the National Health Reform Agreement funding arrangements, which are also going through a period of negotiation with the Commonwealth at the moment. In addition to that, we've also done a piece of focus work on actual small hospitals.

Mr CLAYTON BARR: So with the National Health Reform Agreement (NHRA) block funding, am I correct in thinking that block funding for our small hospitals is funded by the Federal Government? Is that correct?

LUKE SLOANE: Not entirely, no. There is still a match of funding between the states and the Commonwealth, in line with the NHRA, that factors into the build of both block-based and activity-based funding for our health services.

Mr CLAYTON BARR: Can I just call out block funding specifically by itself. Is that Federal money?

LUKE SLOANE: Not only, no. It's a component of two. I might ask Mr Westenberg to describe it. He's being going through the very unenviable task of working through the NHRA negotiations.

GREG WESTENBERG: As Luke said, the block funded component is an amalgam of both Commonwealth and State and Territory funding. Under the current National Health Reform Agreement, all components that are currently block funded are intended to be evaluated for availability for activity-based funding, but at the moment they are still subject to the block funding requirement. They are a mixture of State and Commonwealth money.

Mr CLAYTON BARR: So someone does some work in NSW Health and identifies gaps, and then you go to the National Health Reform Agreement and negotiate how much money. Who does the work to find the gaps so that someone can take forward an accurate, precise and conclusive argument to the Federal negotiation about money and funding for our small hospitals? This seems to be where there is a significant failure of service in our regions.

GREG WESTENBERG: The National Health Reform Agreement provides the overarching architecture for the funding flow from the Commonwealth to States and Territories. However, the particular methodology for funding of public hospital services is developed by the Independent Health and Aged Care Pricing Authority, the IHACPA. They look after the national efficient price and the national efficient cost, which drives the activity-based funding and block funding methodology for payments. In terms of gaps identified, they would usually be worked through with IHACPA to see about inclusion within the funding model for either block-based or activity-based funding services. The National Health Reform Agreement itself doesn't go into the actual funding model per se; it's the funding architecture. In terms of a specific gap, it will be identified and worked through with the IHACPA and the Commonwealth.

LUKE SLOANE: I might also add to that, Mr Barr, if that's okay. It's just to negotiate the addendums of the five-year cycle. I think that's what you're talking about. I'm happy to clarify if you want to expand on service failure in small hospitals. With regard to that cycle, NSW Health and the local health districts themselves plan for clinical services planning. The way that we deliver health in New South Wales is never something that is rigid or not fluid, and it changes depending on the needs of the community or otherwise, and it changes also on the most related evidence-based practice that is the gold-standard delivery to make sure that we are delivering safe, good-quality care at the right place that it should be delivered.

The districts work through a process quite regularly of clinical services planning not only for their district but for sites and towns specifically, or health facilities, in order to do that. We heard yesterday of the collaboration with the PHNs with regard to place-based planning. I would say nearly all of the districts are involved in that and/or release data for that as long as it's clinically de-identified data that pertains to how it's all planned out. From that, the base budget for each one of the districts, in line with their clinical services plan, is used in the way that they see straightforward—and Ms Ludford and Ms Maisey might want to talk to this—as part the whole clinical services plan for NSW Health. If there are gaps identified, we will pivot and we will change a model of care or change some kind of service delivery. That not always comes without some sort of cost or change to other clinical services that may not be as relevant or as needed at the moment, or might not be the most evidence-based care. As part of that, the budget will be realigned to be able to deliver that so that we're doing the best thing that we can for the public in order to deliver that care.

Mr CLAYTON BARR: The progress report indicates that in the recent review of our small hospitals funding there were nine recommendations. Are you able to share with us what the nine recommendations are?

LUKE SLOANE: Did I not furnish that review to the Committee?

Mr CLAYTON BARR: I have the progress report.

The CHAIR: We have your progress report.

LUKE SLOANE: We can work with the Minister's office and make sure we furnish that to the Committee. I'll have to pull that up, or I can take that on notice and come back and get those nine recommendations. One thing I will say about the small hospitals funding review is we did identify—and I think this is probably a little bit what you're saying Mr Barr. We know in New South Wales it is very expensive to deliver services in small hospitals because of—we talk about the diseconomies of scale.

I heard the local mayor of Narrabri talking about Wee Waa very passionately this morning, and I really like his advocacy for those small communities and towns. We've talked about Wee Waa before because it's really quite a perplexing and tricky situation to work for. To make sure we deliver safe, good-quality care, we need volumes of care, and our medical officers and our clinicians need safe volumes of care. If we are talking about, for example, suturing a hand or suturing, it is not straightforward. If it's a hand that we're suturing, it might bring along with it some very precarious things that need to be taken care of that maybe only a plastic surgeon should be looking at. If we're talking about falling off a tractor and breaking your pelvis at night-time, I can tell you right now the safest thing is not to take you to Wee Waa Hospital.

I can also tell you that Wee Waa Hospital, being a 17-bed facility, is very good infrastructure. If we look back at their presentation rates all the way back to 2016 and before, they were having 700 admissions per annum, which is less than 1.9 admissions per day for a hospital of 17 beds. They were having less than three presentations from an emergency department. We can absolutely share this data with the local community and constituents on

a very factual basis because that takes into—not the local ABS statistics; it's actual people who have presented and otherwise. That was at a time when they did have a doctor.

The reason why I say that is because we then have chosen to work with Wee Waa through the Collaborative Care Program to organise care, understand what the health needs of the community are and work through how we can deliver the very best care of them that fits within a funding envelope and that works well for the public dollar. I cannot see how keeping a 17-bed hospital open for 1.9 admissions per day for a local community is the right thing to do, especially when clinicians are unable to keep their skills unless they go away and get their skills up. We need to work out exactly how we can rechannel that funding into a model that delivers the best care for what the community needs. That is that gap stuff.

Where I should get to with that is we know from the small hospitals funding review now that it costs more money to run those hospitals because of some of those things. Our Chief Financial Officer Alfa D'Amato—and we can take this on notice. We have done some work in order to understand that work with local health district chief executives to be able to also give small hospitals, where we know there are that diseconomies of scale but they're working well, they're seeing a lot of patients and they have that volume, an uplift in funding, which is just the start this year, in order to recognise that cost of doing business because we know we've got that community obligation to provide the service where the service has good volume, the same volume and the care can be provided safely.

Mr CLAYTON BARR: I think there would be enormous benefit in having those conversations openly with those different community groups—and you saw that at Narrabri—and all of that sort of stuff.

LUKE SLOANE: Yes.

Mr CLAYTON BARR: But we've got the nine recommendations and there's some work—I wonder if you could provide the nine recommendations and also some progress on how those recommendations are happening. One of the recommendations which is listed in the progress report is that there's going to be a longer term working group established to explore options for the creation of future funding models for small hospitals in New South Wales that ensures small hospitals can provide sustainable integrated rural care. I asked about the block funding specifically because I understand the pie is only so big.

LUKE SLOANE: Yes.

Mr CLAYTON BARR: You slice it up, and you slice it up. If you slice a slightly bigger piece somewhere then something else misses out. But I asked about the block funding and the Federal arrangement because I was hoping that we could increase the size of the pie by getting a bit more money out of our Federal friends for some of the block funding. That's why I was asking that set of questions at the front end.

LUKE SLOANE: Thanks, Mr Barr. I think if anyone is going to agree with you in this room, not only about this being the toughest job but also some of those negotiations in order do that, it's Greg and my colleague who unfortunately couldn't be here today, Mr Scott McLachlan. That is what we are absolutely doing with Mr D'Amato when we're having these discussions about the NHRA—is understanding how it impacts, how it fits in with some of our service model planning, those co-obligations that we talk about quite often that the community just don't see, but making sure we are getting that right amount of money to spend.

It might be helpful if Ms Ludford and Ms Maisey talk a little bit about how they utilise and/or pivot some of their block funding in small hospitals in order to move that. When you say "misses out", sometimes it is about that reduced service or volume and they're better off putting the fire hose—sorry to use the colloquialism—at another site that has that increased volume or otherwise. Again, the budgets are distributed down to the districts in order for them do that through their clinical services planning and whatever is happening on their own horizon.

Mr CLAYTON BARR: Respectfully, to Ms Ludford and Ms Maisey, I won't ask you to do that because I'm very conscious of time. I've just chewed up a big chunk of our Committee time this morning and I apologise to all my colleagues.

The CHAIR: No need to apologise. There is reference to the review of small hospital funding in your report and discussion of the recommendations, diseconomies of scale and future work. I don't think we have received that report. I think it would be incredibly important. That was a key recommendation and it was a concern to the Committee that there didn't appear to have been work on it at an earlier hearing. It sounds as though there has been.

LUKE SLOANE: Yes.

The CHAIR: From what you've just said, that sounds quite important, but we don't have that information. If there's some way we could get hold of that information, it would help us understand what's happened there.

LUKE SLOANE: I do have the nine recommendations in front of me. But, in the essence of time, we can supply that out of session, if that's okay.

Ms LIZA BUTLER: I have to thank you all for your time today. I know you're all extremely busy. But I do have to agree with Mr Barr that we're hearing a very big divide of what you're telling us compared to what communities, mayors and councils are telling us. Today we've heard that there's a shortage of doctors, and that's nothing new across regional New South Wales. Yesterday we heard that opportunities for doctors to remote and regional areas has decreased. At the same time we heard that the locum budget has gone from $130 million to $260 million. What is NSW Health doing to address both of these issues to help solve the crisis in regional, rural and remote New South Wales?

LUKE SLOANE: Can I clarify, because I haven't quite read through all the summaries of yesterday's hearings, what the lack of opportunities for doctors in rural areas are? This is not me being facetious, but we have rolling advertisements for doctors. We'll just re-clarify for the Committee that for private practice and primary care settings, the Commonwealth and Medicare benefits funding scheme provides the funding for primary care and private practice in all of New South Wales and across the jurisdictions. Maybe if I talk about what we're doing from a NSW Health specific point of view, in addition to recruitment and ongoing recruitment for the Rural Doctors Settlement Package and/or other specialist positions and/or just junior medical officers all the way through, and then I'll invite the chief executives to talk about what they're doing in their own districts shortly.

On the whole we understand, and we've spoken about it before, that the rural generalist single employer model—again, kudos to Jill and her team in Murrumbidgee—was set up quite some time ago to be able to recruit doctors. Quite specifically, I'm talking about doctors that will support private practice in primary care. This is outside of the constant recruitment that happens to medical officer positions in our acute care health facilities. Jill at the time, I think, had five recruits go through the program. The whole description of that program is that they get given a four-year length of training contract that is paid for by NSW Health and they work their time between NSW Health facilities and the private practice. We have scaled that, and I have spoken about it to the Committee before, across the whole of New South Wales through two collaborative trials of exemptions that were approved by the Commonwealth Government—up to 80 exemptions.

I'm very pleased to inform the Committee that we more than likely, at the start of January, will have 41 rural generalists going through their training as part of the single-employer model in the State. Does it cover off every single town and district? No. Will they be working in NSW Health facilities? Absolutely, and they will also be working to deliver on their training through private practice in any of the towns that they're working in as well. I think that goes a long way. Whilst it doesn't seem like a big number, it goes a long way to contributing to getting GPs and rural generalists back into regional and rural areas in New South Wales, through the blood, sweat and tears that Jill had to go through to get the model off the ground. I know that is also being picked up in other jurisdictions, working with the Commonwealth.

In addition to that, this year we've been doing some work with the thin-market branch of the Commonwealth health department in order to understand, outside of the Medicare Benefits Schedule and outside of the insurance Act, how we can do innovative thin-market trials to ensure that towns either have a nurse practitioner-led model or a doctor-led model to give them the care they need that's safe and at the right time and at the right place. We are trialling and have identified a couple of sites, which haven't been firmed up just right now to the point of going live, where we will be working outside of those normal funding arrangements in order to put either a medical officer or a clinical lead that's appropriate into a smaller town where there is a thin, veiled or no market, essentially. We're working on that with them.

I know, from evidence I gave at the Special Commission of Inquiry, we've had a massive uplift in Royal Australian College of General Practitioners (RACGP) training positions over the last 12 months, which won't deliver on the ground until a little while in the foreseeable future. I know that there has been a slight uptick in GP training and interest in GP training and interest in moving some of that training and those graduates into rural and regional areas. We continue to work with the PHNs to identify areas of need. It's a very tricky problem to solve overnight. We need communities—and it comes back to that really great engagement—to be able to work with us to identify what is that actual best care. Sometimes it's not always having a doctor on the ground; it's someone to do the hands-on work that might get done. I know we talk a lot about the benefits and the pros and cons of virtual rural generalist services or virtual services, but we'll continue to work with districts on their innovative models with regard to how they not only connect people to medical support but also train those doctors and get them embedded in communities on the ground.

Ms LIZA BUTLER: You talked earlier about how you connect with communities, and you said in an earlier answer that you consult with sites and towns specifically. Ms Ludford, you said that you talked to communities about what they see as priorities. If we think about recommendation 43, about developing

place-based health needs assessment, we heard this morning that even if something is fed back, it's just a talkfest and nothing happens from it. What's your comment on that?

LUKE SLOANE: Is that to me, Ms Butler?

Ms LIZA BUTLER: It's to any of you. You've commented on it this morning.

LUKE SLOANE: I think I mentioned this at one of the first Select Committee hearings. As we worked through the recommendations and tried to put bones around actions and deliverables of the actual recommendations, we became very well aware that some of the recommendations weren't necessarily tested with evidence. We understand that the communities have their story, their truth-telling, and we want to listen to that and work with them. But we have to find some sort of actionable way to deliver on the recommendations. I think I was very clear up-front that as we move through the implementation of the recommendations, some of it will and won't be felt directly by communities as we actually action and deliver on these recs.

Further to that, we have the NSW Regional Health Strategic Plan. It's up to us, as I said, to work with what is engagement, and what is the community's understanding of how we are implementing these recommendations and what may or may not be felt as part of that. I can understand—as it gets harder and harder to access a GP in rural and regional areas, it's harder and harder to access health care, and the recruitment gets harder and harder to do to get people to take a bite and come and live and work in regional areas—that we need to continue to have those discussions with community to be fully transparent about what's happening on the ground.

Ms LIZA BUTLER: Would anyone else like to comment on that?

JILL LUDFORD: I'm happy to comment, Ms Butler. I think it's all about communication. If I can just use a practical example it might be helpful. Through the health service planning that we've recently done with the Finley community, one of the priorities that they saw in their town was renal dialysis. This happens quite a lot with renal dialysis. Communities might think that just popping a couple of chairs in their local hospital is a dialysis service. So that was very much prioritised by their community. But only 40 kilometres away, in Deniliquin, is a specialist dialysis service that is supported by a large tertiary hospital in Melbourne and has the specialised multidisciplinary nurses and allied health clinicians. They are very specialised services, and it is not really safe to do what might have happened a couple of generations ago.

We really need to make sure that communities understand that there are networked services in their region and we are not necessarily going to duplicate that in each of the towns, even though they might see it as a priority. So it is all about communication and being very open about what we can and can't provide. A lot of it comes down to workforce. Some of it comes down to safety and, some of it, the economy of numbers for those services to be viable. But it is really important that we can't always give every community everything they want, but we do just need to be really clear about what we are doing, how we can network services and improve equity and access for people. I just use that as an example.

Ms LIZA BUTLER: I'm really conscious of time. My locum budget blowing out from 130 to 260 I will put on notice to you for a response, because I didn't get one.

Mrs TANYA THOMPSON: Thank you all for your time today on this issue. I just wanted to drill a little bit more down into recommendation 11, which is the development and implementation of a 10-year rural and remote medical and health workforce recruitment and retention strategy. Mr Sloane, I know that you've probably addressed a little of that in your previous response, perhaps. But I'm interested to know how you will measure the outcomes of the seven different strategies to make sure that they are actually improving rural and remote medical workforce recruitment and retention, given just how dire the workforce is at the moment and has been for some time. When would you actually expect to see any positive outcomes resulting from these strategies?

LUKE SLOANE: I'll take exactly how we're going to measure that on notice. My colleague Phil Minns isn't here today. One thing I will say is that we are seeing—not everywhere, and there are still some places that are struggling and are very challenged from the staffing point of view—some positive turnaround in some areas with regard to staff. It is not as widespread as we would love it to be. We will continue to report on and provide feedback to not only the local communities but also wider with regard to those success stories, whether it be re-establishing the midwifery group practice in Glen Innes and being able to attract midwives back to that area under that continuity-of-care practice model; or whether it is the rural generalists graduating who are then staying in the local communities to provide general practice support down in Deniliquin or otherwise. There are also some of other very successful trials in paramedicine that were established in Mudgee, and understanding how we can use a different part of the multidisciplinary workforce to deliver a wide range of services that are contemporary and provide very safe clinical health care.

With regards to a specific monitoring and evaluation framework, as I am sure my colleague would say if he was here, the FTE in NSW Health has grown somewhat. It's never, ever a fixed number. It's never inside of a concrete box. We're constantly taking some people out and putting some people back in all around the system. I wouldn't want to put myself on notice to go through and list the places that have been doing really well from a recruitment point of view, because that would be pretty disrespectful to the people who are struggling and challenged with regard to the different workforce gaps that we continue to have.

Mrs TANYA THOMPSON: We're still hearing that the internal system for recruitment is very slow when there is a need for it to be improved. Are you looking at that system to improve it so you can streamline transfers and streamline that system for those who are wanting to? Three months is still the average time in the internal system for employment. That doesn't seem to be getting any better, even after it has been raised consistently.

LUKE SLOANE: I think the average of three months would not be consistent across all sites and recruitment strategies. If we were to look at recruitment, there would be several episodes where it might take longer or otherwise. We do have some credentialling and checks and balances that we need to do for all clinical and non-clinical staff—Working with Children Checks, criminal records checks, credential checks, qualification checks—in order to on-board. Do we have some work to do to streamline and lean up those processes in NSW Health from the district side of things? Yes, I am sure. I'd love Jill to talk about the process she went through to bring that KPI down in her own district. That is one of things I would probably want to make the Committee really aware of.

It's not just that someone walks in and says, "I'm a nurse," and we pop them into a job. I wish it were that easy. I tell you what, I'd be standing up on a street corner in Taree, handing out flyers, I promise you that. But we do have those checks and balances to go through. What's not always talked about is that it is sometimes quite rigorous on both sides—the recruiting side as well as the person being able to supply that documentation. There are other complicating factors as well around people's physicality and ability to do those jobs. We also need to make sure we've checked their previous work history and credentialling, especially on the medical side of things. Jill, I don't know whether you want to talk about some of the work you have done in Murrumbidgee around the recruitment taskforce.

JILL LUDFORD: I can do it very quickly. We brought down the number of days from almost 90 to under 45. It's quite simple. The people managers who were responsible for doing the recruitment are, unfortunately, so stretched with all their other requirements in running the service that some of the timeframes were running out. We've created a supported recruitment model where we have specialised HR VPs who do a lot of the administrative work for them in the system. Instead of running it all sequentially, they run it all in tandem, so you can actually really accelerate your recruitment. We were also losing candidates from one hospital—I've got 33 hospitals—and if they weren't successful at Berrigan they disappeared into the ether and didn't get a job in Murrumbidgee. But now we capture them and we might be able to offer them a job in Finley. That's been replicated at the State level. There is actually a whole people and culture reform strategy on foot, and that's part of it.

Ms TRISH DOYLE: Thanks to everyone for being here today as we rapidly approach Christmas. A couple of my colleagues have mentioned already that, from conversations that we've had through this inquiry and witnesses who have appeared before us to speak to their submissions, we're hearing very different stories in relation to a whole range of issues that the inquiry is dealing with, whether it is recruitment and retention of staff, cross-border healthcare issues or the implementation of some of the recommendations from PC No. 2.

Mr Sloane, when speaking about some of the concerns that we've heard, you acknowledged, "These are just my corporate-speak words, and sometimes that doesn't wash with communities". That's what we're hearing back. You referred to your tough job in NSW Health, juggling the budget and managing expectations, and so did Ms Ludford. Having worked in emergency services in the past and hearing agencies telling communities they can't put a fire truck at the end of every street during bushfires, I understand where you're coming from in making reference to needing to communicate messages that are unpalatable to communities about them having to rely on networked services rather than asking for what their community needs. I'm aware of all of those issues.

What we are hearing, though is incredibly worrying, and Mr Barr pointed it out when he asked a question. We have to go back to those communities. We're listening to those communities and talking to them through this process. For example, Ms Ludford, you were talking about all the different hospitals in your area that you look after and that communication and consultation. But we heard from one person today that they've never seen you in one of their hospitals and that there is a complete lack of communication and consultation.

I know that it's probably somewhere in the middle of that. It's not necessarily a case of one person specifying their version of reality; it sits somewhere in the middle. But in terms of what communities need and how we manage the health care of people in regional, rural and remote communities, in the main, people are

saying that there is a real difficulty in understanding what it is you're trying to communicate. I go to that issue I mentioned when I began. There are cross-border healthcare issues: different processes for different workers in the healthcare sector; long delays, for example, for paramedics when they want to offload patients between New South Wales and the ACT; and difficulty in transferring patients' medical information across borders, but also within New South Wales. What is being done, under recommendation 22, to allow for a more seamless transfer of patients and their medical information across State borders or between local health districts? Because that's very concerning. There we go—that was a very long way to ask a question.

LUKE SLOANE: I think I'll commence the answer and then hand over to my colleagues if they wish to add anything. We have a massive piece of work happening in New South Wales at the moment, and that is the Single Digital Patient Record. Whilst I'm no subject matter expert on this, it's going to be one of the largest instances of a single digital patient record in the globe, delivered to all NSW Health facilities in general. Further to that, we're working through the process. Again, this is going to be taking nine instances of our current electronic medical record and bringing them into one across a new platform.

In addition to that, the team are working through some pretty complex governance and privacy issues. I have met a couple of times with the Cross-Border Commissioner from New South Wales with regard to that sharing of information. It's not as straightforward as people can just log in or otherwise. There are significant privacy and legal legislative factors that chime into how we do that properly, and then also the functionality of My Health Record at a Commonwealth level to share between general practice and the acute system within New South Wales to be complementary of My Health Record.

I know the new chief information officer who has taken over that program federally has very much vowed to work on different access and functionality in that system to be able to connect to all of the States and jurisdictions to facilitate cross-border record sharing that combine with our Single Digital Patient Record. I know they're working through how they're going to tackle this in other jurisdictions as well. We will seamlessly deliver that information sharing across the State, but it is extremely complex. We have an implementation authority for that in NSW Health. We're advised that there are probably about 16,000 decisions that need to be made as part of prepping and going through just the implementation process of such a big system that's never been delivered to this scale before in the world.

That's one part of it, but there's also the simple stuff that we can get right—things like Western NSW Local Health District working very closely with places like Coonamble MPS and the Aboriginal Medical Service out there to make that sure people who birth off country and return back to country are not only welcomed but given the right documentation to be followed up with the Aboriginal Medical Services. eHealth in New South Wales has currently partnered with Western, Far Western and Western NSW PHN, the Royal Flying Doctor Service and Maari Ma out Far West to develop an information-sharing solution as part of the co-located GP clinics project. The information-sharing solution enables patient information such as discharge summaries, which are absolutely pivotal to the continuum of care for our patients, is enabled and shares between—not only pathology results but the interventions and assessments that the GPs or the acute care providers have done, whether it be NSW Health, private practice or the Aboriginal Medical Service.

It's already been rolled out in Far West. There have been more than a thousand patients or so who have benefited from that at the moment out there. And they've now—because there are also the consent issues and the opt-in/opt-out of the patients to be able to partake in that. There are heaps of other examples that we can furnish. I can also do them outside, but I believe we have put them in our submission as well: Central Coast digital health service, Southern NSW working directly with Canberra Health Services through a joint cross-border organisational committee that Mr Greg Westenberg and myself sit on and have regular catch-ups and discussions with. We had the tripartite cross-border health forum down at Renmark a couple of months ago where all three—Victorian, South Australian and New South Wales—cross-border commissioners got together with deputy secretaries who were responsible for healthcare access as well as emergency services, ambulance services and chief information officers to talk about exactly this.

Ms TRISH DOYLE: Can I just interrupt you there, Mr Sloane? What about within New South Wales? You've covered off and given a few good examples of cross-border communication. What about within New South Wales and that communication between local health districts around patient transfer, patient information and sharing the care?

LUKE SLOANE: If you've got specific examples, I'm very happy to take those on notice and we can follow up as to where it has or hasn't happened well. We know that the different instances of the eMR (Electronic Medical Record) system don't allow that seamless transition and that's why we are implementing the Single Digital Patient Record. We also know that there are some of those privacy and access to information factors that we need to work through from a NSW Health point of view. The discharge summaries and the transfer of information

between acute care and general practice is something that the districts are constantly working on and liaising with PHNs on. But if there are any other specific instances where that's failed or otherwise, it's usually investigated through the incident management system by the Patient Safety First unit, the Clinical Excellence Commission and then local health district clinical governance units where it may have led to an adverse outcome, or it's not happening well.

The CHAIR: Can I follow that up? We did hear some positive evidence yesterday about the Western experience. It was good to hear one of the GPs talk about the fact that he can get a discharge summary because it goes into My Health Record. Is that the Far West and Western PHN scheme that you're referring to—the fact that, with the patient's consent, hospital information is deposited in their health record and therefore the GP can access it?

LUKE SLOANE: I would say that that's spread across New South Wales. If there is a discharge summary from an emergency department or the Cerner FirstNet system, the discharge summary is uploaded, where the GP can be identified—because not everyone presenting to the hospital has a regular or ongoing GP, and also the GP then has to be able to participate, access and be savvy with how to access that information from HealtheNet. Sometimes the GP software doesn't allow for that, but we do have a significant program called Lumos—which I'm not sure I talked about with the Select Committee previously—that does connect all of that data trail up and gives us really good optics around patient journey. The uploaded discharge summaries into My Health Record is something that we usually always opt in for, and we get consent from patients in order to do so, and that happens. But I think the Western program is in addition to that because I think that is the base of what we would do within NSW Health.

The CHAIR: So the Western program is in addition to that functionality about uploading it to My Health Record?

LUKE SLOANE: Yes.

The CHAIR: And the Lumos is separate again to the Western program?

LUKE SLOANE: Yes, that's a statewide program that connects GP data with people that are enrolled—the private practice and GPs that are enrolled with Lumos—for us to be able to work and share that data with them with regard to patient journey, interactions and the continuum of care.

The CHAIR: It would be good to have a bit more information—take this as a question on notice—about the operation of the Lumos system and how many general practices avail themselves of that system. It continues to be a frustration, as I think you would acknowledge, that at the transfer out of hospital to GPs, sometimes that information doesn't transfer. There is the Lumos system and there is the trial in Western and Far West, which you did reference in your documentation, but I don't understand how that's different to the My Health Record or the Lumos system. Finally—this is all on notice; I don't want a discussion now—what will the new Single Digital Patient Record bring to that process of transferring information to general practitioners?

LUKE SLOANE: I'll make the point that a lot of the times where we can't get discharge summaries or that information to the GPs that are either using HealtheNet and My Health Record, or are not able to access it, or if the patient themselves has not identified, because you have to have that GP identified in our system—which would be a regular question that is asked of someone's admission, as to who that's actually going back to—we do find that a lot of times where that information hasn't flowed back there has been a breakdown in one of those layers to it. The guys at Western and a couple of the other districts are doing some pretty significant work around engaging with AMSs around how they can transfer them directly to AMSs, or at least have some sort of reciprocal read-only access to the system as well.

To your other question around the Single Digital Patient Record, there are additional components to that platform, which is the Epic platform, that will allow general practice—and, again, this is one of those things we need to work through. It's a pretty complex place from a governance point of view, not only clinically but from a corporate governance point of view—privacy and legislation. That will have GPs accessing the system directly for their own patients. I can't remember the exact name of the component—it's like "care aware" or "care everywhere" or something—but GPs will be able to log in and look at their patient's information in real time.

The CHAIR: I emphasise that, with that new Single Digital Patient Record, clearly the capacity to have that as seamless as possible transition of information into primary care would be an important component. It sounds like you've identified that as a critical component.

LUKE SLOANE: Yes.

The CHAIR: I accept that there are situations where, if you don't identify a GP and the patient doesn't consent to the transfer of information, obviously that can't happen. But, as you've already described, we sort of

have a patchwork of solutions currently, and they don't always work. The move to the single digital record, it seems to me, would be an important opportunity to get that right. But we might just leave that as a comment at this stage, and I will go back to Ms Doyle.

Ms TRISH DOYLE: I just wanted to turn to NSW Health's submission in relation to recommendation 10. You have provided a bit of an update on the urgent care centres and the Collaborative Care Program. As we expand or grow these services across the State, and hopefully we will—I am hearing some good feedback about them—how will the expansion of these services address this particular recommendation 10, which is about meeting community needs where there are currently glaring gaps in rural health service needs?

LUKE SLOANE: Yes—probably more so around collaborative care. I sit on a committee for the implementation of urgent care services throughout New South Wales, and we've had a lot of discussions around the—what's the word for it—feasibility of urgent care services in rural and regional areas. Because we know quite often they are just, more than anything, being put in a place to either—the premise is to take pressure off an emergency department but, in a lot of rural, regional and remote areas, it's more about how we can get medical services in that place. It's not the need for an urgent care service, as such; it's how do we work with the Commonwealth and/or get good, firm private practice working with the Commonwealth to install that in place?

With regard to the collaborative care, absolutely, I can see that working into the future to work through not only that gap identification—but it's a process that's embedded in communities. We are expanding to five sites. The fifth one is yet to be determined. We were looking towards Mount Kosciuszko for that to happen, but there are discussions still around that. We have commenced in Wee Waa and Leeton—the collaborative care model. I will just make a note that when recommendation 10 came out around the RACCHO—the regional area controlled health organisation—that was quite quickly superseded by a different model called PRIM-HS. A little bit of that ties into comments that I made earlier around some of that thin market work that we're doing with the Commonwealth right now.

Where we can see collaborative care—and I think I have also said this to the Committee before— working well is where we've been to several communities and sat down with them. Probably the most pointed one I'll talk about is Wilcannia. We were in their town hall with a whole bunch of other agencies from across government and we did a whiteboard process of saying, "Right, what services are flowing into Wilcannia right now?" We were able to identify up to 60 services that not everybody in the town knew were flowing in there, albeit that included things like Telstra and Endeavour Energy. But there were things like Anglicare, CatholicCare and NDIS providers, NSW Health being one of them—the Aboriginal Medical Services. For a community, they want to know and have visibility of what those services are coming into their town. They want it to be at a critical mass that can continue to be sustained.

We can see collaborative care as a real—not an all-encompassing, fixing everything—solution. But that's part of sitting down with the community, with a trusted community leader leading the project—and we're seeing that play out in Wee Waa and Leeton—to understand what these services are, both NSW Health services, non-government services, charity organisations and Commonwealth and PHN. We're all at the table. The community are leading this themselves through their project officer that we work with. Rural Doctors Network is a bit of an independent, United Nations-like figure to facilitate this process.

We get the services organised and talking to each other in order to make sure those gaps are identified, but we don't know there are gaps unless we're understanding exactly what's flowing into a town. If we're talking about mental health, for example, for many of the towns we have talked about, whether it be Tumut, Wee Waa or otherwise, it is not only a combination of pointy-end mental health services but it's also mental wellbeing services. Many of those other providers flowing into a town have the ability to be able to provide that and fill that gap. It's just not known and it's not planned for.

The long game on this and the strategy is that the community is in control and very aware of what health and wellbeing services are existing in their town. Not only that, they'll be across the data of the top five or 10 things that they need to be concentrating on—whether it be smoking cessation, diabetes or chronic obstructive pulmonary disorder—as well as having access to emergency care, the right point of care, and transport to a point of care for things like falling off a tractor or a horse or suffering from a snake bite.

Ms TRISH DOYLE: With all due respect, Mr Sloane, what we have heard, not from every witness but from health workers on the ground, community groups, the unions representing those workers and, this morning, the councils, is that they have the solutions. They know what those needs are, and there's a degree of cynicism in communities across the State, around where there are gaps. They have identified them, several times over. A lot of people have talked to us about sharing their ideas and solutions to some of the problems and the gaps in cycles, whether it has been to different individual people within local health districts, different members of Parliament or different inquiries like this. They're tired of this reinventing of the wheel.

But we have, as I said, heard some good feedback about the urgent care services and collaborative care program in different areas. What do you say? How do you attend to, for example, some of the complaints that we heard this morning in Wee Waa, when they talk about how they can't even get a doctor for their hospital, so an ED closes at 5.00 p.m. To Ms Ludford's point, how can patients be admitted to the hospital without a doctor? That's why the data and statistics show that there aren't presentations. They can't be admitted to what they call a ghost hospital. They're asking for those services and programs. They see, down the hill from me, Penrith with this tertiary hospital, which is overcapacity, receiving one, and they don't. How do you respond to those communities and their desperate pleas for services?

LUKE SLOANE: For what it's worth, I'm very happy to meet with—and have met—communities. I'm sure that the district chief executives and people working in the district will join me, as they have on nearly every single meeting that I've had in those communities. The reason why I go back to mentioning the stats around Wee Waa is that, back in 2016, when they were having 1.9 admissions per day, they had a doctor. There was a doctor in place. They weren't running on restricted hours. They moved to restricted hours based on evidence and data and a declining service. Would I love to see that hospital flowing, fully purpose built? Absolutely. Is it feasible? Is it sensible? I don't know. In NSW Health, we work off evidence-based data approaches in order to do it. We don't just do it off a whim. We assess what the presentations are and then marry that up with how we're going to reallocate.

Coming back to Mr Barr's comments earlier, and yours—thank you for acknowledging that—it is tough to have those decisions and conversations. But my response to that would be I would absolutely welcome meeting and talking through any of this, and I'm working very closely with our local health districts. Again, Jill and Tracey, thanks for joining us on this call today. I think it is extremely difficult, but they do a great job of trying to get around and talking to everyone and communicate. But I would also state that everybody receives communication in very different ways, so we need to continue to work with how we do that. I'm not trying to back down from anything. I acknowledge that, and we just need to continue working on that communication and be frank and fearless about what the evidence is telling us.

The CHAIR: Just to follow up on that, you mentioned Wee Waa as one of the collaborative care trials.

LUKE SLOANE: Yes.

The CHAIR: Has that started?

LUKE SLOANE: Yes, we have had several meetings on the ground. RDN have been working in there and had the first couple of kick-off meetings with regard to developing the state of play. I will say the GP in Wee Waa is doing an amazing service for that local community, even if not working at the hospital. He sees and services the community very well.

The CHAIR: It might be worth involving the council in those discussions, given the evidence that we heard this morning.

LUKE SLOANE: We have absolutely involved the council at Wee Waa in those discussions. I know that Hunter New England Health District met with Mayor Tiemens and the member for Barwon very recently to have discussions around collaborative care and outline that, and we have had continual community-engaged meetings with regard to that, in addition to a community taskforce that they have had set up in Wee Waa for quite some time.

The CHAIR: That's good to hear.

LUKE SLOANE: I can supply the Select Committee with the membership of those meetings, should you wish.

Ms TRISH DOYLE: That would be great.

The CHAIR: That would be important. Thank you. Yesterday we heard some evidence about the relationship between the Murrumbidgee Local Health District and the Murrumbidgee PHN, and the model of community engagement and needs-based assessment taking place there. If I can summarise the model, it was essentially that the PHN and the LHD were co-sponsoring, if you like, or responsible together for the Local Health Advisory Committees—there were 31 of them. That relationship between the PHN and the LHD and, clearly, with those local health committees meant that you had a robust framework for a place-based needs assessment. I have to say, listening to that, I thought that's actually how PHNs and LHDs should be working together. That was encouraging.

But what we also heard was that that probably wasn't happening that way elsewhere in the State and that local health districts didn't have a requirement to work with PHNs. I think there's a willingness on the part of

PHNs and LHDs to cooperate, but the reality is, for whatever reasons, that that doesn't happen to the extent perhaps it has in Murrumbidgee. I guess my point is to point out that model in Murrumbidgee—and I accept that each region will have a different approach and each community is different, but it seems to me that that level of engagement with community and between the PHN and LHD would be very powerful if it were replicated throughout the State.

LUKE SLOANE: Thank you, Dr McGirr. Yes, I was quite happy to hear the PHN CEs talking yesterday about their collaboration with the local health districts. I think we'd be hard-pressed not to be across any one of the PHNs in their current format and leadership groups working to their joint organisational MOU to do place-based planning. There needs to be significant data sharing between local health districts and the PHNs in order to do so. Just noting the three core functions of the PHN are really to coordinate and integrate those local healthcare services and collaborate with the LHDs in order to do so; to commission those primary care and mental health services and the health needs and the gaps in service deliveries; and also that capacity building around practice support and primary care and mental health providers, and building that workforce.

The districts, rural and regionally—I think I'd be hard-pressed to find any chief executive that doesn't have a relationship with the PHN CE, as I said, in their current formats. I know Jill and Tracey will both talk to this, because between Narelle and the new CEO down at Murrumbidgee and then Tracey's CO for Healthy North Coast, Monika, there has been a very positive and well-formed relationship around place-based planning and some of the programs that they're doing together as well as apart.

The CHAIR: In the interests of time, I want to make the point that I was not saying there wasn't relationships, and we've heard that there are good relationships. The point we actually heard was that it's often relationship dependent. What I'm trying to say about the Murrumbidgee model is that there's a structural framework there that, hopefully, integrates the roles and the planning and the assessments beyond personalities, and I commend that. I think that's what we should be aiming for. I think there's a lot of goodwill, but without those structural frameworks, it becomes person dependent, and I think there's a huge opportunity there. I'm not doubting the goodwill of CEOs.

LUKE SLOANE: I guess what I'm trying to get to, Dr McGirr, is the fact that there are very clear outlines with regard to the collaboration between PHNs and LHDs and place-based planning. There are clear outlines, not only from the Commonwealth side of things—the Commonwealth Government's website details it all in the strategy—but also that reciprocal work and the memorandums of understanding, or the joint documents between both, which are extremely dependent on the personalities in the roles that deliver those, but those frameworks are there.

The CHAIR: Exactly. We heard yesterday that those frameworks are there, but they're often personality dependent and relationship dependent. There's a huge opportunity to build on the work that Murrumbidgee are doing in that space.

Mr CLAYTON BARR: If that's working well, how do we end up in situations where a town doesn't have a doctor, or aged-care facilities are closing down and those patients are taking up beds in the hospitals, and things like that? If the link between the LHDs and the PHNs are working so well, how do we end up in situations where there are gaps in delivery, to the point where local councils are happy to step in and fund some of these services?

LUKE SLOANE: If this partnership is working between the PHN and the LHD, that's all but one factor in some of those things. The viability of an aged-care service might be another. There's a myriad of factors of why some of those instances might happen. Recruitment might be happening every other day. Private practice might not be viable in a small town through the current Medicare benefit funding scheme from the Commonwealth Government. Are we talking about a doctor that's providing acute care services within a NSW Health facility or are we talking about having a viable private practice in a small regional town? There's a myriad of factors that can lead to those. Sometimes the very best planning succession—strategic, organisationally or otherwise—cannot prevent those things from happening.

Mr CLAYTON BARR: One of the roles for the PHNs—it's on their website—is to commission health services to meet the needs. What does "commission health services" mean when it's a PHN? Does that mean it's going to be federally funded? Sorry to come back to the money.

LUKE SLOANE: I think it's very important to remember that the PHNs are a federally funded body. They are an operational arm of the Commonwealth Government. In order to get commissioned services, they would sometimes do their own planning. I'm not going to speak on their behalf, but they will sometimes do their own planning and engagement with regard to service need in a certain community or otherwise, working with the primary care providers and any other non-government providers that work in that particular catchment for the primary health network. As I said before, sometimes they'll do collaborative planning with regard to services.

We've got examples of that—and they were mentioned yesterday by a couple of the CEOs—around collaborative commissioning. I think Jill, Narelle talked about that firmly in Murrumbidgee and how they do that. But, again, we don't have governance over the public primary health networks as they are a Commonwealth entity. Again, it does rely heavily on relationships, as does the implementation of many things that we do in the very complex health system. You can have the most robust document in the world that says you must do X, Y and Z. But if you do not have good engagement and relationships built and that trade of information between entities, they just simply will not get implemented.

The CHAIR: The issue that was raised yesterday in relation to the rural generalist program was that it was "a pathway to nowhere". That was the quote that we heard. I think what NSW Health has begun to do with the rural generalist program is excellent. I'm heartened to hear that there are 41 rural generalists as of January. As a question on notice, I'd like to know what areas they're training in. Can I also flag to you some concerns that have been raised with me about support for rural generalists by specialists in larger hospitals? Can I also flag with you the quote of a path to nowhere was about training rural generalists, but they need to have positions that they might be able to fill. The question is: From NSW Health's point of view, when you have several generalists, where might they be offered positions? Is there strategic planning around that? Can I give that to you as a question on notice?

LUKE SLOANE: Absolutely.

The CHAIR: I want to acknowledge and commend the work of NSW Health in relation to the single employer model and the rural generalist program, but we do need to build that. Thank you very much for that. I think it has been covered, but I also want to make a comment that urgent care centres are not actually primary health care. I accept that they are a response to focus on emergency departments—and an important one. NSW Health is to be commended for stepping into a gap the Commonwealth left. But, in terms of prevention, complex illness, care planning and so on, they don't substitute for a strong primary care workforce, which doesn't necessarily need to be general practitioner related. I do think it's important that the State and Commonwealth continue to cooperate to build that workforce in regional areas .

LUKE SLOANE: Yes, I agree and know that. Thank you, Dr McGirr. I would just probably make the point out that in New South Wales we have approached this very differently and have quite pointedly used the terminology "urgent care service". With many of the urgent care services that we've set up, as opposed to building a brick building with a specific urgent care centre, we have worked to then expand urgent care services to really cash in on—"cash in" is probably a bad use of phrase, but really take advantage of general practice in New South Wales and their advanced skillset, and their ability to do those things from a primary healthcare lens, and make sure that it's quite pointed at category 4s and 5s.

Not to offend any of my emergency colleagues, category 4s and 5s that are in emergency need to be there; otherwise they wouldn't be. However, the premise around lower acuity patients that need probably a bit of an extra intervention—and to channel my very good colleague and friend Rachel Christmas—GPs can do that work and they do do that work, and they do that as well as manage chronic and complex patients throughout the community as well. We just need to work very closely with our GP medical workforce in rural and regional areas and build on the premise that they can do that but also back that up with urgent care services funding.

The CHAIR: Can I also flag a question on notice requesting a bit more detail about the Future Health strategy access and equity, and what's being suggested for the three rural local health districts. You mentioned that. I don't want to go into it now.

LUKE SLOANE: The shared understanding project, you mean?

The CHAIR: Yes.

LUKE SLOANE: We can provide you with the first line of documents on that once they're finalised.

The CHAIR: Measuring health outcomes, you've taken that on notice with regard to workforce, so that's great. The thin markets work that you're doing, is there any further detail available on that with the Commonwealth?

LUKE SLOANE: Not at the moment that we've got formally ready for implementation. We have communicated to the Commonwealth suggested sites from all of the local health districts within New South Wales and they are working with several of those local health districts in order to test feasibility of the thin market trial in those areas.

The CHAIR: Will information be available on that at some point ?

LUKE SLOANE: Yes, eventually, definitely. But we're reliant on the Commonwealth because it's their program so I'd be making comments that I'm not in control of at the moment, other than the fact that we've suggested sites to them to implement.

The CHAIR: You did mention the increase in general practice training and we've noted that increase here as well. But we heard yesterday that, although numbers had increased globally, they hadn't increased west of the divide, in western New South Wales. I wonder whether you could provide us with some information about your understanding of who is training in rural general practice in western rural New South Wales.

LUKE SLOANE: I'd be able to provide that information directly only to our engagement through Health Education and Training Institute (HETI) with RACGP and Australian College of Rural and Remote Medicine (ACRRM). We can do that.

The CHAIR: I want to use the last 10 minutes of the hearing to hear about the Murrumbidgee Health and Knowledge Precinct. I declare a conflict of interest here. This is a project that I have been working on, as the Committee knows, for some time. But there has been significant progress made in terms of governance and work, and I'm very keen that the Committee hear what has been done. With your permission, Mr Sloane, I'd like to ask Ms Ludford to describe that work for the Committee.

LUKE SLOANE: It'd be great for Jill to outline the work that she's done.

JILL LUDFORD: Thank you, Dr McGirr. The Murrumbidgee Health and Knowledge Precinct, I want you to consider, first of all, is not a building or a set of buildings in a particular location. Instead, it is actually a collaboration of health and social care providers and other partners, which I'll run through in a moment. It's a collaboration of the best of minds coming together in a geographical region—in this case, the Murrumbidgee Local Health District boundaries, which we also share, fortunately, with the Murrumbidgee Primary Health Network. It essentially brings together all health and social care providers across that 126,000 square kilometres. That includes our private healthcare providers, hospitals, allied health and GPs. It also includes education providers, such as schools, TAFE and particular universities. It also includes industry partners. That's really important in regional areas because we've got a lot of infrastructure happening. In my region, we've got Snowy Hydro and Transgrid and a range of things. There's also local government. It is that three-tiered approach, because the primary health network is also a partner. That's the concept.

The idea is that, because we've all got different funding models and different responsibilities, together, with the best of minds, we can address some of the local-based problems. I want to run you through the priorities which the precinct has established. I am a member of the precinct, but it is run separately from the local health district through a governance mechanism with its own independent board and independent board chair. A number of universities and local government are represented on that governance mechanism. There's also an alliance, which is made up of 45 member organisations. That's all of those bodies that I just talked to you about, including Business NSW, which represents some of the local industries. The alliance meetings are really important because, in essence, they're our conduit with the entire community. They become very vibrant meetings for debates about topics, but also independent alliance members can ask for work to be done or ask to participate in work that is being done.

The precinct board has prioritised three areas of work. One is workforce—how can we do an audit of our workforce to understand where we have gaps in priorities? We're doing that in collaboration with our university and TAFE partners, and also some of the other non-government organisation providers. The second group is innovation and research. Again, it is so vital for rural local health districts to be able to identify our own questions that we want to undertake research on so that we can deliver evidence-based care. We have a lot of research done with us, but we don't necessarily always have the capacity or the capability to undertake our own research. There's a lot of capability-building happening in the research subcommittee.

The final one is what we call a one-system integration, which is all about healthcare providers coming together to see where the priorities are where we can meet together and join up an approach. I'll provide Dr McGirr with an example of the paediatric round table that was held in September, if I can, just to help people understand the concept. The one-system integration working party has got two really important pieces of work. One is that we are developing a framework for place-based planning. This work actually fell out of the joint statement working parties, where it was identified that we should bring communities, councils and all of the providers in rural areas together to identify their problems and co-design and look at all of the funding mechanisms to see how they can actually design services that meet the needs of communities, rather than the top-down approach of respective governments.

That piece of work is well underway and will be finalised early in the new year, and we'll be sharing that collectively across the State with our other local health districts. "Collaboration" is one word; it sounds easy but

it's incredibly difficult to implement. Everybody has their own jurisdictional requirements, but there is no reason why we can't do joint needs assessments or the collaborative care models. It provides a practical framework, I guess, for all of the partners to come together and look at place-based solutions.

The paediatric example was that all of the funded bodies from the Commonwealth Government to State Government were all working on different ways of addressing children with developmental vulnerabilities. I think we'll all agree that they have to be our focus because children are our future. One of the big areas of demand that's unmet in rural and regional areas is providing early intervention for children who have developmental vulnerabilities, whether it's physical or social or emotional.

Because we all have little bits of funding around various programs and different levels of government, we decided that we would come together. We got 15 different healthcare providers around the table in a roundtable scenario that was facilitated by Business NSW, and we went through a process where the first thing we did was identify what the problem was. What we all thought was the problem when we went through with the needs assessment data through the early childhood census was something different to what everybody had within their own thought bubbles.

Out of that, we've now identified where the problem is and, interestingly enough, it's in social and emotional development rather than physical development. But we know that we have to address everything. Our paediatricians are a very precious resource, and essentially when a child had a developmental vulnerability, they were just being referred straight to a paediatrician. They didn't have access to immediate functional services that they needed to help them before they got to school. We're focusing on zero to nines, a tier-based approach. It's all about assessment, moving children into early services and then using those paediatricians for the more complex cases at the top of the triangle.

Dr McGirr, I've just used that has an example of how you can bring people together, and everybody's delivering a different piece of the same problem. If you can knit people together—and we're nowhere near there yet because there's all of the NDIA functional things that are coming through from the Commonwealth that we need to be able to address through our respective State governments. It is just an example of how we really need to work in rural areas in a collective and collaborative way to knit together all our bits of planning, all our bits of resourcing to provide people with the services that they need.

The precinct has been fabulously successful. Those alliance meetings are now very vibrant. Lots of people have input and ideas, and I think really feel represented. I think the real challenge for us going forward is we're moving towards becoming a legal entity with limited liability, but the ongoing financial resourcing and membership is something that we're working on now as we're moving out of the planning phase. What it gives local health districts access to is local place-based opportunities to address your local problems and probably opportunities into the future for some different pooled funding models going forward. I'll leave it there because it's quite a difficult concept to sometimes get your head around, and I'll open up to questions.

The CHAIR: I have just a couple of points. I realise we're very close on time. Your leadership has been very important on that, Ms Ludford. It has been a process of some years to build those relationships. There has been some quarantined funding. My view would be that that has allowed the development of some strategic bandwidth to solve problems locally. I think that's an important component of it. Local government has been involved on that right from the start as well, which is interesting. I think you have some documentation that we might request from you to describe that work done to this point for the Committee.

That would be great. That's my tuppence worth. Are there any other questions from Committee members? No. That brings the hearing to a close. Thank you very much. We thank you, Mr Sloane and Mr Westenberg, for appearing, and Ms Maisey and Ms Ludford as well. We may send you some further questions in writing. I think we flagged to you during the hearing that you've taken some material on notice as well.

LUKE SLOANE: Yes.

GREG WESTENBERG: Yes.

The CHAIR: Your replies to that evidence would be made public and it would be part of your record. I understand that you would be happy for that to be the case.

LUKE SLOANE:

GREG WESTENBERG: Yes.

The CHAIR: Thank you very much. That concludes the public hearing for today. I wish to thank all the witnesses who appeared before the Committee today. I also wish to thank Committee members, Committee staff and Hansard for their assistance in the conduct of today's hearing, and our broadcast staff as well.

(The witnesses withdrew.)

The Committee adjourned at 12:10.