REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Jubilee Room, Parliament House, Sydney on Wednesday 2 February 2022

The Committee met at 9:15.

PRESENT

The Hon. Greg Donnelly (Chair)
The Hon. Wes Fang
The Hon. Walt Secord

PRESENT VIA VIDEOCONFERENCE

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Emma Hurst
The Hon. Shayne Mallard

* Please note:
[inaudible] is used when audio words cannot be deciphered
[audio malfunction] is used when words are lost due to a technical malfunction
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Good morning everybody. Welcome to what is the fifteenth and final hearing of Portfolio Committee No. 2's inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes, access to services, patient experience, and planning and capital expenditure in rural, regional and remote New South Wales. Before I commence I would like to acknowledge the Gadigal people of the Eora nation, who are the traditional custodians of the land on which the Parliament sits and I would like to pay my respects to Elders past, present and emerging, and extend that respect to other Aboriginal people viewing this broadcast over the course of the morning.

Before I commence today I would like to make some observations, being the final hearing of this inquiry. This inquiry commenced in August 2020, has received over 700 submissions and over the course of 11 months has conducted 15 hearings, visited seven locations around the State and heard from 220 individual witnesses. The nature of this inquiry is such that the Committee determined at the very start that it was critically important and necessary that we visit regional, rural and remote locations to hear from people on the ground. This was never to be an inquiry that would be conducted out of Macquarie Street in Sydney. The pandemic unfortunately prevented some of those plans towards the very end being able to be met in terms of visiting certain locations. Nevertheless, with respect to the use of technology that is available to us, we have been able to broadcast some of our regional hearings using that technology to ensure the work of the Committee could continue and be brought to its conclusion.

May I take this opportunity to thank the many, many people and organisations—obviously far too many to name—from right across the State who have been involved in this inquiry through both making submissions and coming along and participating at our hearings, either in person or remotely. Your efforts to do so have been greatly appreciated by the Committee specifically and the Parliament more generally because your participation is informing the Parliament of New South Wales, the legislature in this State. Without your involvement we would not have been able to collect the rich and detailed evidence that we will be using to prepare our report and its recommendations.

I appreciate that involvement in the inquiry has been not easy for many of the participants. In fact, it has been excruciatingly difficult, often taking them back to difficult, sometimes tragic, experiences or incidents involving family members and friends. For the individuals providing their evidence this has been raw and deeply emotional. In particular, I thank Jamelle Wells and Liz Hayes who have, arising from their most difficult personal experiences, worked and advocated so hard to bring to light some of the issues that we have examined over the course of the inquiry, from the Tweed to the Murray and out to the South Australian border. We thank you ladies very much for your work and advocacy on behalf of so many citizens of this State.

Can I also take this opportunity to thank all the Committee members who have worked so cooperatively and collegially in this inquiry over many, many months. I will say more of that at the end of the day when we are together privately but I would just like to formally acknowledge the cooperation and diligent work of everyone right across what has been a very long inquiry. And it would be completely remiss of me not to acknowledge the wonderful and outstanding organisational support work provided to this inquiry by the Legislative Council's Committee secretariat. Once again, without acknowledging individuals because there are many, I would like to thank them most sincerely for their work which if it had not been done in such a professional way would not have produced the inquiry to the standard that we have been able to achieve. And of course, in acknowledging that secretarial staff, I must also thank Hansard who have done such a marvellous job in the collecting of the evidence through the testimony at our hearings right across the State. Thank you very much.

Moving on then to today's hearing specifically, it is being conducted virtually and I would like to ask everyone for their patience through what may be any technical difficulties that we may experience. We hope that there will not be any. If participants, for whatever reason, lose their internet connection and are disconnected from the virtual hearing, I am asking that they rejoin the hearing by using the same link as provided by the Committee secretariat. Today we will be hearing from senior representatives from NSW Health. I thank you both for making time available to provide evidence today. I appreciate that you both are very busy in your senior roles.

Before we commence I would like to make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of the evidence provided at the virtual hearing. I therefore urge witnesses to be careful about comments you may make to the media or to others after you complete your evidence today.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the

issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness in accordance with the procedural fairness resolution adopted by the Legislative Council in 2018. There may be some questions that a witness could answer only if they had more time or with certain documents at hand. In these circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days.

Finally, just a few notes about virtual hearing etiquette. Can I just ask Committee members once again to clearly identify yourself when you are asking the question and who you are directing it to. Could everyone please mute their microphones when they are not speaking. Please remember to turn your microphones back on when you are getting ready to speak. If you start speaking whilst muted please start your question or answer again so it can be recorded into the transcript. Members and witnesses should avoid speaking over each other so we can all be heard clearly, particularly for the purposes of Hansard. And further to that, to assist Hansard may I remind members here in the room and also participating remotely, which is the case for some today, and our witnesses to speak directly into the microphones and avoid making comments when your head is turned away from the microphone. With those introductory words, I welcome our witnesses from NSW Health, witnesses who have been before the inquiry and in fact many other hearings before.

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning, NSW Health, on former oath

PHIL MINNS, Deputy Secretary, People Culture and Governance, NSW Health, on former oath

The CHAIR: Can I invite an opening statement? Dr Lyons, will that be coming from you?

NIGEL LYONS: Yes, it will, Chair. Thank you.

The CHAIR: Thank you very much, Dr Lyons.

NIGEL LYONS: Thank you, Chair. Firstly, we would like to acknowledge the traditional custodians of the land on which we meet today, Cammeraygal land and people of the Eora nation, and pay respect to Elders past, present and emerging. Thank you for the opportunity to appear at this final hearing to discuss the issues raised over the course of the inquiry. We personally have listened to the experiences from community members, health professionals and health partners who have given their time to inform the Committee. We acknowledge there has been evidence to the inquiry of regrettable patient experiences and outcomes. To these people and their families we sincerely apologise for experiences that did not meet the high standards of health care we expect in this State. On behalf of NSW Health we reiterate our commitment to continual improvement and to ensure that all patients in the future receive the high-quality care expected and deserved.

The issues arising from the inquiry have been complex. In response, Health is committed to further exploring rural strategies and initiatives from domestic and overseas jurisdictions that have been effective in supporting the delivery of a sustainable rural health workforce that supports the delivery of primary and secondary health care. Health will draw on the experiences outlined through the inquiry and the research that we have commissioned to focus our efforts on four key future strategies for rural health care, including—I will now enumerate them.

The first phase—processes to reduce the divisions for primary care across the Federal and State boundaries. Currently, the constitutional boundaries between Federal and State Government responsibilities for health, and the coexistence of public and private health sectors in delivering health care, hinder the development of an integrated approach. Overcoming this barrier will be critical to success. This requires us to better clarify the roles of the Australian Government and the New South Wales Government in relation to primary care and ensure that funding is aligned with these responsibilities. We must move faster towards a national collaborative approach to the delivery of primary care that rebalances responsibilities in funding for primary care, and develop plans for integrated rural health services.

The second area is identifying and implementing an integrated primary care model. NSW Health reaffirms its goal of ensuring that all rural and remote residents of New South Wales have access to safe, high-quality health care comparable to that available for city residents. We must design future rural health services that better link primary care with the higher levels of care so that communities experience a seamless local healthcare service no matter where they live. Thirdly, we need to better engage communities in local health service development. Central to our efforts will be enabling local healthcare providers to apply co-designed principles, engaging local communities in the creative design and development of new rural health services and in changes to those health services over time.

Fourthly, and most importantly, is strengthening the rural health workforce, aligning training and education with health needs. We must strengthen and align investments in health workforce development to mitigate the identified gaps in service delivery and skill shortages. We must more vehemently advocate for Australian Government investment in the vocational education and training sector to provide specific rural training opportunities for enrolled nurses and allied health assistants. Enhanced multidisciplinary primary care is a key focus to expand the roles of health professionals whose potential contribution may be under-recognised, including nurses, nurse practitioners and paramedics, as well as promoting rural generalism for allied health professionals and doctors delivering primary and secondary care in these settings.

NSW Health is closely considering these drivers and identifying how we can build on our existing initiatives and other areas for further development. It is increasingly evident that the integrated approach of bringing together primary and secondary care and utilising health professionals from different disciplines are likely to provide optimal care for rural and remote communities, making the most efficient use of healthcare expertise and providing job satisfaction for healthcare professionals. System-level change is needed to build and sustain a workforce capable of delivering reliable, safe, high-quality care to rural and remote communities. Finally, we want to acknowledge and thank our staff in healthcare facilities right across regional, rural and remote New South Wales for their dedication and tireless work. Our people are committed, dedicated and continually identifying innovative ways to provide consistent, safe, high-quality health care to meet the growing needs of their communities. And their efforts every day are appreciated. Thank you.

The CHAIR: Thank you very much, Dr Lyons. Gentlemen, what we would like to do is proceed with our usual format of questioning. You are aware there are three groups represented at the table here or remotely today. We have representatives from the Opposition, the crossbench and the Government, and what we would like to proceed to do is have 15 minutes rolling tranches and work our way through to the end of the session. Are you okay with that? If there is any issue as we proceed and go through, just let us know, but I think it should run quite smoothly. It has worked very well thus far so I see no reason it will not work well this morning. With that said, we will get underway, thank you. We will commence with the Opposition, the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Dr Lyons. Thank you, Mr Minns. With the indulgence of the Committee I would just like to say a few words very briefly. I have been involved in the Committee process for more than 10 years and I have to say that the evidence that we received to this Committee has been heart-wrenching, from families, patients, hardworking staff, doctors, nurses and allied health workers in the health and hospital system, and we have received evidence of hospitals without doctors, and emergency departments and hospitals without doctors on the weekend.

The Hon. WES FANG: Chair, apologies, I—

The Hon. WALT SECORD: This is giving context. I am giving context.

The Hon. WES FANG: I understand that, but—

The Hon. WALT SECORD: I am going to give some examples and then ask them something. May I continue, Mr Chair?

The Hon. WES FANG: I have given quite a lot of indulgence, Chair, but this seriously should be a question and answer, not a chance for a speech.

The CHAIR: Are you taking a point of order? Is that a point of order?

The Hon. WES FANG: I just wanted some guidance to members as to—

The Hon. WALT SECORD: I was going to ask—

The Hon. WES FANG: No, I will provide some more indulgence.

The Hon. WALT SECORD: To Mr Fang's point, I was going to provide about four or five examples and then ask them for a comment on that. Based on the evidence that we received, that is why they are here today—the last witnesses we are receiving.

The CHAIR: I think there is reasonable context. He can give a question and I think the honourable member is moving in that direction.

The Hon. WES FANG: I just wanted to make the point that it is not an opportunity for a speech.

The CHAIR: No, I understand what you are saying.

The Hon. WALT SECORD: I understand, Mr Fang. We have received evidence of hospitals without doctors, we have received evidence of nurses purchasing their own medical equipment to support patients, we have heard evidence of canteen and support staff looking after patients, doctors working ungodly hours because they want to serve their communities, paramedics helping to deliver babies due to staff shortages and patients being discharged in the middle of the night from emergency departments in rural areas with no public transport. We have heard evidence that rural and regional families are receiving a second class health system, a system that their city counterparts would never tolerate. Finally, I would like to thank the families that have come forward to share their heartbreaking stories. I know that it was very painful to relive the last moments of their families' lives. I know it was painful and I hope the Perrottet Government starts to listen to the community and improves rural and regional health care.

The Hon. WES FANG: Chair, I would say we are definitely falling into the traps of a speech now.

The Hon. WALT SECORD: Finally, I wish to thank Ms Jamelle Wells and Ms Liz Hayes. I know that your late fathers would be proud of you both for your bravery, for your forthrightness and your love for them. Mr Minns and Dr Lyons, in your opening statement you talked about "a regrettable patient experience". With all the evidence that this Committee has heard, how could you make such an underwhelming statement? What steps are you recommending to the Government to bring rural and regional health up to the standard that we receive in Sydney? Dr Lyons.

NIGEL LYONS: Thanks for the question, Mr Secord. We, like you, have firsthand heard the evidence, and it has been very difficult to listen to some of the evidence of the experiences of people who have loved ones who have passed away and who have had issues around accessing care. We certainly acknowledge that the care

our staff endeavour to provide is often very challenging to deliver to the standards that we would all expect, and that is because of the issues that we have all heard about, which are extremely complex. And that is why I was endeavouring to express our regret about those experiences. We certainly do not want those outcomes for anybody who attends any of our services. We appreciate and acknowledge the impact that has on individuals and their families. We will certainly be striving in everything we do to continue to support improving the care delivered and providing the surety to our rural communities that they can access the health care that they expect locally and, where they need extra levels of care, that they are connected into services that can provide those seamlessly.

The testimony and the evidence provided enormous opportunities that we have heard directly around the things that we can do differently and that is what we are here to discuss with you today—about how we can address those issues. And though we did want to acknowledge the evidence, I am sorry you felt it was an underwhelming apology, but it was an acknowledgement and an apology for that care that was not served to the level expected. And we sincerely offer that and remain committed to improving that care to ensure that others do not experience that in the future.

The challenges we face—you have outlined a lot of them in some of the comments you made at the start of that question. First and foremost is that we have a challenge in workforce in rural communities being available to deliver that care, and some of the work that we commissioned to support the work of the Committee and our efforts in the papers that were provided to the Committee highlight that these issues are not unique to New South Wales. They are not unique to Australia. These are issues that health systems around the world are struggling with because there are a range of forces and factors over the last 20 years that have all driven health care in directions that make delivering health care in small rural communities that are dispersed geographically very challenging.

We have had changes in the regulation of health. We have had changes in the expectations of trained healthcare professionals. We have developed a deep knowledge in health care which means that the days of a healthcare professional providing very broad health services from cradle to grave at a level which could provide extensive support for rural communities are very difficult to deliver now because they are required to have specialist knowledge around things in delivering babies, in caring for children and young people, and even in things like looking after end-of-life care. There is such a deep knowledge now around all of those things that to have an expectation that a GP—in some communities there might be only one or two GPs and, as you have outlined, in some communities none at all. Having a healthcare professional who can actually do all of those things and be available 365 days a year, 24 hours a day—it is not possible to do. So we need to find solutions that enable that to occur at a level of health care that everyone expects to be delivered now. The quality and safety, the level of training offered, the support systems and diagnostics to enable that to be done—all of those factors are driving these changes which are now being experienced by people who live in rural communities and who are attempting to deliver the care, and you have heard directly from many of them about how hard it is to do that.

We are very committed to working with you to make recommendations that will support how we address those challenges and we are very keen to explore with you what sort of further things might assist in that regard.

The Hon. WALT SECORD: Dr Lyons, on practical measures, evidence that was before the Committee here—I would like to take you to Tamworth Rural Referral Hospital. We had evidence that there are eight operating theatres in the hospital but three of them are mothballed—not being used. Now, it has been almost two years since this Committee was set up. Are the three operating theatres at Tamworth hospital still non-operational?

NIGEL LYONS: Mr Secord, this is important I think for us to start to put some context around because just because a facility is built with a certain number of operating theatres or rooms for treatment does not mean that they all need to be able to be operational at all times. We build our facilities with a lifetime of 20 to 30 years into the future. So Tamworth Rural Referral Hospital as an example is a facility that was built just recently to meet the needs of the community, not just now but for 20 to 30 years into the future. It was built with the capacity to ensure that if and when the population grows and the needs are there—and those are planned and thought out with projections into the future and population projections, demographic changes and healthcare needs—that those services are able to be expanded to meet those needs through the capital injection, the capital investment and the built infrastructure.

The Hon. WALT SECORD: So the answer is—

The Hon. WES FANG: Point of order—

The Hon. WALT SECORD: I asked a very specific question. I just want to know if the three are still mothballed.

The Hon. WES FANG: Chair, am I actually—

The CHAIR: A point of order was taken. Yes?

The Hon. WES FANG: I would like the opportunity to actually make my point of order first if it is possible. The Hon. Walt Secord has asked what was first a very wide-ranging, large question to which Dr Lyons was providing a very detailed response. Now the Hon. Walt Secord has asked a clarifying point around Tamworth and once again Dr Lyons is providing a very substantive and full answer. I think he should be allowed to provide that answer without any interruption by any member.

The CHAIR: To the point of order: The question is a specific one that has been asked. I do understand that Dr Lyons is answering the question asked and is giving some context. It has been a fair bit of context. I think it is important that you now, if you don't mind, address the specific question, Dr Lyons. So please proceed.

NIGEL LYONS: Thank you. As I was saying, the operating theatres are planned with those needs in the future. If there is no need for those theatres at this point in time, then not all of them will be used for providing surgical care. Can I also say that that changes during the course of the year, and from time to time we have less surgery performed or more surgery performed. I will give you the example of the most recent six or eight weeks. We actually as a result of the Omicron wave had a suspension of some non-urgent surgery across our hospitals in New South Wales to enable the staff to be able to respond to the extra patients being received with COVID. So Tamworth Rural Referral Hospital would be an example of that where there have been less surgeries performed. Having said that, it was announced yesterday that we are going to recommence elective surgeries in rural areas, and I understand that Tamworth Rural Referral Hospital is one of the hospitals that will be able to commence doing some of that elective surgery quite soon. So there will be more surgery provided and more operating theatres open.

The Hon. WALT SECORD: Dr Lyons, I dispute what you said about the need. If you have three operating theatres at Tamworth hospital that are mothballed, I just checked on the Bureau of Health Information data and the average wait for elective surgery in Tamworth—for non-urgent elective surgery—is 210 days. Given that, how can you stand by the statement that the three operating theatres that are mothballed are not needed? You are saying that in fact they will be open when there is demand.

NIGEL LYONS: Can I firstly say that mothballing is a term which has got a connotation which I do not support. That is your words. Can I just say this, though: The waiting times for surgery in this State have increased recently because we have been through a pandemic over the last two years where we have had, from time to time, the need to suspend some of those elective services to enable us to respond to the critical care needs of the community. So the waiting times have increased, yes. In terms of the response to why aren't the operating theatres active, it is because you need to ensure that the staff who are there to provide services to the community, including our anaesthetists and surgeons, are able to perform those surgeries in a way that is safe for the community. If at the moment we have got a pressure in the system to respond to Omicron, having patients admitted with COVID and having staff redeployed at different services or furloughed, it is not possible even if the physical facilities are there if the staff are not able to safely deliver the care in those facilities. And that is the circumstance we have been through.

The Hon. WALT SECORD: Now Dr Lyons, just mindful of time. I want to take you to another example of evidence we have received. Dubbo Base Hospital has apologised to the family of the late Allan Wells after he went without food and water for three days because family were told that the hospital "could not afford to roster someone on the long weekend to give him a SIP test". If a patient presented today at Dubbo, this weekend, would they be able to receive a SIP test at that hospital? That was one of the most startling pieces of evidence we received. Would they be able to receive a SIP test this weekend at Dubbo Base Hospital?

NIGEL LYONS: Thanks, Mr Secord. I am not the Chief Executive of Western New South Wales Local Health District so that is the organisation directly responsible for Dubbo hospital and the question would be able to be more directly answered by that chief executive. But a SIP test is something which is a basic requirement for the care of stroke patients and our expectation is that for stroke patient care, wherever that is provided and at whatever service of the State, those services need to be available to safely care, so that is our expectation.

The Hon. WALT SECORD: Dr Lyons, the reason I put these specific examples to you is because I saw you sitting in the front row of all of the rural and regional hearings that we had held in rural and regional areas, and I am putting specific examples to you because you were present when this evidence was presented. So that is why I am giving individual answers. Can you guarantee that all hospitals in New South Wales can provide basic medical supplies such as Panadol since the beginning of this inquiry? The evidence we received was that there were hospitals that did not even have basic Panadol.

NIGEL LYONS: Thanks, Mr Secord. We investigated those claims that were made and the evidence that was given and found no evidence that there were basic supplies like Panadol not available in any of our hospitals. So it is not something we were able to get to the bottom of, that there were examples where that had occurred, and we did thoroughly follow up following the evidence that was provided. Those basic supplies are

available in all our hospitals. They are the sorts of things that are basic requirements for healthcare provision and there are very strong and solid processes and systems in place to ensure that those resources are available for the delivery of health care in our hospitals. So it was somewhat of a surprise for us to hear that evidence and our investigations could not ascertain that there was ever a situation where basic things like Panadol were not available.

The Hon. EMMA HURST: Thank you, Chair, and thank you both for coming today. A strong theme throughout this inquiry has really been about the lack of GPs in rural and regional areas, and I know this issue has been flagged in your latest submission as being a problem. But the submission does not actually go into any sort of detail about how you are going to work in with the Commonwealth to actually address this problem. I just wanted to try and get some details. What are the specific steps that are going to be taken, say in the next six to 12 months, to actually change the current situation?

PHIL MINNS: Deputy Chair, we made the point in our submission at the very first hearing that there are many current trends associated with GP presentation or recruitment into rural areas—that they are heading the wrong way. So we have seen a consistent decline in people seeking to register within the Australian General Practice Training Program since 2015. We had a slight rebound up in 2021, which we anticipate would be related to the reduced opportunities for graduated doctors to pursue different career options, particularly any opportunities internationally. It is a significant and enduring problem and it is one that we have to work with the Commonwealth.

But we do a number of programs to try and encourage people to do GP placements in rural areas and some of our most significant, innovative trials are in that space, the best example being the single employer model in Murrumbidgee Local Health District. We are seeking, with the help of the Commonwealth, an exemption needed under the health insurance Act. The hospital in question is the main employer of the GP trainee but the trainee is permitted to rotate through different general practices in the surrounding towns such that they can complete their GP training. We had to look at taking these trials to a greater scale and to do that we need the collaboration of the Commonwealth Government.

The Hon. EMMA HURST: I think you mentioned in your latest submission that you were going to be working with the Commonwealth going forward. Are there any interim plans to try and boost GP numbers in rural areas while that work with the Commonwealth is ongoing?

PHIL MINNS: I do not really think it is something we can do ourselves as a jurisdiction. We have scholarships to encourage people to enter GP practice and we have targeted programs that are about encouraging people to enter those programs from rural settings. So they are already in place. What we need to address is the underlying decline in the willingness of medical graduates to enter a career in general practice. These are matters that we cannot act on alone. We have to work with the Commonwealth.

The Hon. EMMA HURST: Do you have any indication from the Commonwealth at this point whether they are going to support the expansion of those trials that you have been running?

PHIL MINNS: The current framework has a long evaluation period for the trials. I think one of the points we have been making at officer level is that perhaps we need to look at more speedy evaluation so that we can see if we can bring the programs to wider use and more scaled use quicker.

The Hon. EMMA HURST: We have heard a lot of evidence in this inquiry that local councils were actually having to run fundraisers just to be able to raise money to actually attract GPs into the area and they would fundraise to get the relocation costs for GPs to move into their area. Is NSW Health planning to, or would it consider, working with councils who say they need GPs to provide relocation or other costs as needed so that they do not have to continue that fundraising?

PHIL MINNS: The local health districts already work hand in glove with local government when they are trying to fill those particular gaps in certain communities, and the local health district itself has some discretion associated with support for attracting people to employment if they were to accept a GP VMO appointment at a facility in that district. So the paper that we made available to the Committee by the Sax Institute I think really does describe in some pretty compelling detail why there is this generational drift away from both general practice itself and general practice in a rural, and particularly remote, context.

The Hon. EMMA HURST: Sorry, Mr Minns. Just because I do not have much time, I am just wondering why local councils felt that they needed to fundraise if you are now saying that you are working with councils to provide some of that funding. Why are some councils feeling that they still need to fundraise?

PHIL MINNS: I think you need to understand that the decision of a medical practitioner to go and be a GP in a regional town is a matter that relates to the viability of that general practice and that is a matter that is bound up with the Medicare rebate system. So the local council is trying to make the economic and community

conditions associated with a GP practising in their town as favourable as possible to attract people. And in the first instance, if that GP does not intend to be a visiting medical officer at one of our facilities, then we would have no role in that process whatsoever. But if we are in lock step with the council and other entities in government to try and encourage GPs to a town—and often a key player in this is the Rural Doctors Network, which is the chief agency that is trying to support these kind of GP practices forming and being sustained. We all work together but in essence the New South Wales health system is not the jurisdictional governor of general practice in Australia. It is just not what we do and so, if it is not considered viable by doctors to sustain a GP practice in an area, then we will try to do what we can to change those settings but we are not the main player in that.

Ms CATE FAEHRMANN: I just wanted to begin just with a general question about what is being done to—there is bit of feedback on the line. Can you hear me okay?

The CHAIR: We can hear, yes. That is better.

Ms CATE FAEHRMANN: Since COVID began, what new measures has New South Wales put in place to retain existing nurses working in regional hospitals and particularly registered nurses with decades of experience? What new measures have NSW Health put in place?

PHIL MINNS: All of our districts will be practising what they would call their employee assistance programs—their support to staff programs. In addition to those, there have been a few things done centrally. Through the Health Education and Training Institute we have developed websites with tools and resources that provide people with advice about self-care during the pandemic. We have done a lot of upskilling and training of our rural and regional workforce associated with PPE and specialist training to allow people to either return to or cycle through an ICU. We have done work around embedding psychological safety in the daily routines of our facilities and there have been specific initiatives as well associated with support lines, for example, for junior doctors.

In all of our districts and all of our facilities, and certainly when you visit them, it is clear that the wellbeing of staff is on the mind of the workforce facility at all time. I think what we have to acknowledge, and we acknowledge, is that the Delta outbreak and then the Omicron outbreak had been significant and challenging developments in all of our workplace settings. Towards the third quarter of 2020 our central workforce teams worked with every district around their sort of emergency service plans and their alternative initiatives within the framework that were designed to say "How do we get additional resourcing? How do we support? How do we use more students? What are our options for relieving registered nurses of some tasks by getting other people to do other things?

All of those early strategies were in place and were set but you would have to say when Omicron hit, and the speed with which it hit, and the speed with which it led to all of our staff, overwhelmed our strategies. We acknowledge that and our chiefs acknowledge that. At our peak, I think, on 14 January we had about 6,300 staff unavailable and not all of those are medical and workforce and I can give you the breakdown if you would like it. But that happened so quickly and it also happened in a period where, as of the middle of November, our districts had been working really hard to encourage people to take a break over what is traditionally the quieter period of Christmas and early New Year.

We were a system that having recovered from Delta and we were saying to our staff "Take a break. It is time to get some energy back" and then we were hit in a very fast and short period with an escalation of Omicron and our 6,300 staff unavailable to us. A large proportion of it were not infirmed because they were close contacts, they were infirmed because they had COVID. About 90 per cent and I think actually 95 per cent of those COVID cases in our workforce were community derived, not workplace derived. Once it became overwhelming in the community it had a very, very significant effect on our workforce. Most of our reserve strategies were exhausted. They had been tapped out. They did not have any more capacity.

Ms CATE FAEHRMANN: Thank you. One of the things that the Committee has heard throughout the inquiry increasingly as the result of Omicron is, you have just said it yourself, the exhaustion of frontline health care workers and an increasing the number of very senior nurses who have been working in the profession for a couple of decades—three decades and sometimes more—who were not necessarily close to retirement before COVID and some are walking away, and threatening to walk away. In fact, at Lismore Base Hospital over the Christmas period, 18 staff left, many of them nurses, to go over the border with better conditions, better pay and what have you, many of them, to work over the border.

How can NSW Health begin to talk about the ease to operate incentives to nurses to do something to retain them? I note in your notes you have got the supplementary submission to the inquiry, with the Sax report looked at various ways to encourage the retention of the workforce. I note that the financial incentives is dismissed a bit. I would really like to know the thinking of NSW Health on this and whether you have considered that as a

way to really retain those more experienced nurses because we are losing their skills, we are losing their experience right now.

NIGEL LYONS: Ms Faehrmann, there are a couple of things I can disclose and some that I cannot. We started thinking about work towards the end of October that was designed to take a complete look at workforce status, supply and demand issues. Just to give you a couple of cases that illustrate why we had to really think about starting over again, a lot of our regional LHDs in border areas rely upon a supply that comes over the border. It is interesting staff go both ways from northern New South Wales to Queensland and vice versa. When we went through the periods of lockdowns and border restrictions a lot of those people made decisions to say, I'm not going to continue doing that. So we just lost pockets of workforce that had long been available to us, even when borders re-opened. That affected our border-based LHDs quite significantly and still is.

So as an example a part of it has changed in our context. So we are doing work with our partners to understand the totality of what we need to re-think about our workforce structure and our workforce capacity. We are actually talking to a project about workforce recovery because we know that our staff were tired after Delta and they are more tired now. Although we are hopeful of a pattern of the focus working to the models that have been in the public domain, winter is ahead and we look ahead to the fact that we may face a challenging winter. We definitely want to put in place recovery strategies for our workforce. We are doing that thinking right at this time in Ministry. I am afraid as a public servant I cannot comment on the advice that we are thinking of happening to go with it.

The Hon. WES FANG: I thank Mr Minns and Dr Lyons for appearing today. I take this opportunity, and ask for the indulgence of the Committee, to acknowledge as did the Hon. Walt Secord, the attendance through the majority of the hearings by Mr Minns and Dr Lyons. I think that is an example of how, even through a pandemic, NSW Health has taken this issue very seriously and has been committed to looking at the issues. I want to make that point known and thank you both for your efforts into attending the hearings and providing information to this Committee. I think all members join with me to have that acknowledged by the Committee.

Today the Committee has discussed a number of times the provision of doctors in regional and rural areas. We know that, as other members have asked questions around it, there are difficulties with attracting and retaining, for example, general practitioners in smaller centres. I want to ask, given potentially GP trainees will go to rural and regional areas to train or perhaps a newly graduated GP who may be looking to go to a rural, regional area, in your opinion what incentives are most attractive and actually work in being able to draw those trainees or new GPs to an area? Can you provide some insights as to what you think or what you have acknowledged will work?

PHIL MINNS: The report we provided to you from the Sax Institute is almost to the point that it is a multi-disciplined strategy to try to address this issue of what has happened to regional and rural health areas. It is not dissimilar to some of the issues that are faced by the Australian Defence Force when it relocates its members throughout different parts of Australia. You are not seeking to recruit doctors but you really have to bring their family they have with them. You have to try to retain their family over time. That is the case for doctors, it is case for nurses, managers, and allied health professionals. It comes down to things like how sustainable is the community they are joining in terms of the employment outcomes for their family and their educational opportunities available for their children, and the housing stock that is potentially available.

You probably note, as we have, it is one of those factors that we will consider in our recalibration of workforce strategies. There has been a movement toward regional centres but now it is creating a choke point around accommodation in those places. It is pricing out some of the essential workforce that might already be there or might be thinking about going there. It is all of those factors and at the end of the day if someone is seeking to engage in general practice they will need to have an appreciation that it is a viable and economic strategy for them so that comes down to the size of the town, what they can expect to achieve in earnings through the Medicare system and how many other GPs might already be there. They are all factors that flow into it. We need to work with the Commonwealth. We need to work with other New South Wales Government agencies to try to deal with things like the housing issue and education issues.

NIGEL LYONS: Can I add? I notice that it is in a paper that points to the benefit of actually ensuring that people who are trying hard in communities are rightly having the opportunity to gain training from the professions and that is possibly driven by some assurance and is partly driven by a pathway for the ongoing benefit of these communities whether in nursing, allied health or medicine. I think we have got real benefits regarding the rural clinical schools, having our rural preparation model so we can actually have doctors preferentially relocate to gain their rural training. I think we have to build on that to ensure that for the latter there are issues for vocational training of people to be more professional so that they can do that in situ as well. That normally is not the case at the moment and I think we need to do more work especially in colleges, the College of Nursing as

well, and ensure that there are other arrangements for that skill to be gained and that experience to be gained in a way it can keep people in those rural environments rather than having to go to the city to gain that experience.

The other thing, of course, is these are multiple issues and training of nurses so often takes place in the NSW Health system and then they go out into the general practice for training. Having a single role that people come here for their employment means that people can have certainty about their employment arrangements to finish their training, I think, even though they work with the Commonwealth and they are trained it will ensure that there is more people.

The Hon. WES FANG: Thank you for that. That was very comprehensive and interesting. What I wonder though is that a lot of these, I guess, structural changes have already been implemented and perhaps are being looked at being implemented. How long is the pipeline for those changes? They will not overnight produce a raft of more doctors for rural and regional areas? They do take some time. Is that correct?

NIGEL LYONS: Yes. On the medical side a lot of these things are already in place. The opportunity to try to gain a university degree in the health profession is available now. The opportunity to gain pre-vocation training in rural health is available now. It is when we get into those sections of training, vocational training areas we refer to more to the specialist oncology on how it could be done differently and better in rural environments. I think the other issue for us is we have got to have structural issues around private practice and whatever it is around exponentials to all of our general practice. Yet the relationship between the service that we provide and the service that is provided by GPs in private practice are so inextricably linked that we have got to come up with a model which enables that to be done in a way that is still attractive to somebody. To recruit people to general practice in and to pay a fee for service whilst they are there you need to go where there is enough population to generate fee-for-service activities for somebody to go live in that environment. We have got to have different model in a way that somebody will stay and continue to live and arrangements to remunerate GPs in a way that makes that sustainable in the long term.

The Hon. WES FANG: Coming back to the question that I asked, we are going to see soon those structural changes start to make a difference to the number of doctors we have coming through. You are also saying, I think, for example, it was Wellington where the Committee held a hearing a number of GPs were in town but they were not providing VMO services to the hospital. What we need to do is to ensure is that we have that Commonwealth-State Government linkage because Medicare is obviously Commonwealth based, and provision of services within the hospitals is from NSW Health, is finding a way to better work together with the Commonwealth. Is that a good summation of what you are effectively saying?

NIGEL LYONS: Absolutely. I think we will look to opportunities like recommendations from this Committee that would actually assist in ensuring that we have a better focus on things that make a difference. That is what we are prepared to advise on. In respect to the Sax Institute, we included advice in the submission to enable members further background on these issues.

The Hon. WES FANG: I do thank you for that supplementary submission and the attachments, of which one has been published to the web site for the Committee. Earlier we talked about Tamworth Hospital. I want to give you the opportunity to provide a little bit more context about that. For example, if the State Government builds a road with one-lane each way and it serves a capacity now, we know that in 10 to 15 years the road will become traffic jammed because of the increase in traffic. Is it effectively the same with hospitals; that their life-span is such that you plan for future and so the additional capacity is effectively there for future use? Is that a fair summation?

NIGEL LYONS: That is exactly right. We have had a program for the building of hospital infrastructure, health care infrastructure over the State in the last 10 years, and that will continue but increasingly our actual building has been for facilities in the rural and regional environment which would be needed because they have not been there in the past. I think that would be the benefit from that. When we do finance a facility we look not just at the preparation now but we look at the projections for the next 20 years. There will be planning for health care utilisation challenges not just now but in 10, 15 years' time. And so we build those facilities that enable that flexibility to arrive at future facilities. I mean when we do have a lay of the land you heard before, we often do the build because we know that there will be increasing demand over time and various factors are designed to try to help the environment to be operating, including care at the same time.

So the data I find is actually the best way to do it. We recognise that until that data is sought after when we do that planning it may not mean that we use those facilities immediately. People do not quite understand that it is done on the basis of the needs down the track. It does not mean that if you build it now and commissioned to be used straight away. Previous health care needs are intimate and people will have opportunities to say you should have done more. It is not always about the physical structure I would say, it is about the workforce that is delivering

that care as well. We have talked about the challenges, particularly for rural and regional areas, and it is not just about the physical facilities, it is about how the regions supply health care as well.

The Hon. WES FANG: So like a road that is perhaps at capacity from the first day that it is opened, and in 30 years it is a traffic jam, could you perhaps provide some insight to what might have occurred in, say, a regional centre where a hospital was built with the number of operating theatres at capacity from day one and what issues that might have caused in 30 years where the ability for expansion was not built into the hospital?

NIGEL LYONS: In some ways if you build a hospital and it is utilised as soon as it opens then you have difficulty down the track when you find an increased demand due to demographic changes. It is really important that we look not only at our finances but we believe that our reputation on a shared ethical balance sheet supports the community that may have difficulty accessing that care. So it is really important that we allow that community to access that care. I think it is important that we do not compromise the needs right now and think about the future because it otherwise means that those people will not have access to that care.

The Hon. WES FANG: Thank you very much for that. I think the nature of politics would have been that there would have been criticism had we built a hospital that was at capacity from day one. It is just interesting to get those insights and put them on the record because I think it is very important that we acknowledge that they are for expansion and it is not that they are mothballed as perhaps they might have been described earlier. I will just see how much time I have got left. I will pass back to the Chair.

The CHAIR: We will return to the Opposition for another set of questions for 15 minutes.

The Hon. WALT SECORD: I want to take you back to evidence that was provided in western New South Wales. I know that you gentlemen would be familiar with it. It was Gulgong hospital and doctors in emergency departments, doctors in hospitals and the tragic case of Dawn Trivett who died, I think, in September 2020 when she bled to death with no doctor present but she was on Telehealth. It was because there was no doctor in the hospital. Does Gulgong hospital have a doctor now and since the evidence was presented on the front page of *The Sydney Morning Herald* and to this Committee?

NIGEL LYONS: We are still charged by the local rural plans about having 24/7 coverage of doctors in every hospital. I think one of the things that has been highlighted in evidence to this Committee is that the ability to do that is challenged by the workforce that is available. We heard that evidence. What we indicate is that we cannot guarantee that every hospital will have a doctor 24/7.

The Hon. WALT SECORD: Dr Lyons, I only have 15 minutes and I am asking very specific questions so I take it that Gulgong hospital still does not have a doctor available in the hospital?

NIGEL LYONS: I have no specific details. I will take that on notice about the particular question around Gulgong. I was giving a general reflection of the situation in rural hospitals.

The Hon. WALT SECORD: Okay, so we still have—

PHIL MINNS: There is one further point I want to make. A refer to our statements 15 months ago, we went spending a number around $140 plus million on locums in rural and regional hospitals. It is not as if we have been shovelled into recruitment activity that we down tools and we do not show any interest in getting a doctor to a place like Gulgong. A huge amount of effort is deployed to try to attract a locum to cover those mythic shifts. A large amount of expenditure is outlaid in providing locum coverage. But then with that there are occasions where locums cannot be found or they dry up at the last minute and we know that we have that extra thing and it has been made worse by border issues because in a large number of instances locums were coming in from interstate.

The Hon. WALT SECORD: I return to earlier evidence, Dr Lyons, when I asked about nurses claiming that New South Wales country hospitals lack basic medical supplies, including Panadol. I remember the evidence also included incontinence pads. You said that you were unable to confirm those reports. Did you, in fact, investigate those reports?

NIGEL LYONS: Some evidence about that has been provided. We requested the district investigate the assertions that had been made. The answer we received back was that they could not gather any evidence that that situation as outlined in the evidence occurred.

The Hon. WALT SECORD: Did they talk to the nurses?

NIGEL LYONS: That is the feedback we were provided. The district would have spoken to people in those hospitals around the assertions that were made and the feedback was that there was no basis in the situation that the evidence could be confirmed.

The Hon. WALT SECORD: Would you also confirm that patients in emergency departments in rural and regional hospitals are still getting teleconference consultations in the emergency departments from doctors based overseas in Europe? Is that still occurring in New South Wales?

NIGEL LYONS: So the issue around where the doctors are from, I do not know the details. But there is still the situation, as my colleague has outlined, that every attempt is made to ensure that we have a health care professional physically in the facilities of our services.

The Hon. WALT SECORD: I understand that—

NIGEL LYONS: What happens is that the staff who are on site go to use telehealth options whenever there are arrangements that need to be made to get support from other health districts and some of them may use a teleconference—

The Hon. WALT SECORD: Yes, I understand that some doctors—

NIGEL LYONS: And they are health professionals who are acting in the same way as the health district usually. This assertion about overseas, there is no evidence of that occurring.

The Hon. WALT SECORD: This Committee received evidence from the company that provides the in telemedicine. In fact, representatives have approached Committee members in airports to talk about how wonderful their service is and how they have doctors in Europe, including countries like Switzerland on teleconference with doctors in country New South Wales. Do you think a doctor in Switzerland has the knowledge and understanding to provide advice to an emergency department in western New South Wales and would have the knowledge and understanding of the needs of patients in situations?

NIGEL LYONS: Mr Secord, having given that evidence myself my understanding is it is a balance of helping people come to a potential solution to the situation that rural New South Wales was in, not that they were actually providing those services now. I indicated that Telehealth enabled you to do things that we would not have thought of, including support for people in that situation. They were from a private company offering a solution to the situation we found ourselves in in rural and regional health care. That is how I understand it as a member providing services in New South Wales. I will take that question on notice.

The Hon. WALT SECORD: Okay, so you are taking that on notice. I am very pleased with that. The Committee also heard at the hearings that the 66-bed operating theatre in the hospital at Leeton has been unused since 2016 because the recovery room is 11 centimetres too small. Has that been fixed since it was revealed to the Committee?

NIGEL LYONS: I would be very surprised if a room could not be used for recovery if it were 11 centimetres too small. So the person who provided that evidence may think of a reason why it is not being used but I suspect the reason it is not being used is because there are not people with the skills to enable the care to be provided. I am happy to get that sort of detail for you on that. I think that a recovery room that is 11 centimetres is too small would be very unusual for me not to provide care.

The Hon. WALT SECORD: That was the evidence provided to this Committee but you are taking that on notice. I want to take you to southern New South Wales. In 2019 the Federal Government announced that Bega, Eurobodalla, as a targeted region to fund regional radiation treatment centres with about $48.5 million in competitive grants which closed on October 2020. Southern New South Wales Local Health District did not apply for funding for cancer treatment in Eurobodalla. Why did they not apply for cancer treatment in rural and regional areas, particularly southern New South Wales where there is a desperate need for cancer treatment and people have to travel up to 2½ hours for treatment?

NIGEL LYONS: It is a fact, Mr Secord, in New South Wales when you deliver cancer care you do not look at providing radiation oncology in isolation of all the other components of cancer treatment including chemotherapy, surgical gynaecology, and the other components that you provide in cancer care which is multidisciplinary with multiple specialists so you have got to look at the environment to provide comprehensive care. Having a linear accelerator available in a town by a separate pathologist is the first factor. The second factor is that to utilise that equipment it is not only the equipment but you have got to have the people with the skills to operate the equipment. So you have got to have the ability to attract and retain specialists, and for a linear accelerator it is not just the doctors who provide the treatment, it is the radiographers who provide the use of a machine, it is the physicists who calibrate the machines. There is a range of specialist clinicians who need to be retained to allow that to occur.

I think the final factor is when you look at the population, and the need for cancer care, I think the numbers indicate that there will be about one patient per day in that geography that would require radiation treatment. It could be assumed in that community you would use it for one patient per day and it is multiple

millions of dollars of capital equipment. It is all those specialist teams that I talked about. It is the other services linked into it and when you look at it it is hard to justify that investment for one or two patients a day.

The Hon. WALT SECORD: So you are standing by the decision of the local health district not to apply for those grants?

NIGEL LYONS: I think in the circumstances they considered potentially the needs of the community and the ability to deliver the services in a way which is comprehensive and the decision it made was it would not apply for a grant without all those other factors in place.

The Hon. WALT SECORD: I know that you have been following the evidence given to this Committee. I have seen you sitting in the front row at all of the hearings. Are patients still being dumped on the street in Lismore Base Hospital in northern New South Wales, especially emergency department patients? There is no public transport there and are patients still being dumped on the street?

NIGEL LYONS: That is an unfortunate use of words, Mr Secord. I am referring to primary health care in smaller communities because there was a view that their clinical conditions were also assisted by staff who had no training and students who were unrecognised in their local town. There is no doubt that we are challenged. When we choose to discharge a patient from our level of care, and they are subsequently discharged from our care and they are well enough to go home, how are we going to change?

Our community is going to try to ensure that the person is connected with a transport option to get home recognising that in the rural communities there are limited options, and to ensure trends to provide that support. It is very difficult for our services to ensure that transport is available but we are doing everything to ensure that people are able to make arrangements to get home. We see that across hours of the day, this is a target that has been reinforced since the the evidence of the inquiry, that if somebody is well enough to go home that they are not requested to leave at 2 o'clock in the morning; that there are arrangements in place to ensure that if they can get transport home from a family or friend that that is accommodated by way of neighbours that the person is to be cared for until that transport arrives.

The Hon. WALT SECORD: Would you accept that patient transfer discharging patients in rural and regional hospitals is a major challenge because the Committee also has evidence in Cobar and Dubbo hospitals of a patient having to have a toe amputated because there is no transport available to get to Dubbo? What is the State Government doing about patient transfer and getting people between rural and regional hospitals from smaller hospitals to larger hospitals where there is no public transport available? You talked about northern New South Wales, I want to know has there been any programs or any assistance or any moves to remedy the problem between Cobar and Dubbo?

NIGEL LYONS: Just to put this in context. If someone presents to one of our services, and needs to be transferred to another facility we absolutely take that as our responsibility and make the arrangements about transfer whether that is by ambulance or by a transport service that provides service to our health districts in which they operate. The challenge for us is in situations where someone is going to a specialist consultation in private practice in a rural town and has to travel from a rural town to get to that service. It is challenge for us. It is very difficult for us to be responsible for every aspect of transport services in rural communities but certainly we do what we can in relation to supporting access through things like the Isolated Patient Travel and Accommodation Assistance Scheme subsidy. If people are required to travel we provide a subsidy to support the cost of that transport if they are provided authority. It is very difficult for our transport for services in every town for every treatment every time for our agency to be functioning—

The Hon. WALT SECORD: Dr Lyons, this will be my last question of the entire parliamentary inquiry. You have heard almost two years of evidence. As a senior health official in New South Wales and a person with his hands on the levers, were you surprised or shocked by the evidence that turned up to this inquiry to the personal stories—the first-person stories? Were you surprised by the extent and deterioration of health in rural and regional New South Wales?

NIGEL LYONS: I think we were all shocked by some of the stories that we heard, Mr Secord. What it highlights for me is that we have been working extremely hard to ensure that rural communities continue to have access to quality care. What we have done is continue to make efforts to improve that to address the issues of our emergencies. What I was surprised about was the extent to which, despite all of the efforts that we have made, all the improvements we have put in place, all the investments that have been made, all the additional infrastructure that has been invested and the staff that have been employed, there are still so many factors that are working against those things that we put in place that are still leading to the challenges that you have heard about ensuring that people get the care they need when they need it. I think the heartbreak of all of this is that we need to work doubly hard to address those issues that emerged and that is why we put in the supplementary submission. The

harder where we see we could make further inroads rapidly to address those issues because none of us want to see the care we have heard about being continued but we want to improve the care that is provided to our citizens in rural and regional areas.

The Hon. EMMA HURST: An issue that has been raised by many different rural or remote communities is connected to local maternity care. We heard a lot of stressful stories of women being forced to give birth on the side of the road after failure to get to a hospital. What is NSW Health doing to try to address this state of mind?

NIGEL LYONS: Can I say many different models of care is being put in place to try to ensure that we can provide maternity services safely and appropriately in rural settings. Many models of care that have been supported are training programs that are for doctors to be in rural health to be skilled in both maternity care, in anaesthesia. For a doctor to keep providing effective services you need to support doctors that are appropriately skilled in delivering a baby but if there are any complications then a caesarean section is required, requires an anaesthetist to give an anaesthetic. All of those things are being supported by a program investing in people's skills to be able to do those things.

What the Committee received in the supplementary submission is that to maintain skills in those different areas there is now the task to have certain multiple procedures each year to ensure that those skills are maintained at a level to provide safe and quality care. In many of our rural centres there are not enough deliveries to keep the people with the skills to enable one to be certifying to be able to continue to do that clinical care. Another example is the changes that occurred over the last 10 years that have driven us to have less sites providing the specialist skills needed in these settings, but concentrated more into settings where there are more cases being done to ensure that the care is provided safely and the people maintain the skills, but that means that they are often consolidated. That means that services that used to be provided locally are not being provided into the future. This is one of challenges that we know what the intention is but it is continuing to grow the change that we need to support.

PHIL MINNS: If I may, the nursing graduate pipeline that is operating in New South Wales is really a case of over subscribing. We hire the graduates that we need and we have been growing that every year and we will require a significant amount this year to try to support the workforce as a result of the outbreak. But that is not a case with midwifery graduates and so the circumstance with midwifery is, we have two ways to bring them into our workforce. One is through a direct undergraduate program and the other is through a Midstart program where an already qualified registered nurse takes part in a midwifery training program. We offer scholarships to try and promote people into that pathway. We would say that whilst we probably can recruit nurses on a macro scale as we need them, not so the case with midwifery. Of course, with nurses we know there is an issue about recruitment to certain regional locations.

The Hon. EMMA HURST: We have heard a lot that having some continuity of care model with midwifery really reduces a lot of the issues, and obviously this is a major problem in remote and regional New South Wales if we cannot get that. It sounds like there are a couple of problems in the fact that we do not have enough midwives, but you are pushing the training. What do we need to do to actually get more midwives into these areas where people are not able to get to these hospitals in time?

PHIL MINNS: We have talked with some of the rural and regional LHDs about a range of innovative strategies that are designed to try and fast-track the training of those new graduate nurses. Part of the issue is getting an RN to go to one of the smaller MPS sites or a smaller regional facility. They might not have the confidence to go to such a place where they might be in charge on shift as a relatively new graduate. In western New South Wales they are looking at programs to try and bring new graduates in, take them to the major centres, and expose them to a structured training program and supervised work practice such that they can then have them going back out with confidence into the smaller facilities. That kind of "grow your own" strategy within a district is what we need to see happen with the MidStart midwifery program as well.

The Hon. EMMA HURST: What I have heard speaking with the groups in the area is that statewide, only 10 per cent of women can access a known midwife at birth. In New Zealand apparently 90 per cent of women can access a known midwife. What do you think is happening in New South Wales and why is it so different to New Zealand? What are they doing that we can learn from?

NIGEL LYONS: I think you need to look at the context of how services are delivered in different jurisdictions based on a range of different factors, and looking at midwifery in isolation to how the services are provided is somewhat problematic. You have got to look at the overall model of care. We have had a model of care in Australia that has directly been through medical models with midwifery supporting them. Increasingly, we have got models now with midwifery providing holistic care in a continuous way, which I think is a very welcome thing, but historically that has been different in New South Wales. I am not sure what the arrangements

have been in New Zealand historically, but I suspect they have had a different model of service delivery for some time. That might explain that.

The Hon. EMMA HURST: Is there any discussion of expanding publicly funded home birthing programs to provide women with more options as to where to actually give birth? My understanding is that they are available in some LHDs but not all LHDs.

NIGEL LYONS: Yes. Birthing services are reviewed. They look to provide holistic care with a range of options for women to make choices about how they would like to have their maternity care and their baby delivered. Where possible we are offering arrangements like homebirths, where that is appropriate and safe to do so, and where the staff have the skills available to do that and are available geographically to be available close to where the mother is going to be delivering the baby. So you can see as we get away from the concentrated populations into more dispersed communities, it is more difficult to provide those types of models of care. But we are very open to continuous support both being made available and having staff who are willing and capable to provide that care being supported to do so.

The Hon. EMMA HURST: So at the end of the day it really just comes down to the fact that it is more likely to be available for larger LHDs but for rural and remote it comes back to this same issue that we keep talking about, getting the qualified people in the area to be able to offer these services. Is that right?

NIGEL LYONS: That is correct, Deputy Chair. That is the main factor.

PHIL MINNS: The other point that I think was really interesting in the Sax Institute report, Deputy Chair, is that it makes the point that what is now available in major regional hospital settings is almost on par with metropolitan. So we have seen the expansion of the availability of workforce and services in the major regional centres, but we have got a series of systemic factors that give us the issues that we have in remote and rural.

Ms CATE FAEHRMANN: I wanted to turn to the Government's supplementary submission just to get a point of clarification on something in here on page 9, where it says under the heading "Recruitment and retention of the rural medical workforce". I understand the Sax inquiry has looked at different evidence—or some evidence—in relation to financial incentives. This is carrying on from what I was asking before. It states here:

> Evidence shows that financial incentives are less important in the recruitment and retention of the rural health workforce than a favourable social and working environment.

I just wanted to check, that is for GPs, isn't it, in terms of that research as opposed to nurses?

PHIL MINNS: I think I would have to check with Sax to understand if they are making that point generally based on various data studies.

Ms CATE FAEHRMANN: I did have a look some. I did have a look the footnotes based on Sax's inquiries. I have just had a look at that and it does seem to be GPs. So I just wanted to flag it with you in terms of the submission you have made just to triple check, and just be careful if you can. We are talking about the overall workforce and whether financial incentives are good for retention. If it is just GPs you are referring to, I think it is important that you specify that because of the disparity in wages there.

NIGEL LYONS: No worries.

PHIL MINNS: No worries.

Ms CATE FAEHRMANN: I now want to turn to ENT specialists—ear, nose and throat specialists. We heard quite shocking evidence in the hearing that we held in the Taree-Manning-Great Lakes area about the wait for children on the public ENT waiting list was anywhere from three to five years. So if a family could afford to go private, they could get their kid sorted straightaway. But if they had a three-year-old with really severe things like grommets, for example, that affected their hearing, they would have to wait potentially three to four years. What is the Government doing about that situation in Taree and Manning, which is just unacceptable; you would agree, I am sure?

NIGEL LYONS: There is an investment in additional surgery that has been focused on ensuring that there is better access for paediatric patients in particular. There are more resources being provided out in the districts to address issues around the waiting times for care, particularly for children. So that investment has been a commitment of the Government and it is focused on ensuring that those waiting times are brought down. But I think we would all recognise that the challenge is where you have got less of the specialists available and the demand from the community—the need from the community—there, the waiting times tend to be longer because there are less specialists in that community. So we are constrained by the number of specialists that are available. Even if we put more resources in to enable them to do more operating, we are still limited by the number of specialists that are there providing those services. So it is a challenge for us, particularly in those environments,

but we are committed to getting the waiting times down. And I know that the local health district is focused on what they need to do to make sure that children in particular get care within the clinically appropriate waiting times. That is the focus.

Ms CATE FAEHRMANN: I did not quite catch the last sentence that you said there. But for parents now living in Taree and Manning who cannot afford to go to the private system—you said more investment, but specifically for that region is there any relief in sight, do you think, over the next year or two, to be a little bit more specific?

NIGEL LYONS: There is more operating time being provided to the surgeons to enable them to bring the waiting lists down, wherever possible. The challenge, as I said, is if there are not a large number of surgeons in that community then you cannot get the surgeon to do more than they can do, even if you offer them more operating time, if they are committed to doing other things in providing care in different settings. So the challenge is how much workforce you have got available sometimes in those rural environments. I know the districts do explore, from time to time, opportunities like seeing whether they can get the care transferred to another surgeon who has got less waiting time, and that may be outside of the town. If that occurs then people are supported to gain access to that operatin if it is going to be a shorter waiting time.

Ms CATE FAEHRMANN: It does not sound promising. Again, in your supplementary submission, the Government has said that they have recognised the issue of affordable housing for healthcare workers. I was wondering if you could give more detail of that. I note that in this it does not seem to say, for example, that northern New South Wales is one of the focused, but I know that there is a real crisis in affordable housing for healthcare workers right across the State, but particularly real estate in northern New South Wales has gone through the roof and rental accommodation is really hard to find. Could you give me a bit more detail on the overall package, but specifically what is happening in northern New South Wales, because it is not mentioned in the submission?

NIGEL LYONS: I do not think we had anything specifically targeted in terms of further capital investment for northern New South Wales at this point in time, so that is something that we will need to further explore. There is no doubt we have been focused on more rural communities away from the coast, because historically it has not been as much of a challenge to attract and retain people into the coastal communities that are rural and regional. That has been an easier task comparative to the others. We certainly are focusing on investing in affordable housing for our healthcare workers in western New South Wales, Hunter New England. We will be focusing on the southern New South Wales-Murrumbidgee area as well. We have plans and there is investment being made for us to build some accommodation to support our healthcare workers who are either being recruited into or being located at those environments.

Ms CATE FAEHRMANN: Just quickly on this—I am sorry, Chair, because I cannot hear the bell when it rings but if I can jump in with one more. The issue of our healthcare workers, the issue of rental affordability right up and down the coast since COVID is absolutely horrendous. I am hearing that one of the reasons, of course, that nurses are resigning is because they are not able to find rental accommodation and they are not getting paid enough to be able to afford increasing rents. Is it on NSW Health's radar now, given how atrocious the rents have become in coastal areas as well?

PHIL MINNS: It is obviously part of that mix of issues where we want to re-look at our current workforce settings and all that applies to them. It has been a development that has happened across the last 12 months. And there has been recent public discussion about issues in northern New South Wales, but I think it is likely to continue into other places. So we are doing this piece of work to try and understand how we respond to the context that COVID has given us—what settings do we need to change and how do we support our workforce to sustainably operate and to recover? And that work is underway now.

The Hon. WES FANG: I wanted to start this line of questioning with an acknowledgement that we have heard some very hard-to-listen-to personal stories. But I am keen to know, obviously NSW Health does a lot of feedback loops with patients. Can you provide some insight into what the patient survey results might be for some of the rural and regional areas, say, in comparison to what we are seeing in the urban areas where NSW Health would also be conducting those patient surveys?

NIGEL LYONS: The feedback from our rural hospitals is overwhelmingly positive. I think that is the first point to make. We recognise that that is in large part due to the close connection that our staff have with the people who live in those communities and the care that they provide and their unwavering commitment to provide services. We have heard some of the challenges that they face in doing so, so I just want to acknowledge their commitment to their own communities and the care they provide. The Bureau of Health Information, as you know, undertakes patient surveys right across all of our services. One of the insights that they provided was looking at around 4,500 adults that were admitted to the 98 small rural public hospitals from July 2019 through to June 2020.

They released this report in June last year. Almost all patients—that is 95 per cent—said that overall the care they had received was a very good or good, which was very pleasing to hear. Around nine in 10 of patients said that they were always treated with respect and dignity, which is also very pleasing to hear. Around eight in 10 patients said the health professional would always explain things to them in a way that they could understand.

Very interestingly, given some of the evidence that was provided around telehealth, there was also a question around had people received care via telehealth. Around one in eight patients, or 13 per cent of people who responded to the survey, said that they had received telehealth services in the three months after leaving hospital. And of these patients, 92 per cent said they have benefited from these services via telehealth, and 89 per cent of them rated telehealth as a good or a very good way of receiving care, which I think is really important for us to acknowledge and to hear that feedback, because it is something that we will continue to provide—those services—because it gives people better access, and it is pleasing to hear that that is what was received by the people who do provide the feedback through the surveys.

So they were very positive results. And while I have not got all of the specific details around the rest of the surveys, comparatively those are higher results compared with metropolitan services. The ratings of the care that are provided by rural patients tend to be on the higher side of the response surveys statewide.

The Hon. WES FANG: So do you think it would be fair to say that the vast majority of patients who are treated in rural and regional areas by NSW Health are very happy with their treatment and with the service that they have been provided?

NIGEL LYONS: That is what that survey result says, Mr Fang. So, yes, we would be happy to confirm that that is, as a result of the survey, what we could say.

The Hon. WES FANG: Thank you. I think that is interesting to note. I noticed you also raised the telehealth question that was obviously part of that survey. We have heard quite a bit about telehealth throughout this inquiry, and I keep using the word "demonisation" because I think that it has been perhaps demonised and politicised. But there has not been a real opportunity to present the positives that can come out of the telehealth system—i.e. the Telestroke system. Are you able to provide some insights as to the services that can be successfully provided by the telehealth system, and perhaps some of the outcomes that we have seen with the utilisation of that system by NSW Health?

NIGEL LYONS: Yes, certainly. I think the benefits of using technology like telehealth is that you can provide support to the clinicians delivering care in the community with special backup that would not otherwise be available in real time to support the care that is being provided to an individual patient when they need it, and the telehealth connections enable that to occur. I think the systems we are putting in place to support that occurring for particular conditions like stroke—and I can talk about that in more detail—are enabling our rural citizens to get access to world-class care in their rural communities, and I think that is a real benefit. There would be no way that we would be able to provide that level of specialist knowledge and input into the care without the support of telehealth.

Some of the other benefits of telehealth are that it is reduces the requirement for patients to travel. If you think about outpatient appointments and the need to travel for a specialist consultation, if you can deliver that via telehealth, the person can stay in their own community, does not have the travel cost. We have heard from Mr Secord about the challenges of transport for people who do not have transport to get from one town to another or to a larger centre. So it negates the need for those things to be provided and it enables people to get access to care and expertise and knowledge to support their care without them having to leave their town. So there are enormous financial and social benefits from applying a technology like telehealth to the delivery of health care.

But if you go back to the Telestroke issue, we have now implemented Telestroke across many rural centres. We are very closely evaluating the clinical outcomes of the treatment provided, and that is being monitored. I think we have had many rural patients now receive access to clot-busting drugs for stroke or being transferred to centres that deliver endovascular clot retrieval, which is where highly skilled specialists put catheters into the arteries in the brain and take the clots that are causing the stroke out. And we are now seeing outcomes from that care which are consistent with world's best practice through the implementation of that Telestroke service into our rural and regional communities. That is an example of what we can achieve by the appropriate application of the technology to support the best of clinical care being provided.

The Hon. WES FANG: Do you think it would be fair for me to categorise the lumping in of all telehealth services into one pot as somewhat simplistic, and, in fact, they can be quite varied in their application and their outcome and the response that is provided?

NIGEL LYONS: Absolutely. There are so many different ways that telehealth can be delivered to support clinical care being provided for a range of different health professionals, and also a range of different

settings. So we have got examples like the critical care context, where we have got our critical care specialist linked in to emergency departments and close observation units in rural hospitals to enable the care of somebody who is critically ill while further arrangements for their care are being sorted out. They can dial in through the telehealth to visually look at the patient, to look at what the clinicians on the ground are doing, to review their critical signs and some of the diagnostics. They can review ECGs and chest x-rays over that technology. And they can provide advice and support and guidance to the clinicians who are on the ground about how to provide the best care. So that is the critical care environment; and then I have talked about the outpatient environments, stroke environments—you could go on. There are so many different ways that telehealth is a really critical and very important technology that we must continue to use to support the best care that we can provide.

The Hon. WES FANG: I will not ask you if you believe it has been undermined; that would be asking your opinion and I know that would be inappropriate. I will make that assertion that is has been deliberately undermined by certain people. In your opinion, the undermining of that telehealth system, does that create a danger to patients where they perhaps have less confidence in the system because of that undermining when we have seen really good outcomes coming out of what could be, for example, the Telestroke system?

NIGEL LYONS: I think from our point of view what we are doing is promoting the positives. We are looking at every opportunity to provide to rural communities examples of patients who have received care—with their agreement, of course—to tell their stories, to indicate the benefits and allow people to talk about that firsthand and to share that with their own communities about the benefits that are provided, because it is important that we give positive messages about the importance of this not only for providing care, and that people feel comfortable and confident in its ability to help them when they need it. So that is the focus that we have got.

I think what is very positive is the feedback in the survey. When people do receive that, they talk about it very positively. That is another way to get the support out, because people will tell their families and their friends about the positive experiences when receiving care in that way. And we need to continue to provide the evidence about the clinical outcomes as well that can then give people confidence that this is actually delivering better care than they would otherwise be able to receive. We have got a very strong focus on that and a very strong campaign to deliver it. We are also evaluating very carefully, both from the patient and carer point of view but also from the clinicians who are delivering care through telehealth, about how they see it working for them and how they believe it is providing high-quality care and what we need to do to support them to be comfortable and confident that they are delivering care in the best possible way through telehealth as well. So there is a lot of room in the system going on to grow that investment and that support to enable that model into the future.

The Hon. WES FANG: I noted that earlier you touched on the greater complexity of health services that we see these days as opposed to perhaps 20, 30 or 40 years ago. I know that throughout the inquiry we have heard people ask, "But we used to be able to do this here and we cannot do it now." Are you able to provide a little bit of insight about how some of the provision of a treatment might be more complex now and might fall under a specialty as opposed to perhaps something that was able to be done by a GP, but also how that greater complexity of the procedure or treatment means that there are certain specialty training currency requirements, multidisciplinary support and the importance of maintaining efficiency. You might only see one patient with this every so often where you have not got that density of population? Could you provide a little bit of insight into that so that people can have an understanding of the difference between now and, say, 30 or 40 years ago?

NIGEL LYONS: Yes, certainly. There are so many things that you could talk about in relation to this. I think this is one of the factors that has driven the changes in service delivery, not just in New South Wales but around the country and around the world. Unfortunately, it has been perceived by rural communities as being cuts, that is us not investing in services. That could not be further from the truth. We are providing more financial resources into our rural services than ever before despite the workforce challenges but also these drivers of specialisation and the quality of care that is provided that need those skills.

If I can use the example—I think we were out at Dubbo; it might have been Wellington—where we heard about at one stage people could have surgery in their town, their GP could do surgical procedures. You could have your gall bladder taken out in their hospitals and they no longer could have access to that. Gall bladder surgery now is not something that is provided by a GP; it is provided by not just necessarily a type of general surgeon, it is often provided by an upper GI surgeon, gastrointestinal surgeon, and it is done laparoscopically. It is done through an operating telescope, whereas 30 years ago a GP would have done it as an open procedure with a large cut; a big surgical incision. It is now done through a small incision through a laparoscope. That equipment is highly expensive, but more importantly it is actually the skills to use that equipment which are the skills that need to be obtained by surgeons having access to that sort of surgery in an ongoing way, otherwise you can actually have very bad outcomes in gall bladder surgery because complications can occur because it is such a small incision, and because people are operating through a camera remotely.

I think it is an example of where technology and specialisation into even things like gall bladder surgery have meant that the things that used to be able to be provided in many places by people who had general skills are no longer possible. That is not often, I think, acknowledged or appreciated by our community. They do not understand or appreciate how much things have shifted. They see the fact that it was once provided and is no longer provided as being something we have deliberately done or made a decision not to do to deny them access to that service locally, and it could not be further from the truth. We actually want to ensure that if people have access to that type of surgery, it is done in a way that is safe, high quality and they get the best outcome. Unfortunately, that means that services can no longer be provided like it was 30 or 40 years ago.

That is unfortunately a shift we are seeing as technology and knowledge and specialisation and diagnostic services and treatment services become so technologically supported and highly skilled that those changes mean that we cannot go back to the way things used to be; it is not appropriate to go back. So we need to now think about how do we set the system up to support people to gain access to that care appropriately and what changes do we need to make as a result of this inquiry and what we have heard to give people confidence that the way the system is working is actually ultimately for their benefit.

The Hon. WALT SECORD: Dr Lyons and Mr Minns, you would be aware that on 21 December 2021 Premier Dominic Perrottet appointed Bronnie Taylor as the Minister for Regional Health. What is the responsibility as the Minister for Regional Health, what interaction have you had with her, and is she also responsible for the board appointments to rural LHDs?

PHIL MINNS: The secretary of the department has created a process that she has consulted with both Ministers on to work through how we approach the dual ministry with respect to the way the ministry and the system operates. That work has commenced. It has got a short time frame. It needs to look at the governance arrangements and the communication protocols and any approval protocols that arise from the dual ministry. That work is in train, so I cannot explain much more about it at this stage, except to say that your example of board appointments is a case in point where we will need to have an understood protocol between the two Ministers.

NIGEL LYONS: If I could answer this, Mr Secord. In relation to our supplementary submission, I personally briefed Minister Taylor and her team on the content of the submission that we were proposing to put in as a supplementary submission so she was across what we were putting in it. Both Minister Taylor's office and Minister Hazzard's office had an opportunity to review that prior to it being provided for the Committee's consideration.

The Hon. EMMA HURST: We have heard a lot of community members and healthcare workers throughout this inquiry who feel like their local health district is not listening to them or responding to their needs. I notice that you acknowledge the problem in your latest submission, but it did not really offer up any solutions. Is there anything that is going to happen other than encouraging LHDs to actually listen to the community?

NIGEL LYONS: I think, Deputy Chair, what we indicated in there was despite the best efforts of our local health districts—and I need to say that they do work hard to try to ensure that they have good community engagement processes for each rural community. That was very clear in the evidence that that is not working to the level it needs to be, because there was quite a degree of feedback that people did not feel like they knew what was going on at their local services, did not have enough involvement or say in what happened or how it happened. So we do need to strengthen that up. In the supplementary submission you will see we see the importance of having co-designed services, so that the community is actually involved with the health service and the health services that are provided in the town to look at how those services are delivered, who delivers what where, how that is arranged, how we ensure that we meet the needs of the local community.

There is a concept in there of the rural area community-controlled health organisation of something we could look to develop. If we can work with the Commonwealth to say that for a regional area, a rural area, let us bring everything together, this will be how it is funded, how the workforce across all of the services that we are responsible for and the Commonwealth deliver—it might be in private practice as well—how do we support them coming together to think about how they deliver to the needs of the local community in a way that the community has more involvement in directly? We have promoted that concept as something that could be explored as a way to address this issue. But we are very conscious that as a result of what we have heard, we need to do more to strengthen the relationship between our service providers and the communities that they deliver care in.

Ms CATE FAEHRMANN: You also state in your supplementary submission that you have heard that the Aboriginal community and witnesses have expressed their concern about culturally unsafe practices or not feeling culturally safe in hospitals and what have you. They particularly mentioned telehealth as something that they are struggling with. However, it does not say in your submission that you recognise that telehealth is an issue for Aboriginal communities. There was a recent contract for medical services at Walgett Shire which was given to a new company that has seen face-to-face primary care services reduced by 50 per cent, for example. So it

seems that it is getting worse in regional communities with high Aboriginal populations. Has NSW Health heard this and what are you doing in terms of Aboriginal communities' reluctance to engage with telehealth services?

NIGEL LYONS: Some of this is relatively new in terms of the new models that are being delivered by our telehealth, and we are very conscious that we need to do more to ensure that they are appropriately provided and that they are culturally appropriate for Aboriginal communities. We also need to do a fair bit of work for culturally and linguistically diverse communities as well. So it is a focus of us. There is more work needs to be done. There is no doubt about that, Ms Faehrmann. We have got more work to do in this space. It is acknowledged, though, that it is important to get it right, and it is important that we hear and listen to the feedback and we address that as we take steps to further support the introduction of this modality of care. It is going to be important that we address those issues. So we are conscious of it. It is early days and we are investing in it. But we have got more work to do, there is no doubt about that.

The Hon. WES FANG: I want to thank the witnesses today. For my final question I am keen to know—we have heard a lot about the pressure that has been put on NSW Health staff at the moment. I think Ms Cate Faehrmann raised separations. Do you have any figures on the number of staff who are separating from NSW Health given the outbreaks and the increased pressure that we have seen?

PHIL MINNS: Yes, Mr Fang. The first thing is to give you a bit of context. NSW Health has what you might call a relatively low turnover rate if you compare it to other sectors and other industries. If we look at 2021, our overall turnover was 8.4. It was 7.1 for nursing, 8.3 for medical, and in rural and regional it was 6.5 per cent for nursing and 8.2 for medical. What has happened under COVID is yet another testament to the commitment of NSW Health staff. The separation rate declined across medical and across nursing and midwifery workforce. It demonstrates their commitment to understand the context of the pandemic and to lock in. But what we have seen towards the end of Delta is a return to what you would call a pre-COVID environment. We have returned our separation rate to where it was in 2019, so it is a material movement of about 1.5 to 2 per cent. That, in part, is why we want to work on that rethinking of our workforce context and our workforce strategies in a post-COVID world, or in a living with COVID world, and I have talked about that work that is underway already.

The CHAIR: That brings us to the conclusion of today's hearing and, indeed, the public hearings for this inquiry. On behalf of the Committee members, I thank you both as senior representatives from NSW Health for not just appearing today and being very frank and fearless with your answers to questions but also for your participation in this inquiry, which has been over a long period of time. I appreciate that you have got senior and significant responsibilities but you have faithfully followed this inquiry around the State, being there yourself in person if at all possible or having some representative there who, I am sure, would have reported back to you. To have such direct engagement from NSW Health is very valuable in the first instance but is to be acknowledged and thanked for, because it does give some confidence to the Committee members and the inquiry itself that there is this exchange of information going on between ourselves.

Can I, on a concluding note, ask you please to pass on, once again on behalf of the Committee, our sincere thanks to NSW Health, but in particular with respect to all those working at the coalface of delivering services and health care to the citizens of this State. As a general statement, we have seen that being done and being done to a high standard, and we would like to thank all those people for that, but also particularly acknowledging their deep commitment and hard work during this difficult time that we have all faced as a community with respect to the COVID challenges that we have been facing in recent times. We would ask if you could please pass that on, we would be most grateful for that.

That brings us to the conclusion of today's final hearing. We thank everyone who has joined us today and over the course of the inquiry. Now it is the hard work of the Committee, working closely with our secretariat, to develop the report and recommendations. That is the job ahead. Thank you all very much, and we look forward to being in contact in the future.

(The witnesses withdrew.)

The Committee adjourned at 11:19.