REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY COMMITTEE ON COMMUNITY SERVICES

INQUIRY INTO THE HEALTH SERVICES AMENDMENT (SPLITTING OF THE HUNTER NEW ENGLAND HEALTH DISTRICT) BILL 2025

At Preston Stanley Room, Parliament House, Sydney, on Friday 22 August 2025

The Committee met at 9:15.

PRESENT

Mr Clayton Barr (Chair)

Ms Liza Butler
Ms Donna Davis

PRESENT VIA VIDEOCONFERENCE

Ms Trish Doyle (Deputy Chair)

* 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: Before we start, I'd like to acknowledge the Gadigal people of the Eora nation, who are the traditional custodians of the land on which we meet here at Parliament. I also pay my respects to Elders past and present, and any other Aboriginal or Torres Strait Islander people who are present for the hearings or watching proceedings online. I'd like to pay my respects to all of the Aboriginal nations that we represent in this House. Welcome to the fourth and final hearing for the inquiry of the Committee on Community Services into the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025.

My name is Clayton Barr, and I am the Committee Chair. I am joined by my colleagues: Ms Liza Butler, the member for South Coast; Ms Donna Davis, the member for Parramatta; and online, I'm happy to announce, we are also joined by the Deputy Chair of this Committee, Ms Trish Doyle, the member for Blue Mountains. Welcome to everyone attending the hearing in the public gallery and online. We respectfully ask everyone in the gallery to keep mobile phones on silent and to refrain from talking. We thank the witnesses who appear before us today and many stakeholders who have made written submissions. We appreciate your input into this inquiry.

Councillor SUSANNAH PEARSE, Mayor, Moree Plains Shire Council, before the Committee via videoconference, affirmed and examined

Councillor KATE DIGHT, Mayor, Inverell Shire Council, sworn and examined

The CHAIR: During these proceedings, the Committee staff will be taking photos and videos that we may use for social media. If you would prefer to not have your image used for those purposes, please let us know and we will be happy to comply. Before we start, do either of our witnesses have any questions about the hearing process?

KATE DIGHT: No.

The CHAIR: Would either of you like to make a short opening statement before we start questions?

KATE DIGHT: Thank you, Mr Barr, for the opportunity to appear at this inquiry for the Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025. I appear before you as the Mayor of Inverell Shire Council. Our council has resolved to support this inquiry and appreciates the genesis for the bill, that there is a decreasing level of health service provided by Hunter New England Health for the rural and remote health centres within the health district. I speak on behalf of our local area of Inverell shire, with a population of 18,000 people, and the services provided by our local generalist district hospital, which is categorised as MM 4. It's well documented there have been many calls for the splitting of Hunter New England Health ever since the health area was created in 2005.

Inverell Shire Council has understood that in the past, most recently in 2022, we received a huge public support for the split, evidenced by the petition commissioned by the former member of Northern Tablelands MP, Mr Adam Marshall. Our community was incensed with the lack of hospital services that they had access to at our facility. There were regular stories of patients being transported elsewhere because our hospital was not able to deliver the service. Given that the Inverell Hospital is a well-renowned district hospital which has always provided excellent obstetric and maternity care, it was the decline of these services in particular that resonated throughout our community. Further reports of the decline of anaesthetic services at the hospital exacerbated the problem, and the perception of general service delivery decline snowballed.

Following the failed outcome of this petition, Inverell Shire Council took a different approach and created the Inverell Health Forum. This was to bring all relevant parties to the table to address the concerns raised within our community and to find ways forward to improve our situation. The forum is now well established and regularly hears from the Hunter New England Health executive; Inverell Hospital; Rural Doctors Network; Primary Health Networks; Australian College of Rural and Remote Medicine; Royal Australian College of General Practitioners Rural; the local medical practice; University of New England; allied health; the Aboriginal health centre, Armajun; and community spokespersons for health. It has been supported by Inverell Shire Council and has been very effective in acknowledging the community issues, providing a greater depth of understanding and collaborating to create models of care that are suitable for our community.

It has actively engaged with Hunter New England Health for a productive purpose. While there remain issues with service delivery, we have seen evidence that Hunter New England Health are working to overcome these and are listening to our local community. For example, the forum has enabled the opportunity for the Hunter New England Health executive to meet directly with our doctors, and it is addressing having a local training workforce in the Inverell Hospital. This will bring more training practitioners through the colleges and Hunter New England Health to Inverell, allowing more care to be given locally and reducing the transfers to other

locations, which is the all-important factor. Ultimately, the forum has provided an opportunity for the invaluable flow of communication and to mutually recognise local quality of service between Hunter New England Health and the community. We want the forum to continue to work collaboratively to build health care that will work in the long term for the region.

Our council's resolution to support this inquiry was fundamentally based on establishing exactly what implications the split in Hunter New England Health would have on the level of service to our local community. We requested further information from Mr Roy Butler, MP, but have not received this detail to date. Hence, at this point in time, Inverell Shire Council recognises the need for a focus on health service delivery to our local communities, but we remain neutral as to whether a divided health district will deliver an improved outcome. We need to establish the implications for the specialist services coming to Inverell; how the medical training facilities will be impacted; and whether the cost to changing this machinery of government will warrant and deliver the desired outcome. We champion the positive collaboration the Inverell Health Forum has achieved and will continue to work with Hunter New England Health in this space to enable the flow of communication and ultimately build trust with the community. On behalf of Inverell Shire Council, I thank you very much for this inquiry and for having me here today to investigate the validity.

The CHAIR: Thank you very much, Councillor Dight, and I applaud the establishment of the health forum. It's so good to hear what's coming out of that. Councillor Pearse, would you like to make an opening statement on behalf of Moree Plains Shire Council?

SUSANNAH PEARSE: Thank you for the opportunity to provide this statement to the inquiry into the splitting of the Hunter New England health district. I join you this morning from Gamilaroi country and the north-western corner of the health district. Our shire is home to 13,000 people, spread across 18,000 square kilometres, from the border town Mungindi in the north-west to Boggabilla and Toomelah in the north, Biniguy in the east and Gurley in the south. We live and breathe agriculture and are home to a 22 per cent Aboriginal population. Like many rural areas, we have our challenges with access to medical and health services. Whilst we are delighted to have a $105 million hospital redevelopment underway, it's the level of service that our community cares about, and it's often found wanting. The splitting of the Hunter New England health district has long been touted as a potential solution to the problems.

I'm no expert in state health structures, but I can tell you what our community feels is working and what is not. Health staff have often explained that our connection to John Hunter, in Newcastle, is incredibly valuable, that being part of the same network means the teams at John Hunter have to take our call when we need them—they have to take our people when they need treatment that cannot be delivered locally—that more specialists want to live overlooking the blue ocean waters or the grapevines than the hills or plains of New England. Connection to a properly resourced tertiary hospital like John Hunter is necessary but, at the same time, we have massive gaps in our local service delivery. We're now in a situation where there are seemingly regular periods of no doctor in our emergency department, with some patients driving three hours to Tamworth to be seen.

In 2016 our hospital was fully staffed by local GPs, including three surgeons, four obstetricians and four anaesthetists. We now have one obstetrician, one anaesthetist, two surgeons and 97 per cent of our emergency department shifts being filled by locums. Recently, I'm aware that some patients have been assessed by a doctor virtually, with a computer wheeled in on a trolley, only to have the connection be so bad that the doctor asked for the video to be turned off to preserve audio quality. We are down to one local GP obstetrician, and hence the vast majority of birthing is covered by locums, if the health service can get them. We are short on midwives and on bypass 50 per cent of the time. That's a statistic that we find incredibly alarming. That's not great for our district hospital, which services a massive area, or patients with increased risk in a region that is expected to grow.

In a rural area like ours, the hospital plays a much bigger role than in urban areas. We don't have 24-hour medical centres that can take care of the coughs and broken bones, so our teams are doing that at the same time as handling industrial farm accidents; drug, alcohol and mental health patients; and highway traumas. Our hospital is under immense pressure to manage it all with seemingly less capacity to do so. Our local staff do a wonderful job and are incredibly committed to their roles in the community, but when we are getting to the point where there is often no doctor, pregnant mothers having to go to the next town and many patients seeing reduced outcomes, that's the point where I think we need to ask some questions.

Our local health district is massive in terms of its size, but also in terms of its population that it serves. If a patient from Mungindi or Boggabilla is transferred to John Hunter, it's a 600-kilometre eight-hour journey for a family member to come and support them. If you're admitted in Moree but discharged at John Hunter, it's your job to get yourself home and your up-front cost. Then you can go and find your way through getting some form of reimbursement through an IPTAAS form. Often these are Aboriginal patients and families who are already facing significant health and economic disadvantage. I understand that the health districts of the Hunter and

New England were combined with the intention of reducing administrative duplication, resulting in an improved level of service across the board. We are now at a juncture where we need to take a hard look at whether those original desired outcomes are being achieved.

Our region is one with huge potential. Thanks to the Moree Special Activation Precinct and Inland Rail, our town alone is expected to generate 2,000 new jobs over the next 20 years. We support the splitting of the Hunter New England health district only after significant resources are put into our services in the New England, including, in particular, the level of service and resourcing at Tamworth Hospital. The structure is not our main concern—that's not our area of expertise—but we do think it is time for a critical review and investment in better services resourced and delivered locally in the New England.

The CHAIR: You've both given a fantastic description of the challenges facing your communities by way of health. I do just remind everybody that in 2019 the New South Wales Parliament undertook an inquiry into rural, regional and remote health that was tabled in 2022. It landed on and agrees with much of what you said about the deficiencies in those health districts. Subsequent to that, there's been a select committee of this Parliament following up on that. Not to put aside or ignore those issues, the focus of this Committee has to be on whether or not to split Hunter New England Health and the pros and cons for that.

Ms TRISH DOYLE: Thank you to our two female mayors. It's wonderful to hear of your commitment, sharing your knowledge with our Committee today, and to have you with us. I'd like to acknowledge that both of you talked about a number of problems and articulated those very well indeed. As our Chair just pointed out, it's not news to us. If the bill doesn't pass, what changes would the Hunter New England Local Health District need to make to improve services in the New England region? We've heard about a number of the problems, and, as our Chair has indicated, we don't disagree with what you've outlined. Can you give us a few examples of solutions to those problems, regardless of the bill passing or not? You've just indicated one, Councillor Pearse: more resources. Would you like to elaborate a little and give us some examples, please?

SUSANNAH PEARSE: One of the challenges we have, like many areas, is obviously recruitment of positions. As a mum of three kids, I have personally seen a reduction in the service of our hospital over the last 10 years, who is actually staffing our hospital and the reliance on locums. I think our community really had a much higher level of service when our hospital was able to be staffed by local GPs. I know that is a result of a reduction in GPs across the board, but when we did have a full complement of local GPs staffing that hospital, it resulted in much better patient outcomes.

We had far higher reliability in terms of service. We didn't have the issue we're currently seeing where there is just not a doctor on in our emergency department. We need to see greater incentives for doctors to come to the regions as well as for other critical staff like midwives, nurses et cetera. There have been some positions in our hospital that have been vacant for some time, including critical roles that actually do the rostering for doctors et cetera, and that is really challenging. I suppose incentives for people to come here is better accommodation, those non-material but very important supports for people to come to our community, but a better focus on attracting and retaining staff.

KATE DIGHT: The Mayor of Moree has put it very succinctly. Further to that, I think the way of attracting staff is to make some of these district hospitals into training centres of excellence. We need our hospitals to become training centres. That enables the staff to stay within our communities through their period of training while they're getting their qualifications. The issues at the moment are that once you finish your medical degree, you have to leave our district hospitals in order to further your training. That's what we need to try and reverse, and really investigate how we can maintain some of those training structures within our district hospitals. That will ultimately keep a lot of these doctors in our communities for a longer period of time once they've completed their training, which is ultimately what we're all after. In answer to your question, Mr Barr, it is about resources and Hunter New England Health prioritising these district hospitals so that they get serviced and they're resourced in the best way possible. They do it very well. We want to work with them.

Ms LIZA BUTLER: Thank you for joining us. You brought up three really good questions around the training in your opening statement: training, the cost and referrals. That's come up quite a lot in what we've been hearing through this inquiry. The cost to split administratively would be around $100 million, we would lose access to training through John Hunter, and referral pathways for patients would be more difficult because they're going from one health district to another and often you go to the bottom of the list. Do you have any comments on those three issues you raised?

KATE DIGHT: You're absolutely right. We don't want to lose those services. The services offered at Newcastle, particularly the specialist services, are exemplary, and we really value that opportunity for us to work into that. The issue is that the hub-and-spoke system of Moree, Inverell and Glen Innes isn't prioritising our hospitals. If that were improved, these problems would be overcome. Improving that isn't necessarily by splitting

Hunter New England Health. That has been our position. We'd like to investigate the relevance of how that would actually be in practice. There are big questions. I am aware of the cost of that split, and I thoroughly believe that it can be better spent elsewhere by simply prioritising our hospitals.

The CHAIR: You said the hub and spoke isn't prioritised in your areas. Could you give us examples of how it's not prioritised in your areas and/or what prioritising would or could look like?

KATE DIGHT: Particularly it's our transport and transfers. The number of transfers going from Inverell Hospital over to Armidale Hospital is well documented. That is simply because the Inverell Hospital isn't being given the authority to do those medical examinations where we are at our district hospital.

The CHAIR: The authority? Do you have the clinical skill set to do it?

KATE DIGHT: We think we do, but I'm not a clinician.

The CHAIR: Nor am I.

KATE DIGHT: We think we absolutely have those skills, and we've had them for a very long time. There is evidence that comes out in the health forum regularly. But that certainly becomes jeopardised, for whatever reason, and we find that we're having to transfer patients very regularly to Armidale—to a different hospital. That's what we want to really address.

Ms LIZA BUTLER: Councillor Pearse, would you have anything to add to my original question?

SUSANNAH PEARSE: I think Mayor Dight has covered it fairly comprehensively. One thing I wanted to add—Mayor Dight touched on this earlier—being able to grow our own is really challenging when the number of people who can study medicine at the University of New England is limited. I understand that's through the Federal college, but I think there's a role for our state government in advocating to get more doctors trained in the New England region. We're really fortunate that we do have a medical school in our region. That should result in more local people becoming doctors and coming back to work in our region. I know that GPs aren't a state government responsibility, but the delivery of services in the state is. I think if we could take an innovative approach and be a bit more open-minded as to how many people can access that course, that would provide some long-term solutions to the problems that we're dealing with right now.

Ms LIZA BUTLER: You say that you've got the collaboration between councils and that you're feeding back to the health district. How does that work? Are things happening on the ground because of that feedback?

KATE DIGHT: We like to think it is being very effective. We've managed to get all those people around the table. At this point in time, that has included Gwydir Shire Council, and we're very open to it including further afield. That said, we have certainly had the opportunity to liaise directly with Hunter New England Health. They have always been a part of the forum. We had a meeting with them only just this week. That's certainly delivering outcomes, and it's enabling them to recognise what we're dealing with at our local levels. I think that's sometimes what gets lost. They're not even aware of the degree to which our community is feeling they're not receiving the service. It's an opportunity for us to give hardcore examples of that.

Ms LIZA BUTLER: Mayor Pearse, did you have something to add to that?

SUSANNAH PEARSE: I'd agree with Mayor Dight, but in terms of getting that feedback from the community, I think that is a little lacking at the moment. I'm not sure if our local health committees are really filling that void. As a council, we've got a great relationship with Hunter New England Health, and we are meeting with them regularly. I suppose one of the challenges we have is that we are hearing that roles remain unfilled. I do wonder if there needs to be greater resourcing put around the recruitment and attraction of those roles, because it is a consistent message in those meetings. Hunter New England Health is incredibly available to us. We'd probably just like to see a strengthening of that relationship between Hunter New England Health and the people who actually utilise their services.

The CHAIR: Just on the back of that, to the Mayor of Moree, do you have a local area health committee up and running at the moment?

SUSANNAH PEARSE: Yes, we do.

The CHAIR: What about over at Inverell?

KATE DIGHT: Yes, the hospital has its own committee.

The CHAIR: Health committee?

KATE DIGHT: But we utilise the Inverell Health Forum in that capacity.

The CHAIR: I think the forum is a bit of a gold standard, but there is a requirement and an expectation that a local area health committee should already be established and set up.

KATE DIGHT: Yes, and that is established and set up.

The CHAIR: Which is community representation and information sharing about what's happening at the hospital.

KATE DIGHT: We certainly have that set up in Inverell as well. I think the only thing to comment on there is that we need to ensure that the information from that structure gets delivered to the community. We need to make sure that information flow is happening.

Ms DONNA DAVIS: It's so nice to see female mayors, having been one myself, but especially in regional New South Wales. It's great.

The CHAIR: Do I get to say I'm a minority in this room?

Ms DONNA DAVIS: You are, but you are the Chair. The Moree Plains Shire Council's submission refers to the Indigenous population in the community. To what extent is the health care provided by Hunter New England Health culturally safe and considered? Do you think that splitting the health district would do anything to improve the current situation, or are there other things that we should be doing to actually address current concerns?

SUSANNAH PEARSE: I think we're probably likely to see a pretty significant improvement here, especially with our hospital redevelopment. Our local teams are pretty well practised in dealing with our Aboriginal community. I think some of the challenges there are actually around facilities and spaces. The new hospital redevelopment is slated to improve that quite significantly, with special areas for families et cetera. Rather than in the local delivery of service, where I think we are let down more is when people leave Moree and the challenges they experience when they are transferred to either Tamworth or Newcastle et cetera.

We have a population already suffering pretty significant socio-economic disadvantage. Being transferred out of the community just exacerbates that. Many people in our community cannot afford to get themselves back from Tamworth, so transport is also an issue, because we don't have public transport systems from Tamworth back to Moree, or it's very limited. If we were looking to improve the level of service delivered to our Aboriginal community specifically, it's more what's happening outside of Moree and when they leave our community.

Ms DONNA DAVIS: We know that there is subsidised transport, but that's very limited, and we also know there's volunteer services. Through your local health committee or your forum in Inverell, have you worked through some solutions or ideas that we could potentially adopt to improve transportation for people, especially outside of nine to five?

KATE DIGHT: We have talked about it. It's just a matter of working out who should take responsibility for that service. Ultimately, it's a failing of the health system, so the health system should provide the transport service. To be honest, the ambulance is going very regularly out of our community, which we object to anyway. As Moree has already alluded to—we've got a 14 per cent Indigenous population as well. I would suggest that it becomes particularly apparent for maternity services. We don't want people leaving country to go and birth elsewhere. We want those services to stay in Inverell. The absolute failing of that is around the anaesthetic services. If we don't have the anaesthetists, issues really prevail. It's that snowballing effect of how that service delivery declines because of those. We might be lacking a scrub nurse so therefore it has to be a transfer out. It shouldn't be like that.

Ms DONNA DAVIS: Was there anything that Mayor Pearse wanted to add?

SUSANNAH PEARSE: As someone who grew up in the city, I find it a very weird concept that someone can be admitted to a hospital, transferred to another hospital eight hours away and expected to get themselves home. There's an issue in the system there. I think if you are admitted as a patient at the Moree Hospital that essentially the state health service has a responsibility—I would like to see them discharged at Moree Hospital and transferred back. It's not their doing or their fault that they've had to be transferred. They've been transferred because obviously they have significant health issues. For someone to endure that and then be expected to get themselves home and arrange transport, people in urban areas would not necessarily think that was an okay level of service.

Ms DONNA DAVIS: I have personal experience of that. I can fully appreciate your concerns.

Ms LIZA BUTLER: When were maternity services at Inverell either reduced or removed?

KATE DIGHT: They're certainly not removed. I apologise if I've given that implication. Maternity services are alive and well in Inverell. The issue is really around anaesthetic services. That really means that you cannot perform those obstetric services in there.

Ms LIZA BUTLER: Thank you for clarifying. You're on the regional, rural and remote health, and we've heard a lot that when maternity services are reduced, you lose the anaesthetist. I just wanted that clarified.

Ms DONNA DAVIS: I can't remember where that expert was from the other day, but they were talking about the complexities of giving birth in 2025 compared to 15 or 20 years ago. We have a lot of people now that have more complex health needs, particularly, sadly, in regional areas. Is that something that has been brought to your attention at all as a reason why people aren't able to give birth at Inverell and are moved to Tamworth?

KATE DIGHT: My answer to that would be around recognising our quality of service within our district hospitals. Whether or not the scrutiny for that and the bar has been raised is out of my area of comment. What we do really want to recognise is that we in these district hospitals have excellent service and excellent quality of maternity and obstetric care. That really needs to be—I hesitate in using the word "honoured", but that's nearly what it is. We've got that great service, and we need to capitalise on what we've got and honour that within our regional hospitals and our district hospitals. People have always been able to have maternity services and obstetric services in district hospitals. That's what we're trying to maintain. Someone shouldn't get to 35 weeks, have some degree of risk and then be transferred out. We have the abilities in our own communities to look after that risk.

Ms DONNA DAVIS: And potentially have the expertise brought in rather than out.

KATE DIGHT: Yes. It's that mutual recognition of service that I would really like to make a point of.

SUSANNAH PEARSE: What we've seen in Moree is probably a result of declining local resourcing over the last 10 years. We're part of a bypass network now, rostering where on any given day, hopefully people can give birth in Moree, Inverell or Narrabri and have some obstetric coverage in those areas. We are down to one local obstetrician and down on midwives. That has an impact on the level of service and the quality of service that can be delivered locally because of the pressure that those individuals are under. We have actually had a couple of fetal deaths on the ward in the last 12 to 18 months, which are incredibly challenging for the very small number of people who are providing that service as well.

The CHAIR: Just on that last point, it must be difficult in small communities to be the medical practitioner who is there at the time of a tragedy like that.

KATE DIGHT: That is really why we go to the next step of saying we need training services to be available in our communities so that doctors feel they have their own cohort and their own community that they can turn to within our area and within our district hospitals. We recognise that, and we don't want them to feel alone. They need their own level of peer support. That's why the training facility needs to be encouraged.

The CHAIR: Councillor Pearse, are you aware of the IMAP project, which is a program where Hunter New England Health services send out specialists into the Moree area to gauge the pipeline of births, whether there are complexities around some of the births and who might be able to safely birth locally versus who might need more specialist services at a larger hospital? Are you aware of that program or project?

SUSANNAH PEARSE: I wasn't familiar with the specific terminology of it, but I was aware that these things are being planned for and discussed with the patient.

The CHAIR: One of the statements in the Hunter New England Local Health District submission to this particular inquiry is that, were there to be a separation of health districts, projects or programs like that would have a new border, which would be well short of Moree. It might stop at the top end of the Hunter Valley itself. I could only imagine that reduction in services which are currently feeding from the John Hunter would be a concern. Would that be fair for me to say?

SUSANNAH PEARSE: I think that is a fair assessment. We've got to be very careful not to throw the baby out with the bathwater. Our community cannot handle a reduction in service and access. The challenge is that we don't have the same level of specialist currently available in our region. It's just like you said, Mr Barr: Those services aren't coming out of Tamworth Hospital at the moment. Long term, we would love to see those services come out of Tamworth and for our region to be more self-sustaining. But until we've got that in place, I do think that being cut off from those kinds of services would be at the detriment of our region and our people.

The CHAIR: For both of you, the Hunter New England Health submission also openly identified and accepted that they currently have 3,000 vacant medical positions: scrub nurses, theatre nurses, doctors, whatever the case is. That's out there. We know that's a problem. There's a lot of work and that will take a long time to fix.

I wanted to clarify a figure that I thought I heard Councillor Pearse use right at the start. Did you say that 97 per cent of your ED doctors are locums?

SUSANNAH PEARSE: This was a statistic I was given by a local GP. It was earlier in the year that this data came from: that 97 per cent of shifts were being filled by locum GPs at the hospital.

The CHAIR: Staggering.

Ms DONNA DAVIS: Minister Park has done a lot of work with Health around incentivising training for nurses and ancillary health professions. One of those is assistance with HECS. Is that something that you think is widely known and promoted in your local government areas or something that should be promoted more, so that we can encourage locals to get into this training.

KATE DIGHT: I'm aware of that. I'm really pleased to see it happening, and I commend the state government for taking that initiative. I think it's a great question as to whether or not that is well-known and understood within the health community. I would just like to add that these council areas we're talking about—Mayor Pearse, Gwydir and I—are all border communities. We have so many different practitioners very easily going to Brisbane and Queensland. I think the fact that he has raised the bar from New South Wales's point of view is really relevant to us and I really commend that. I've also recognised the work that Hunter New England Health are doing to try and retain their workforce, but everyone is. We've just got to work harder on that. Sorry to put it bluntly. We just have to keep advertising. Whether it's because my social media feed has picked up on it, I'm starting to see many more advertisements come through, and it needs to be really promoted within our communities that these positions are available. That has certainly improved. That's great to see.

Ms DONNA DAVIS: Mayor Pearse, would you have similar feedback?

SUSANNAH PEARSE: Yes, absolutely. Moree is about an hour and 15 minutes from the border, so if health staff are looking at where they live, they might be in Goondiwindi and work in Goondiwindi, just across the border, because they will be paid better. The disparity across the states actually does make a pretty significant difference. Also, I'm not sure whether there's enough being done to inspire our local youth to take up careers in health. I suppose it's a challenging pathway, because their training often takes them out of our shire, and then it's very hard to get them back. Anything that promotes local people taking up these career pathways and being able to do as much training and development as possible in our region will help this issue on a longer term basis.

The CHAIR: I certainly hope our year 11 and 12 students are talking about the HECS subsidy. Thank you both so much for appearing before us today. Following today's proceedings, we will in the coming days be sending to you a copy of the uncorrected transcript. You may seek to make some corrections if we have misheard you or misunderstood what you were saying. We, as a Committee, may also develop additional questions we'd like to ask in writing on the back of the hearing today, which we would also send to you with the transcript or close to that time. We ask that you turn those around as soon as you possibly can, hopefully within seven days, but please talk to us if that's not possible. Other than that, I sincerely thank both of you for your important and valuable time today to be with us.

(The witnesses withdrew.)

Councillor BRONWYN PETRIE, Mayor, Tenterfield Shire Council, before the Committee via videoconference, sworn and examined

Councillor GREG SAUER, Deputy Mayor, Tenterfield Shire Council, before the Committee via videoconference, affirmed and examined

Councillor DARRELL TIEMENS, Mayor, Narrabri Shire Council, before the Committee via videoconference, sworn and examined

Councillor ETHAN TOWNS, Councillor, Narrabri Shire Council, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you for appearing before us today. We welcome your participation. Would one of you like to make an opening statement of up to two minutes?

BRONWYN PETRIE: We did put in a submission. To summarise that, we strongly believe that the current Hunter New England Local Health District does not serve the many regional, rural and remote communities outside of the Newcastle/Hunter region adequately. This belief has been informed to council by receiving a constant flow of complaints and concerns from community members about the deterioration in and

lack of services over the past 20 years since the establishment of this extremely large health district, which I understand to be the largest in New South Wale—certainly eastern New South Wales. This has been reinforced by numerous personal experiences and examples of councillors, staff, family and friends not receiving satisfactory medical care over this period, and actions taken, against instruction, achieved through our local member and meetings with our personnel and two Ministers.

It's just such a disparity of range. Newcastle is at completely one end and we're at the other end, as is Moree to the north-west. We argue that that above-mentioned diversity of community spread over such a large geographic area makes it impossible for one single health authority to adequately and effectively deliver health services and outcomes for all of the residents living in these different locations. We have also seen, within the health district in the New England, continual undermining of services availability and delivery over this time with the downgrading of not just our hospital but also those to the south of us, especially Armidale. We did adopt in March 2025 to provide this submission—and, previously in 2016-17, to, if need be, move us to the Northern Rivers. Part of our shire is already part of Northern Rivers. That itself is problematic with communications. Ambulances don't like having to go in large areas with no communication. As recently as March 2022, the New England Joint Organisation of councils unanimously voted to split Hunter and New England.

The CHAIR: We do have a submission from you. It's submission No. 27 in our register. It includes a motion that was resolved and carried regarding the council's position on Hunter New England health services as at February 2025. Thank you for that. We really appreciate that.

Ms TRISH DOYLE: It's good to see you again, Bronwyn, even if it's a long distance apart and online. Thank you for explaining in your opening statement some of what we know. Obviously you both have experiences as representatives in your community regarding the views of that community and examples from the community of where there is disparity in health services and a lack of access to healthcare services and hospital services. If the bill doesn't pass, so there isn't a split, what are some of the changes and solutions that the Hunter New England Local Health District needs to make to improve health services for your community? We know about the problems, and we agree; we've heard you loud and clear. Besides resourcing, what are some other solutions? Can you give us some examples, please?

BRONWYN PETRIE: Certainly, Trish, and it's lovely to see you again too. We know you've been in our shire at least a couple of times. Janelle, our local member, is very exercised on this issue as well. She and I have had a couple of meetings with the Minister, who said a few months ago that he would come up very shortly. We have a couple of complexities. We are a border community. Our shire boundary—if you look at the map of New South Wales, you'll see the straight line which finishes just above Tenterfield, and then it goes straight north pretty well for another 200-odd kilometres.

We've got three villages up there. We do have an arrangement with Queensland for them to go in, but there's an issue here in Tenterfield where there is a very obvious push from some people in our local hospital, and certainly from Hunter New England as a whole, to prevent transferring patients across the border. The number one argument with our local people is that interstate border transfer. Minister Hazzard had said they must be able to travel interstate if there's a bed available for them and the patient wishes to go that way. Time and time again, that has been refused.

There have been recent cases, because we've been pushing and pushing it, with follow-up meetings with Minister Park where they have actually offered that—whether the message is getting through depends who the patient is, particularly if they are a councillor or a member of the family. The issue being that Newcastle is a seven-hour drive away. Toowoomba is a two-hour drive away, with the same level of hospital service. Most people up this way do have their specialists either in Lismore, a two-hour drive, up in Toowoomba, also a two-hour drive, and Brisbane. In fact, the manager at one of our health meetings two years ago said, "We are Hunter New England, and they shall go south." He's since backed down on that a bit because I keep quoting it.

If someone is really sick, they can go up there and their family can go up and back in a day. We've got an agricultural community as well, so it's really important that someone can come back to the farm. Seven hours away is a huge impost for people, and Greg will explain further the issue about coming back. The other thing that we need is to stop having our services stripped. We need more staffing. There were public meetings here a few years ago because the ratio was dropped. We've got local nurses who have resigned. They had offered to be on call, and that wasn't accepted, so it's the ratio. We've got a new emergency department. We had a Coroner's inquiry into a death that happened two years ago. If you're speaking with Janelle, she can refer you to some of those issues.

If we've only got two nurses on, if something happens in the ward where we have older patients requiring care and to lift et cetera, they are often in there for potentially hours, unattended, whilst in emergency you have to have two nurses active there. The ratio is simply not good enough. We are also at the intersection of major highways. If there is an accident, you've got to have people coming in from ambulance, police and Fire and

Rescue, because we do not have sufficient staff there, as much as the manager may say that the ratios are fine. Janelle and I were informed that there is performance management in place. Prior to this, council has also requested a review into the running of the hospital because of the severity of the various complaints and the reported toxic culture. I understand there has been some improvement there, but it still needs to be better.

The other issue is a lot of people from here get transferred to Armidale—and then get crisscrossed between Armidale and Tamworth—with broken hips, and all sorts of dramas, or not attended to for a week, because every time they're scheduled for an operation, something else happens. So they are lying there, elderly patients requiring hip surgery. Only a few weeks ago, they were having to wait five days before the surgery could take place. You can imagine the pain they were in. When one of our councillors was in hospital there earlier in the year, I happened to be there with her. When they came to get her lunch order, they said, "There are no vegetables and no gravy"—this is Saturday—"until Tuesday," when they get the order in. I said, "Surely someone can purchase stuff locally?" They said, "No, that's not in place."

I'm not sure how that goes for patient care with people who require soft food and everything else. Once you get outside Newcastle, the whole system seems to be falling apart. As an another example, we did have a named doctor report that—one of the excuses we get is, "It's hard to get people to come out into the bush." We did have an anaesthetist who was willing to live in Tamworth and operate from Tamworth. He was refused registration in Tamworth by Hunter New England Health, but they offered him registration in Newcastle. I think that pretty well encapsulates it.

Ms TRISH DOYLE: Mr Deputy Mayor, would you like to add to that? Are there solutions that you see to the many problems that you've clearly outlined?

GREG SAUER: The Chairman asked what changes would be required. It's got to be no longer Newcastle-centric, as Bronwyn was summing up there. They seem to have the attitude that if everybody's fed down there, they can give all the good care down there. They forget, as Bronwyn said, we are seven hours away by road. We had a very tragic example of this some three or four years ago. An elderly gentleman was taken to Newcastle, had some sort of procedure—it just escapes me what happened—and he was left to his own devices to get himself home, unaccompanied. It's a train ride to Armidale and a bus from Armidale to Tenterfield. He gets in at eight o'clock at night, or thereabouts if it's on time. He was exhausted. He went to bed and he did not wake up the next day—a heart patient, abandoned. I don't even know whether they took him to the railway station or gave him money for a cab or whatever. That's an example. Unless their attitude changes, we're going to potentially have more of those cases.

As Bronwyn summed up, it seems to be a push to get them down south. My wife, during the influenza epidemic four or five years ago, being a bone marrow recipient from Royal Brisbane Hospital—her records are there. On that particular afternoon, they had agreed to take her. Yet when the aircraft landed at Stanthorpe to pick her up, because that is the closest strip that a fixed-wing can operate out of, they took her to Tamworth, even though Royal Brisbane was prepared to take her. They're making decisions to suit themselves, not what is best for the patient.

The CHAIR: We have Narrabri Council online. We have just had our first question to Tenterfield. The questions may be directed to Tenterfield or Narrabri, or both.

Ms DONNA DAVIS: I'll ask my first questions to Narrabri as they haven't had an opportunity yet. We heard the other day from witnesses that, in 2018 and 2019, Wee Waa hospital experienced significant changes to the operation of services and that there was very little action taken by the Government at that time to try to reverse that decision. We've been to Narrabri and seen the challenging situation that people are experiencing with the ED operating on reduced hours. Can you talk us through the changes that happened in that period and how that has impacted from 2018 through to today?

DARRELL TIEMENS: The Wee Waa hospital has obviously gone through a considerable amount of changes, and it's just this slow winding back of services, but that has also happened at Narrabri Hospital as well. I also wanted to reassure you that it's not just Wee Waa hospital that's a struggling hospital in our shire. Narrabri shire has got three hospitals. All three of them have had real [audio malfunction] and a lack of responsiveness. For instance, one of the challenges being with Wee Waa hospital, as I've mentioned, but a lack of consultation and a lack of engagement by Hunter New England Health. I'll give you an example. About a year ago, myself and the Deputy Mayor travelled down to Newcastle. We travelled down there to present to the Chief Executive and also a couple of the senior executives there with very constructive, well thought out thoughts and ideas around how to improve our hospital and medical services in Narrabri generally. They've been developed by clinicians, nurses, doctors, members of the public and experienced retired clinicians. [Audio malfunction] any of our thoughts or suggestions.

Ms DONNA DAVIS: It might be easier if you turn off your video. You're breaking up.

DARRELL TIEMENS: It's been very [audio malfunction] to engage with Hunter New England Health as an organisation. A year ago, the Deputy Mayor and myself travelled twice down to Newcastle to engage with senior executives. We gave them a whole list of ideas and suggestions, very constructive [audio malfunction] ways they could improve both the health services in Wee Waa and Narrabri. We gave them an extensive list. It was well thought out, well researched, supported by clinicians, nurses, many staff members and also patients who were based [audio malfunction] enough of the neglect, what they perceived to be the [audio malfunction] Narrabri and Wee Waa hospitals. We haven't received a response from Hunter New England Health about the ideas that we have had. We've been pretty much fobbed off. Never in the whole time that I've been mayor has Hunter New England Health ever reached out [audio malfunction] serious concern—

Ms DONNA DAVIS: This morning, we heard from Inverell Council, who have established their own local forum of health practitioners and a range of different experts and people from across their community.

DARRELL TIEMENS: They've established their own local forum?

Ms DONNA DAVIS: Yes.

DARRELL TIEMENS: Which I think is a wonderful thing. That hasn't happened in Narrabri shire. They have not done that. New England Health haven't done that.

Ms DONNA DAVIS: It was the Council that did it, not Hunter New England.

DARRELL TIEMENS: Yes. I have reached out to the executives at Hunter New England Health, as have senior members of our staff. We've been basically fobbed off by them. It is what it is. Our LHAC for Wee Waa hospital has not met in four years. The Deputy Mayor is a member of that, and it hasn't met in four years. The LHAC in Narrabri didn't meet for almost two years. It has just started meeting again in the last couple of months, obviously because of pressure. Our general thinking is that [audio malfunction]. Hunter New England Health needs to engage more with local levels of government. They need to respect the [audio malfunction] of government. They don't do that. We have very little engagement with them. I have texted a number of the senior executives there and we get very little response.

Ms DONNA DAVIS: Our Deputy Chair asked this question to Tenterfield. If the bill doesn't pass, what changes would the Hunter New England Local Health District need to make to improve health services in the New England region?

DARRELL TIEMENS: I think it would be a very sad thing for the bill not to pass. If it didn't pass, what we are calling for is an evidence-based approach by Hunter New England Health. We've called them out a number of [audio malfunction] made claims about—they were going to shut down Narrabri's pathology lab a bit over a year ago. There was an outcry from the community, with 500 people turning up to our local RSL. They reversed that decision thanks to Ryan Park, who has been a great [audio malfunction] has been fantastic, but he's being stonewalled [audio malfunction].

The CHAIR: We might just put a pause on that there. You're dropping in and out. The last thing we heard was that there was a community rally at a local hall about the shutting down of pathology and the decision got changed. You were reflecting on Minister Park being accessible and available.

Ms LIZA BUTLER: My question is for Tenterfield as well. I want to delve a bit more into what Ms Davis said, and that is around the unintended consequences. We have heard that the cost to split would be around $100 million in administrative costs. We've heard that you would lose your access to training facilities and that referral pathways may be harder for people because you would be referring from one health district to another, meaning that they would then fall to the bottom of the list. What is your response to those issues?

BRONWYN PETRIE: I think Mayor Tiemens also referred to an evidence-based approach, and I would question some of that cost. Certainly the cost would not have been as high had Tamworth and Armidale hospitals not been systematically—and we believe in a calculated way—degraded over these years. Had that not happened, a simple split would have been much easier to have occurred. Those decisions to downgrade those two hospitals to the level they have been falls squarely at the feet of Hunter New England hierarchy. If it costs $100 million, it costs $100 million. What price do you put on the health outcomes for people in rural and regional, let alone remote, New South Wales?

You've only got to look at the Country Mayors Association reports into the different health outcome expectancies of people who live in our districts. It is quite telling what has happened to Armidale and Tamworth hospitals, let alone our own one, which was a 66-bed hospital with operating facilities, obstetrics, et cetera, and is now down to about 13 or 14 beds. It is just absolutely criminal. I'm not sure about the access to training. We aren't

one state. I'm sure that the New South Wales Government would make provision for training to be available for the non-metropolitan health districts to have access to training facilities.

With regards to referrals, we have patients who get referred into Lismore public hospital, in the Northern Rivers Health District, of which, as I said, part of our shire is already part. Depending on what happens when the chopper arrives, they often determine where someone has to go, so they're already going into another health district as it stands. That is facilitated through those existing arrangements. If it was split, I would expect those transfer arrangements to recognise the intricacies of rural and regional areas requiring a higher level of service, or even on those border arrangements, where residents might be closer to the neighbouring health district than the one they happen to be in. The other thing is there used to be a visiting medical officer capacity here and in many other towns. Hunter New England has killed that off at huge cost—massive cost—with visiting doctors, locum doctors and everything else at several thousand dollars a day, as opposed to our local GPs being able to practise in there and visit their patients et cetera. There's been a real increase in costs that was unnecessary and could be reversed.

I do understand, through Susan Heyman, that that's something they were looking at. But I have to say, as a resident—and this is our rule too in our family; we're on farm—if you're a little bit hurt, you go to Tenterfield hospital. If you're really, really hurt, you ring 000 to get to Tenterfield hospital and get out, because you know you're going to have to leave. But if you're in between and you know you need an operation, you drive as close as you can to Stanthorpe, over half an hour away, before you ring 000, because you do not want to end up in the Hunter New England Health system and head to Armidale, then to Tamworth and then to Newcastle. That's a pretty crook way to be living up here where we are.

Ms LIZA BUTLER: I'll ask my next question to Tenterfield. As Ms Davis said, we heard this morning from Inverell that they have organised and arranged a health forum with a range of stakeholders. The feedback they provided this morning was that the Hunter New England Local Health District is really working well with them. Do you think that that is required to create better communication and pathways of what individual regional communities actually need and having Hunter New England Health respond to them, instead of splitting the health district?

BRONWYN PETRIE: As I said, only three years ago the whole New England Joint Organisation of councils—Armidale, Walcha, Uralla, Glen Innes, Inverell, Gwydir and Tenterfield—unanimously voted to split. Unlike Narrabri, who have been fobbed off by Hunter New England, we have had quite a few engagements with the Hunter New England Health hierarchy. We have not changed our mind because we have not seen the level of service that should be provided, and we continue to see the erosion of the Armidale and Tamworth hospitals. Getting back to what Trish asked earlier about if the bill doesn't pass, I think it's fundamental that Tamworth and Armidale be returned to high-level hospitals, not just focusing everything on Newcastle, so that the higher population areas don't get as much kickback from down there that they're getting from the rural areas that are being treated so appallingly.

Ms LIZA BUTLER: Would the Mayor of Narrabri like to respond to those two questions? And the other person online there who's been very patient, Councillor Towns.

DARRELL TIEMENS: From our point of view, 15 years ago there were eight health districts in New South Wales. They were split into 15 health districts, and Hunter New England Health argued that splitting would fragment care, duplicate systems and cost millions and millions of dollars. They've used these same old arguments. It's just the gift that keeps giving from Hunter New England Health. The lived experience is very different from us. Moree was talking about double diversions. We get more than just double diversions; we get diversions from Wee Waa to Narrabri to Tamworth down to John Hunter. Sometimes John Hunter is on diversion, and you end up in one of the hospitals in Sydney. The lived experience is pretty bad.

I'm with the Mayor of Tenterfield. I'm not sure that even engagement and better communications is really going to do much, because these bureaucrats are really good at what they do: They are really good at diverting the resources from rural and remote parts of their vast area, half the size of New Zealand, and sending it back down to Newcastle. We're used to it. We are just used to our nurses, our doctors and our clinicians being squeezed of resources in our hospitals and sent back down to Newcastle.

I want to introduce Ethan Towns for a moment. He's one of our young councillors. He's a young Aboriginal fellow who's just finished his PhD. He lives in Wee Waa and was born at Wee Waa hospital. I thought it would be useful for him to present some of the rationale behind why we need strong towns and strong hospitals in these towns. He's the kind of generation of young Aboriginal people that we need in our local towns. He's definitely not going to stay, and none of his mates are going to stay, if they don't feel safe in their town. This is what the lived experience is not just for the young Aboriginal people but for the community more widely. I thought it would be good to get Ethan to say a few things—he's just standing next to me—while we jump in an Uber.

ETHAN TOWNS: I'm 27, from Wee Waa. I was born back in Wee Waa hospital when they used to allow maternity and to be born Wee Waa hospital, one of the many things that have disappeared since Hunter New England Health has taken over. This year's theme for NAIDOC is "The Next Generation". I opened all of the NAIDOC ceremonies in Wee Waa, and the next generation has asked me, "How's the hospital going?" I look at them and think that it's not going well. The town is dying. One of the big reasons Aboriginal people have left this area, out in the country—and we want them to stay out on Country—is simply because they need access to better health care.

Young families like my sister—her daughter has epilepsy. They're likely going to have to move. She's a principal at the schools. We lose so much more than just the hospital; we lose all the people that make up a town and educate the next generation. It's not fair that a single health organisation is literally eroding away people's lives. Out where we are, every single ambulance is basically a glorified Uber driver, and they get bypassed straight from Narrabri half the time. My friend's mother last month got into an ambulance because they thought she was going to have a stroke. It's an hour-and-a-half drive to the next hospital that looks after strokes from Wee Waa, and the ambulance crashed on the way. It's a dangerous job, a dangerous style, and it's not fair. Things need to change. The model isn't working.

The CHAIR: I said at the start that there have been inquiries through New South Wales Parliament in recent years around the levels of health delivery across New South Wales, particularly in regional, rural and remote areas. All of those reports identify the shortened life span and reduced levels of service. In this particular inquiry, we're trying to understand, what is the Hunter New England Local Health District particularly well or particularly badly that is somehow different from what is occurring in every other regional, remote or rural health district? For example, you've got Western to your side, Far West out there, and Murrumbidgee down the bottom of the state. That's really the focus for us—just this idea about splitting.

To go back to the question about setting up a new level of administration and that costing somewhere in the vicinity of $100 million, even if it was half of that, that would be another $50 million going into administration instead of frontline services. Could you possibly explain to me how spending another $50 million on frontline services might somehow bring about an improved level of health care, given that that $50 million is going to admin as opposed to health care? I'll start with the representatives from Narrabri.

DARRELL TIEMENS: With all due respect, Chair, I think $100 million, given the plethora of AI tools and various other things that are taking place—

The CHAIR: That's why I said I'm happy to accept it's half of that. Let's work on 50.

DARRELL TIEMENS: I'm not even going to accept 50, to be frank, because a lot of the tools that they're talking about highlighting are contributions to statewide platforms. Most of the platforms are NSW Health platforms. They're not unique to other Hunter New England Local Health District. I've read their submissions. Their submissions are exactly what you'd expect from people trying to protect their turf. We just don't accept that. At the moment, we have huge failure in our remote and rural parts of the community. If it costs an extra $50 million, which I would challenge, to mean that Wee Waa hospital stays open 24/7, there's an emergency department and a doctor assigned to the local hospital, to support our Indigenous community and the rest of the farming community, so be it.

Narrabri shire is a bigger economy than Armidale. Our gross regional product is the tenth largest in the whole of the local health district. We're a huge area—we produce huge amounts of the food, fibre, coal and energy needs for this State—and yet we have Third World health situations. When one of the professors, the head of NSW Pathology, visited Narrabri Hospital, he said the services were so paper-thin at Narrabri Hospital. He spoke to the clinicians and was shocked, simply because of the lack of resources, at how they were able to provide the quality services that they were.

The CHAIR: The question about Hunter New England health district and having another layer of administration would be a little bit like putting a proposal to you that you separate Wee Waa from Narrabri council and allow Wee Waa to set up a whole new administration.

DARRELL TIEMENS: This is the only health district in all of New South Wales where there's a big metro area and a huge rural and remote rest of the district.

The CHAIR: Correct.

DARRELL TIEMENS: If that logic prevailed, why don't you merge all those 15 local health districts back into the age that they were 15 years ago? I understand the logic, but I think you need to challenge these bureaucrats who are feeding lines to the wonderful Health Minister and the Premier. [Audio malfunction] to be frank, are exaggerating the amount of administrative nightmare that it would be by splitting up this district. I think

it should be split up into three health districts. There should be the metro area around Newcastle, the Hunter and then the New England.

The CHAIR: We are already over time, and I do want to give Tenterfield the opportunity to respond to my question. If we end up spending more money on another layer of administration, how do you see that as potentially bringing about a better health outcome and delivery of health services given that X amount of dollars is going to be spent on administration as opposed to frontline services?

BRONWYN PETRIE: I think it comes back to what the Mayor of Narrabri has said. It's about distance, service availability and the fact that you do have this monstrous—the admin is centred in that metro area, so their focus is on delivering the services there. If that was excised out, the focus would be on delivering services in our regional, rural and remote areas without being tainted by stressors of what was required in that massive metro area. If the reason was just to reduce administrative costs, why not join the Far North and the Mid North Coast and save $100 million there? You've only got to look at the disparity.

If Newcastle had been located where Tamworth or Armidale was, there might have been a different outcome. They are right at one end of the place. It's the decisions made by the administration, that's the issue. Those decisions have been to systematically downgrade every single hospital outside of Newcastle, which has led us to where we are today. If there had been a fair and equitable delivery of health services throughout the area, we wouldn't be unhappy. But this has not happened. Despite years and years of protest, it's still not happening.

The CHAIR: Mayor Petrie, your suggestion about joining Northern Rivers Health District, geographically, that might be applicable to Tenterfield, but it certainly wouldn't be applicable to a whole bunch of other parts of the Hunter New England health district. Am I correct?

BRONWYN PETRIE: To save administrative costs, if it's going to be $100 million extra to split Hunter New England, if you use that logic, you would get rid of the Far North Coast Health District and the Mid North Coast Health District. You'd just join them together and save yourself $100 million every time. I'm supporting what the Mayor of Narrabri has said.

The CHAIR: Sorry, I misunderstood. Earlier in your evidence, you did talk about that there could be an opportunity for Tenterfield to be in that Northern Rivers as opposed to Hunter New England Health. I've just confused it in my mind. I apologise.

BRONWYN PETRIE: No, that was as a last resort, because ambulance really—we're on the top of the range. You've got 125 kilometres of no phone service that obviously ambulance don't want to take. That is completely as a last resort. That was in our desperation of trying to not have our patients go from here to Glen Innes, Armidale, Tamworth, back to Armidale and then sent off to Newcastle and dying meantime. I don't want my people dying anymore, as multiples have. It's the time to get that medical service. They're shunted from pillar to post. We've had that many cases just in the last 12 months. It's ridiculous.

The CHAIR: Thank you all for appearing before us today. I also want to acknowledge the difficulties that faced the mayor and councillor from Narrabri Shire Council in terms of weather delaying their flights and making it not possible for them to be here in person, even though they've made an incredible effort to do exactly that. I also want to thank the Mayor and Deputy Mayor of Tenterfield for your valuable time that you have spent with us today.

Going forward from here, we will send you a copy of the transcript of your evidence that's been provided today. You may seek to make corrections around that if you think that we've somehow misheard or misquoted you. There were times today when it did drop in and out, so that may be something you want to pay attention to. We as a committee may also develop supplementary questions that we would seek to send to you in the coming days. We would ask that you respond to those as well if that's possible and to do it in seven days. If that's not possible, please talk to us and we will work from there.

(The witnesses withdrew.)

Dr ERIC BAKER, affirmed and examined

The CHAIR: Thank you for appearing before the Committee today to give evidence. I just note for you that members of the secretariat will be taking photos and film that we may seek to use on our social media pages. If you have any concerns about that, please talk to us and we're happy to oblige by not using those images. Before we start, do you have any questions about the hearing process we're about to embark on? You don't. Dr Baker, we

of course do have your submission, submission No. 55. Would you like to make a short opening statement to lead us into some questioning?

ERIC BAKER: I think I wrote that when I was a little bit upset after a couple of bad cases involving trying to get people out of Guyra. I'm a locum doctor. I've retired from Armidale. I was 40 years in Armidale, and now I'm virtually restricted to doing locums in Guyra because that's more than enough work for me. I think I put my points there. I have not a lot of opinion on whether Hunter New England should be divided up or not, but I did outline in my submission that there were major issues. Number one is support for rural hospitals, which I've just heard from Narrabri and Tenterfield. You could say the same for Armidale, Guyra and Walcha, where I've worked a couple of years.

Obviously there's a huge amount of stress on the medical service because of the lack of doctors. They are just not able to get enough doctors out there. That's why I'm nearly 75 and still getting called up to do locums when I'd far prefer to be retired. That's probably a separate issue. That's not necessarily an administrative issue, but you do see issues where administrations—through Hunter New England, for instance, they recruited a doctor to go to Guyra because there are 3½ thousand people there and one doctor who's over 60, and that's more than three times the national average and he's trying to cover the hospital as well. They recruited a doctor to help him but he ended up being a first-year trainee not able to work in ED. You think, "Well, that was a great decision."

I think the other issue I put there was—maybe I did put it in—support for locums because that was very problematic. It took me a long time to actually have a contract when I was working there when I started because the administration just couldn't get me a contract. I had to go because the other doctor was leaving, and some weeks later after I'd finished I got the contract. That has improved because they've actually, because of those problems, allocated people to start to look after locums in the area. But it was a worry because I was working without insurance there—the Treasury Managed Fund insurance—for quite some months.

I was talking with a friend of mine who's in Armidale. He's a very experienced doctor in his mid-fifties. He has every qualification—obstetrics and very good ED qualifications. He lives in Armidale and he will not work in Hunter New England. He does nothing but regular locums, and he says that he'd prefer to drive a day to Coonabarabran, Coonamble, to western or far western because there, he says, if you have problems, you ring the base and they provide a service for you. You talk to people about the case. You get the transports you need depending on the urgency of the case. He just said his experience in Hunter New England was not good, and it's the same as mine.

The CHAIR: Can I just interrupt there, because I'd actually like to ask a question specifically about that example you just gave. So we have a doctor now who lives in Armidale who is very experienced. They actually travel out to western New South Wales to do locum work.

ERIC BAKER: Yes. He prefers western.

The CHAIR: And sometimes there are complexities where you want someone else to talk through that. As a doctor, you want to talk through that with someone else and get a second opinion or a different set of eyes. When you said "call back to base", does that mean Dubbo base or Orange base?

ERIC BAKER: Western is Orange.

The CHAIR: As the centre?

ERIC BAKER: Yes, that's the base hospital. But Dubbo is very good too, apparently.

The CHAIR: So when he travels into western as a locum, if he needs that second opinion or different set of eyes or whatever, that seems to be pretty streamlined and easy. But your experience and his experience inside Hunter New England Health is that—who would be your base that you rang? John Hunter or Tamworth?

ERIC BAKER: John Hunter.

The CHAIR: And sometimes they don't take the call or there's not—

ERIC BAKER: It depends on where I think the patient needs to go. I've had good experiences. I had a guy in the middle of an acute infarct and I got onto the cardiac support in Newcastle. It was excellent. We just went tele with the whole thing and the guy there was terrific. That service is set up for that and it worked incredibly well. I gave an example in my submission where someone had a large tumour eating through one of his vertebrae and also compressing his spinal cord. He was unable to walk. It took 10 days. At any time, that vertebra could have collapsed and he would have been paraplegic. The amount of talking to try and get that guy moved out of Guyra was just unbelievable—three calls to Newcastle, two to Tamworth. This is over days because no-one wanted to take him.

The CHAIR: Forgive me, I thought that within the health district there wasn't a choice about taking a patient that needed that service.

ERIC BAKER: It's a problem. If you get onto a registrar, registrars can be three years out and think they know everything. They can be senior registrars who are absolutely excellent, but you do quite often get a reception—I'm the locum VMO in Guyra and they think you know nothing. The problem with this chap was I said, "You've got all the CT results there. It's on your screen. You've got the reports. You've got the protein analysis. This guy's got some sort of haematological tumour", and the registrar said, "Where's the MRI?" I said, "We don't have an MRI." He said, "We're not taking him without an MRI." I said, "Well, we don't have one. There's one in Armidale. It's a private one. It's down for 10 days." So he said, "You better ring Tamworth then because we're not taking him without an MRI."

The CHAIR: This is within the health district?

ERIC BAKER: Yes. Then it took three days just to convince Tamworth because they said, "We're not taking a case like that. That's too risky for us."

The CHAIR: There is something important about the work of a doctor as a VMO that I wanted to touch on. Your experience has been to be a local GP in Guyra and a VMO—

ERIC BAKER: I'm still a VMO at Armidale Hospital. Even though I've retired from practice in Armidale, I'm still actually on the—not that I'm doing any work there.

The CHAIR: Because in your submission it said you were a VMO at Armidale, but you at the start said you're only doing locum work now.

ERIC BAKER: At this stage, yes.

The CHAIR: My apologies. Talk to us about the process of being a local GP and getting signed on to be a VMO. Obviously, VMOs play such an important role in our regional and rural hospitals in terms of the EDs and the after-hours service at the hospital et cetera. We have heard some concerning reports suggesting that there are sometimes barriers to getting signed on as a VMO, it's difficult or negotiations fall down, or whatever the case is. Can you tell us about how that might work?

ERIC BAKER: I signed on 40 years ago.

The CHAIR: It might have been simple back then. But surely you talk to people now.

ERIC BAKER: I've made sure I've renewed every time. But, for instance, I talked to this other locum, [redacted by Committee agreement], who I was telling you about. I said, "Look, they really need people at Guyra. You should get signed up again." He said that when he went to do it, they said, "There's a whole panel of education you've got to do on how to use the prescribing program, how to wash your hands." There's 20 minutes on handwashing and then you have a 10-minute test at the end. It's a few years since I've done it, but it's hours and hours of work. There are various other things about cultural sensitivity and so forth. It's a while since I've done it, but he did it and he said, "I did that four or five years ago when I was a locum," and they said, "No, you've got to do it again." He said, "I don't want to sit down for another 10 hours and do all that again just to go to Guyra and be a locum for two weeks." He said, "I'm not that keen," because I was trying to talk him into it because the situation there was so bad.

Ms TRISH DOYLE: Thank you, Dr Baker, for your very measured response to very difficult situations. Thank you for your submission and for being with us today. Regardless of whether this bill, which would potentially split the local health district, passes or not, I'm interested in a comment you made in your submission. You said:

> … the central culture of not having knowledge nor respect for the needs of the outlying and less resourced areas needs to fundamentally change.

In your view, how can this culture be changed? What are some of the steps? What are some of the solutions here?

ERIC BAKER: I outlined one, where you can have a culture in the base hospital where the registrars and the clinicians are educated as to what goes on out in the bush, so to speak. If I go back 40 years, when I started in Armidale, Armidale Hospital was a self-governing hospital. It had a board and a medical staff council. It had very few administrators, amazingly. It had an accountant, a secretary, 180 beds, a medical superintendent and a director of nursing, and each one of those two had a secretary. We were attached to St Vincent's Hospital in Sydney, and the arrangement was that that was our referral hospital. That meant that St Vincent's supplied doctors to Armidale Hospital, which was very useful because when you rang people in St Vincent's, especially the registrars, quite a lot of them had been to Armidale and knew what the situation was. I wouldn't have necessarily

expected them to be turning up at Guyra, but it was good if they knew what was out there when they were taking these calls.

You all know about recruitment. It's a terrible situation at the moment. When I'm at Guyra, I'm encouraging the RNs. The RNs there are just terrific. I cite the example of me being on the end of a phone driving to Guyra hospital, and by the time I got there all the work was done. The drips were up, the IV antibiotics had been given, the blood cultures had been taken, the blood gases had been done—all the blood work was done by two RNs who were there. The only way I can see it in the future is to encourage more clinical nurse consultants out in those areas, because for ED presentations clinical nurse consultants would certainly have all the abilities needed to do 90 per cent of that work. The humorous thing was when I got there, I said to the RN who was in charge, who'd done all the work, "You didn't even need me here." She said, "Yes. You pay the bigger insurance premiums."

Ms TRISH DOYLE: Thank you for sharing with us some of your thoughts.

Ms LIZA BUTLER: Dr Baker, thank you for your submission. I can hear your frustration coming through today. I want to explore one of the staffing issues that you brought up in your submission around a radiographer or a sonographer. You stated in your submission that the cost would have been negative because of the Medicare rebate. What do you see as the barriers for the health district not providing that other employee and then actually losing an employee because of it?

ERIC BAKER: I won't comment on that because it might have involved personal issues between who was managing somewhere else and their relationship with the staff at Armidale.

Ms LIZA BUTLER: Since that time, have they now got one sonographer or radiographer, or have they got two? Is their workload still—

ERIC BAKER: I can't tell you now because I haven't been there.

Ms LIZA BUTLER: If we didn't split the health district, what do you see that really needs to happen for services to improve west of the Great Dividing Range?

ERIC BAKER: There's got to be some sort of autonomy out there to make decisions. We had the situation a few years ago when we needed equipment in Armidale, and the CEO said, "Well, it'll take months because I can only approve things up to $1,000." At that time it was a hospital with a $60 million budget. Things had to go up the line just to get a piece of equipment approved. So some autonomy, and also having communication to get a few things done when it's necessary.

Ms LIZA BUTLER: Do you think there's a lack of communication between regional hospitals and the decision-makers in the Hunter?

ERIC BAKER: The channels aren't clear. That's one of the things. If there were problems with medical equipment, we had a medical staff council that would meet. They would then meet with the director of nursing, the CEO and the medical superintendent. We would discuss those things, and things would get done or not get done. But the channels of communication, I just don't know what they are anymore, if you know what I mean.

Ms DONNA DAVIS: Thank you for appearing today. I have a question but first I want to go back to the scenario that you spoke about with the patient where you were advised by the junior registrar that they needed the MRI and then Tamworth said no, you've just got to push for—

ERIC BAKER: Yes.

Ms DONNA DAVIS: Is there a known pathway to escalate an issue like that at Hunter New England? Is that maybe the challenge in your situation?

ERIC BAKER: I didn't know it. I eventually got onto a haematologist in Newcastle who escalated because I had the data saying this looks like a haematological tumour. I rang them. They looked at the scans, got back to me and said we've got to do something. So that got things moving—at least at Tamworth. I mean, it should have gone straight to Newcastle a week before.

Ms DONNA DAVIS: But, administratively, are you given a line of command that you can follow? Or do you think that's something that's currently missing, which is that, if you're in an unusual situation or you're getting roadblocks, you should in your position as a VMO, or as a locum, be able to escalate to someone about a serious issue?

ERIC BAKER: That's right. I suppose with that sort of thing in the old days, you would have rung the medical superintendent. But who the medical superintendent is and how you get onto them—I just wouldn't know. I don't know if the medical superintendent for, say, Newcastle is available to talk about those things either.

Ms DONNA DAVIS: Yes, maybe rather than getting you to redo the same training every year, you should—okay. The district submission stated that a split would cause disruptions to clinical placements and reduce opportunities for medical training. Could you comment on the level of support the district provides to students and trainees at sites in the New England region? I know you've referred to the past, but what about currently?

ERIC BAKER: I can't really. My only experience with training has been training the registrar who came. I've trained registrars for 30 years—and medical students, because we've always had medical students from the Joint Medical Program coming through our practice because we were sort of one of the biggest practices in Armidale. But I can't comment on the actual hospital experience. I gave one example there where the nurses turned up and there was no internet, which rather shocked them. I had to tell them I'd been battling for two years to try and get internet.

Ms DONNA DAVIS: How long ago was that?

ERIC BAKER: That was about the best part of a year. We've got internet. Apparently one of the local councillors heard about it and took it to the new member, Brendan Moylan. He got onto someone so, eventually, it's now there.

The CHAIR: I was literally going to ask about that because we've heard from a lot of our witnesses in submissions that attracting and keeping staff is difficult et cetera. I read in your submission about that internet problem, which I thought to myself that this has to be such a simple fix to make it attractive and enjoyable for a health worker while they're staying in the health accommodation.

ERIC BAKER: Sure, but the local manager was unable to do it because she said it has to go through IT in Newcastle. I went and saw the medical superintendent in Armidale, and emailed the local area manager about the situation. They both said, "Yes, this is going to happen," and ordered it. We arranged to get it done. Then it was the best part of—many months went by and nothing had happened. I talked to the local manager. She said it's got to go through Newcastle, so we've just got to wait. Anyway, through political channels, that got done.

The CHAIR: I imagine that in health there would be somebody—I get that you've got your nurse manager and your clinical processes, but wouldn't there be a role that's like an infrastructure person who would have responsibility for all the buildings and the practical facilities within the buildings—piping, plumbing, hardware, door jambs, tiles, paint and internet?

ERIC BAKER: My understanding is it just goes through the local manager who insources—or outsources—all that sort of work because there's no local maintenance onsite. They're battling to pay the RNs there and battling to pay the wages, probably, without having an extra person.

The CHAIR: The other part of your submission is, "After a year of no action, I stopped doing 24 hours on call"—and you've got the costings there—"and left the night ED on call to the tele-doctor service", which has got to be at least three or four times more expensive.

ERIC BAKER: The fee for me to be called out at night after hours is, if it's a not a category 1 or 2, about $150. If it's category 1 or 2, it's about $250. The tele-doctor I've heard—I don't know exactly—is $550.

The CHAIR: Yes, $550 is what you have in your submission. Importantly, I want to ask, the tele-doctor fee comes out of the local Guyra hospital budget—is that right?

ERIC BAKER: That's what I got from the manager, yes.

The CHAIR: By comparison, if you continue to be available on call, which budget does that come out of?

ERIC BAKER: I presume it's Guyra's again, isn't it? Because they would be paying for all of the VMO. The $16 an hour overnight, do you mean?

The CHAIR: Yes. From the phrasing that you've used and the way that you've structured, characterised and described the problem, I was thinking maybe the telehealth doctor comes out of the local hospital budget, but somehow, as a VMO or something, you might come out of the Hunter New England Health bucket of money.

ERIC BAKER: I'm not sure, but I think it's all the same.

The CHAIR: I'll check that with Hunter New England Health. We have them coming in this afternoon. The other thing I was going to ask about was onsite managers of the different health facilities. You've been in the area for a long time. Do the managers tend to swap and change quite frequently, or do you tend to get someone who sticks and stays for some long time?

ERIC BAKER: In Armidale, they've turned over. I've only been there just coming up to three years—back and forth to Guyra—and it's the same manager. It's the same at Walcha, so they haven't changed in three years.

The CHAIR: Three years, in my mind, isn't a long time.

ERIC BAKER: No. I haven't had experience with those hospitals, but three years would be a long time at Armidale.

The CHAIR: Would it?

ERIC BAKER: I'm not sure how quickly they have been changing. For instance, the manager changed when I had that internet issue. The local area manager changed during that time, so the emails had to go somewhere else after that.

The CHAIR: I just want to double-check something that you said earlier about this $1,000 expenditure limit for the local CEO of the hospital.

ERIC BAKER: That was some many years ago. That was probably halfway through my—that could have been 15 or 20 years ago. That was the situation that the CEO of the hospital, as he was called then—he was an excellent manager. I met him and I said, "You've left." He said, "It's just too frustrating." It wasn't really a manager's job. Everything had to go higher and that was it.

The CHAIR: Did that particular manager—and I'll specifically ask you to not name him—leave the health system and just go and do something else or did they change to a different job within health?

ERIC BAKER: I don't know, actually. Sorry.

The CHAIR: Again, attracting and retaining staff is a problem across the board. Hunter New England Health have recognised that they've got 3,000 vacant positions right now, as of their submission. I wanted to ask about any updates you might be able to provide about the slit lamp for examining eyes. It broke down at some stage and was never replaced. Is there any advance on that?

ERIC BAKER: No. The X-ray machine is fixed.

The CHAIR: So the X-ray machine broke down for two months.

ERIC BAKER: Yes, and a few weeks after I wrote that it was fixed again. I'll put more pressure on for the slit lamp because they are only a-couple-of-thousand-dollar items. The expensive ones and the nice ones are $5,000, but you don't need that.

The CHAIR: But for the patient who arrives with a foreign body in their eye—

ERIC BAKER: I've had a number of foreign bodies I've had to send off to Armidale.

The CHAIR: So the patient has to go off to Armidale because the slit eye—

ERIC BAKER: Yes, because it's not there. It broke down and it hasn't been replaced.

The CHAIR: In instances like that, are you calling an ambulance to do that transfer?

ERIC BAKER: No.

The CHAIR: Thank you for appearing before us today. Two things are going to happen. Number one is that we will send you a copy of the transcript for any corrections that you may seek to make. We ask that you turn that around for us. The other thing that might arise is that members of the Committee may develop some additional written questions that we might like to send to you as well. If that happens, we ask you to try and turn that around in seven days, if that's possible. If that's not possible, please talk to us about that and we will work on an alternative arrangement. The Committee will now take a short break and return at 11.30 a.m.

(The witness withdrew.)

(Short adjournment)

Ms SUSAN SARGENT, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our next witness. Thank you for appearing before the Committee today to give evidence. Members of the public are not permitted to film or photograph during the hearing. Please note that

Committee staff will be taking photos and videos during the hearing that we may seek to use for our social media purposes. If you don't want to be used in that way, please let us know and we will make sure that we do not use your image. Before we start, Ms Sargent, do you have any questions about the hearing process?

SUSAN SARGENT: No, all good.

The CHAIR: Would you like to make an opening statement before we start our questions?

SUSAN SARGENT: The main thing I want to get across is that splitting up at the moment is going to not really fix a lot of the issues that we already have. We work in quite a fragmented system, so splitting up is probably only going to make that worse.

The CHAIR: I understand from your submission that you are a nurse and a midwife.

SUSAN SARGENT: That's correct. I'm dual registered. I work across medical, surgical and maternity.

The CHAIR: One of the things that we have been hearing about in this particular inquiry—and I know that Parliament has heard about it in other inquiries—is the shortage of maternity services, which in part is connected to obstetricians and midwifery and the number of midwives we have. Thank you for the work you do. I am going to start the questions, if that's okay. Obviously we have your submission, but could you outline the pros and cons of what you think would come about if the health district was to be split into two?

SUSAN SARGENT: As I mentioned, we are very fragmented already. I can tell you lots of stories where I had to try and transfer someone and it just hasn't worked. I also worked down in Murrumbidgee. That gives me a bit of perspective into how a health district works that doesn't have a tertiary centre, which is one of the things that would happen if we were split up. We would be administered from Tamworth rather than from Newcastle. A big issue with that would be that we would have no tertiary referral centre. Transferring someone who needs a high level of care is already difficult. If we are transferring to a different health district, that makes it 10 times harder. You've got that extra layer of patient flow, they need to talk to a different health district and you've got ambulance issues across health districts. I can't even get someone from Narrabri to Armidale at the moment, which is within Hunter New England, without a whole lot of difficulties. Not having that tertiary centre takes away that extra level of care.

We were restructured last year into the Hunter and into New England, roughly. It hasn't fixed any of the fragmentation at all. I think formally splitting the district is not going to make any difference. We still have staffing issues. There are a lot of difficulties, as you are aware, of recruiting and retaining staff in rural areas. You could put in place some systems that, if they're recruited to the Hunter end of the district, they have to rotate out to rural. You might not be able to do that if you split the district because it's completely separate. Those are the main things. I've sat here at 11 o'clock at night for three or four hours on the phone trying to transfer out a woman in labour because we're on bypass. I've got nowhere—the destination has changed three or four times. The systems don't talk to each other—absolute nightmare.

I'll give you an example from Murrumbidgee. Our tertiary referral centre was Canberra. That's not even a different health district. That's a different state. So none of the systems talk to each other. Murrumbidgee is on eMR. Canberra have a different version of eMR. They don't talk to each other. They're not connected. The same thing happens here if we're trying to transfer to Sydney. They don't talk to each other—total nightmare. So I sent this poor lady out to Canberra. She had her baby. Canberra discharged her with a less than 24-hour stay. We were not aware that she'd been discharged. She called us 48 hours later in absolute tears, because everything had just fallen to pieces around her and we ended up having to readmit her for three days. Those are some of the issues that you find when you've got this fragmented care. Splitting us up isn't going to fix that in the short or medium term.

I've seen a lot of stuff online, particularly from the mayors and the councils that they'd love to have their own administration. And, yes, absolutely, that would be wonderful. We would love to have some administration out here, particularly around Wee Waa. Everyone knows about Wee Waa at the moment—the difficulties there. But I don't think splitting up Hunter New England is going to fix that problem either at the moment. I think we'd be far better off to look at perhaps the funding arrangements, look at having some administration centres here that stay within Hunter New England so we do have that tertiary support.

The CHAIR: Susan, can I ask you about something that you mentioned partway through there. You said that there was an internal restructure last year. Is that what you said?

SUSAN SARGENT: Yes.

The CHAIR: Can you please give us some advice about what that looks like, how that works in practice and what was the point and purpose of it?

SUSAN SARGENT: I can only give you the perspective of a clinician who works on the floor. I obviously wasn't involved in any of the high levels of that. Previously we were split up into clusters. We had Mehi sector, we had Peel sector, and Tablelands sector, which was around Armidale. Those are all gone now. They've moved it so we've got New England north-west, which is us up here in the boonies, and then there's Hunter and lower Mid North Coast. So basically it's two areas now, rather than a whole lot of little ones. From a clinician's perspective, it hasn't made a lot of difference except that we don't all know who our upline managers are anymore.

The CHAIR: Is one of the outcomes of that that there is decision-making being made closer to the New England area? Is that one of the outcomes?

SUSAN SARGENT: Probably it was intended to be that way. I'm not a decision-maker so I don't know how that works in practice specifically but, discussing with a former health service manager, she thinks there might be actually an extra layer to get to a decision-maker.

The CHAIR: I wanted to ask you about the IT systems as well. You use an IT system presumably where you are working.

SUSAN SARGENT: Yes.

The CHAIR: Inside of the health district, does that talk across the entire health district?

SUSAN SARGENT: Certain systems—some of the clinical applications definitely do talk across the entire district. But we are also still paper based for a lot of it so a lot of it doesn't. It's really frustrating. I think we're the last health district to still be paper based.

The CHAIR: Do the IT systems from one health district to another health district—if we stay in New South Wales and don't transfer to Canberra, do the IT systems across health districts speak to each other?

SUSAN SARGENT: No, they don't. Not at all. If I send a woman to RPA, for example—which has happened—I have to print stuff, I have to photocopy stuff, send it all across. The same thing would happen if they were transferred back and then sometimes it doesn't happen because they think we have eMR and—yes, nightmare.

Ms TRISH DOYLE: Thank you, Susan, for your very frank and fearless sharing of knowledge and some of your ideas about how to perhaps get around some of the problems that you've identified. Thank you very much for your work. With an administrative hub in a rural centre and attending to some of the solutions to the problems that you've identified—sharing information, what you've just been talking about. If there was a rural hub or an administrative hub in a rural centre, what functions particularly—you've identified IT. But what other functions would the local health district be best to deliver in that rural centre through an administrative hub?

SUSAN SARGENT: One of the biggest issues that we as clinicians have is patient flow. We have a wonderful patient flow unit in Hunter New England and they do a fantastic job. But sometimes it just doesn't work. I read a news article. The doctors in Tamworth were complaining that it was difficult to transfer a patient to Newcastle. There's a whole lot of communication issues there. We have the same issue transferring from here in Narrabri to Tamworth. There's just a whole lot of layers of communication that you have to go through. If I was transferring out a woman in labour because we're on bypass, the doctor would first have to find an accepting doctor, we'd have to speak to the transfer coordinator and then it all has to go through patient flow. Then we have to contact ambulance. There's a whole lot of layers that take me away from that labouring woman just to get her somewhere through this tiered network to have a baby. The destination can change. That, from my perspective, is a huge one that we really need to have sorted out from our rural perspective.

Ms TRISH DOYLE: I know there are quite a few questions that my colleagues have, so I'll leave it there and again say thank you, Susan.

Ms DONNA DAVIS: I know it's a little tongue in cheek, but sometimes it can be frustrating trying to move a patient from one ward to the other, can't it, let alone from one hospital.

SUSAN SARGENT: Absolutely. We only have one ward so that's not too problematic.

Ms DONNA DAVIS: In your submission, you say:

> Having worked in other districts that frequently require transfers to other health districts, even another state system, I can tell you that moving a patient to another separate health district is far, far worse than the patient flow system we have here. Until we have statewide linked systems to facilitate these movements, changes to LHDs should not be prioritised as they would further fragment care, which is shown in research to have poorer outcomes.

With that in mind, could you elaborate on your support for the abolition of all health districts as separate entities?

SUSAN SARGENT: We're all NSW Health. Sorry—not necessarily the complete abolition of health districts as an entity, but we definitely need more statewide systems that speak to each other. If I could log in—or patient flow, probably, would log in—and say, "Okay, we've got a bed in Sydney. Off you go", that would be fabulous. But now I have to go through a transfer coordinator. We have to go through patient flow. We have to go through ambulance. I'd really, really love if that whole system-wide thing could happen. The same with the electronic medical records—as I said, we're still a fair bit paper based. Obviously, we don't talk to anyone. But if I could log in to CIAP, the clinical application system, and have someone's records from the entire state, that would just simplify things so much better.

Another thing that I noticed when I returned to Hunter New England, which was 18 months ago is that the policies and procedures are slightly different between health districts. So, when I first went to my—I was practising under what I practised under in Hunter New England. Then I actually got in trouble because policy was different, just in minor ways. And it was the same sort of thing when I came back. I was a bit confused because it's the same care but the policies are slightly different. So I would love statewide policies and procedures, not district-level ones. It would be a lot easier, as well.

Ms DONNA DAVIS: And have you been given a timeline on when you may go electronic with your records?

SUSAN SARGENT: In the near future. I know they're working on it at the moment, but we haven't really been given a specific date yet.

The CHAIR: It's a good question for Hunter New England Health this afternoon.

SUSAN SARGENT: You can ask Tracey.

Ms LIZA BUTLER: Thank you for joining us today, and thank you for being a nurse and midwife in a regional area. It's really important. In your submission, you gave the example where women are referred to Tamworth for their care because of a risk factor but then they're told to go to Narrabri to get scans, ultrasounds and you don't offer them. So it sounds like it's not just that you're disconnected from the Hunter base hospital in Newcastle; there's a disconnection even between Tamworth and Narrabri. How do we solve that problem? Do we need people doing rotations so they know exactly what is in that hospital? How do we improve that communication?

SUSAN SARGENT: I definitely think rotation is a really good idea. Way back when I was a student midwife, a long time ago, midwives would come out from John Hunter and work with us for six to eight weeks. We had so many that came out, lasted a couple of days and went, "No. I don't know how you do this." They didn't have any idea what it's like in rural because you're a sole practitioner, compared to—birth suite in John Hunter has lots of midwives on one shift; we have one. I have to do antenatal, postnatal, birthing, all at the same time. I've got to look after everybody. So that's a huge disconnect.

A specific example, which was what I was thinking of when I wrote the submission, was a lady. She rocked up to maternity, as they do—they just walk in. She said, "Tamworth told me to come in and get an AFI done." That's an amniotic fluid index. It's a specific type of ultrasound. We're a level 3 service. We don't do that. Our ultrasound probably could, but they're booked out six weeks in advance. For a non-emergency they don't have the capacity. So I sat with her in the antenatal clinic office, and she rang the doctor in Tamworth, and he said, "Just get them to do a bedside." I'm a sole midwife. That's not a skill that I possess. Our single one lonely GP obstetrician can do an ultrasound, but he's not qualified to do one. So the fact that Tamworth is sending them back is a huge disconnect. They just don't understand what it's like when you've got no resources.

Ms LIZA BUTLER: We heard—I think it was Dr Baker—say that often there used to be doctors from St Vincent's that would come up that referral pathway, whether it's St Vincent's or Hunter, and that they worked in that hospital, so they knew exactly what was there. Would that go some way to improving services? Then they understand exactly what's happening on the ground in that particular hospital.

SUSAN SARGENT: Absolutely. I would love something like that to happen for medical and midwifery staff. The other upside to that is they could certainly provide us with some education. We don't get away to education days like our metropolitan counterparts do. For me to do most things that are not mandatory, I would have to go to Tamworth or to Newcastle myself. I'm a single mother of five kids. I can't exactly drop everything just to go to an education day. So, if they came out here, that would be amazing for us as well. That would be one fantastic solution.

Ms LIZA BUTLER: Would it be fair to say, then, that it—to me, it appears that each hospital is working in a silo and not really understanding other hospitals and services and the challenges they're facing.

SUSAN SARGENT: Definitely, to some extent. We do have a little network here that we jump on every day, and we check in with all the hospitals around us, like Gunnedah and Inverell and all the little sites. Outside of that, we're really on our own until we need something.

Ms LIZA BUTLER: Do you feel a health forum with a number of stakeholders that could feed that back to Hunter would assist, rather than splitting the health district?

SUSAN SARGENT: I think that would be more helpful, definitely.

Ms DONNA DAVIS: This is something to take on notice, but it would be really helpful to get some idea of the types of basic machines that you don't have access to. That really would make life a lot easier and for you to be able to refer patients to other hospitals. We just heard previously about the fact that in Tamworth there is only one MRI and it is privately operated. To what extent would having—

SUSAN SARGENT: We don't even have an MRI.

Ms DONNA DAVIS: No. So to what extent would having access—and I know that that also comes with needing staff, but it would be good if you could take that on notice and have a think, please. Thanks a lot.

The CHAIR: Thank you so much, Ms Sargent. We really appreciate you both making the submission and taking the time to appear before us today. We are going to do three things following this. We are going to send you a copy of the transcript of your evidence today. You may wish to seek to make some amendments or adjustments to that if you believe you've been misheard or misquoted. That last question there that Ms Davis asked you to take on notice—we will send you a copy of the transcript with the context around that question and the nature of the question you've been asked. That will help you to prepare a response to that in context.

We as a committee may also develop some supplementary questions that we would like to send to you in the coming days. If we do that, we do ask that you try and turn that around within seven days. But, given what you just described to me as a very busy life, if that's not possible, please do talk to us, and we'll make sure that we work out some other arrangements. Other than that, we again sincerely appreciate you for taking the time for the submission and to be with us today.

(The witness withdrew.)

Professor FRANCES KAY, Chief Executive Officer and Institute Director, Hunter Medical Research Institute, affirmed and examined

Dr MICHELLE GUPPY, Head of School, School of Rural Medicine, University of New England, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Members of the public are not permitted to film or photograph during the hearing. However, the Committee staff will be filming and taking photos during the hearing. The images may be used for social media and public engagement purposes. If you do not want your image used, please let us know, and we will happily abide by your request. Before we start, do you have any questions about the hearing process?

FRANCES KAY: No.

The CHAIR: Excellent. Would you like to make a short opening statement before we ask questions?

FRANCES KAY: As the submission from HMRI—Hunter Medical Research Institute—indicates, we are not in favour of splitting the district. I think the Hunter New England is really unique in New South Wales and, indeed, in Australia. With a footprint spanning metropolitan, regional, rural and remote communities, the scale of this district supporting nearly a million people is not a burden but a competitive advantage, especially for us as a medical research institute, Australia's largest regional medical research institute and the largest in New South Wales, the only one sitting outside of a capital city. I think the current district provides the population base and infrastructure that we need to sustain world-class clinical services but also world-class innovation and research that cannot be replicated anywhere else in Australia. We have a very unique footprint and are highly invested in growing the networks and building the governance and structures we need to make sure that we can continue to make a difference and impact in this way.

MICHELLE GUPPY: The School of Rural Medicine at the University of New England is one of the partners of the Joint Medical Program, which is a partnership between the University of New England, the University of Newcastle, the Hunter New England Local Health District and the Central Coast Local Health District. The School of Rural Medicine is not in favour of the split of the Hunter New England LHD, feeling that

the split would likely result in duplication of administration and a focus on recruitment in setting up new administration. We see this as problematic because the real workforce issues are around incentivising and recruiting health and medical workforce rather than administrative workforce, and we don't believe this is a solution to that.

Instead, we would like the Government to invest in the medical training pipeline, particularly for rural, and there are some examples that we would like to highlight. One is the Riverland Academy of Clinical Excellence in South Australia, which we are in the process of attempting to replicate up here with the New England North West centre for medical training excellence, which is just in its infancy of being established at the moment. I'd also like to refer to the Medical Deans Australia and New Zealand document called *Thriving Rural Doctors*, which describes what needs to be done to increase rural workforce.

Ms TRISH DOYLE: Thank you, both, for being with us today and providing your expert opinion on some difficult issues. I'm just going to turn to Dr Guppy, first. You've already answered one of my questions, which was about centres of excellence. Can you talk to us more about the School of Rural Medicine's medical program and clinical placements in the Hunter New England region and, particularly, if this bill were to be enacted, the impact that would have on medical trainees and clinical placement arrangements for universities?

MICHELLE GUPPY: The joint medical program has 200 students in each year group of five years. We have 1,000 medical students across the footprint, of which 60 are based out of the University of New England and the remainder out of the University of Newcastle. For UNE, we need to place around 200 students in clinical placements each year. At the moment those clinical placements are spread from Narrabri, Inverell, Moree, Tamworth, right down to Taree, the hospitals around Newcastle and Maitland and the Central Coast. Our clinical placements are spread across the two local health districts, and our students need to be credentialled to attend hospitals in both of those health districts. There is a separate credentialling process for each of the LHDs, but our students can move freely between any of the hospitals in the Hunter New England LHD and just need a separate credentialling process if they spend a year or two down in Gosford on the Central Coast.

Ms TRISH DOYLE: Further to that, regardless of the bill going through or not, what would you like to see to support that ongoing traineeship placement arrangement from NSW Health and the local health district?

MICHELLE GUPPY: I think the issue for us has been that what we call the training pipeline is broken. In medical school, our students need to see a variety of different clinical specialties in order to get a broad spectrum of training. Areas where that has fallen down have been things like emergency care in the emergency department, mental health care, as well as at the moment things like paediatrics and obstetrics, just because of the lack of specialists in the smaller hospitals outside of Tamworth. We've had to put arrangements in place so that our medical students have to move in order to be able to see all those specialties.

Improving the specialty workforce in places like Armidale Hospital is really important to enable that training to occur, and then when our students graduate from medical school, there needs to be a rural training pipeline for them to stay in the region. It makes no sense for our students to graduate and then have to leave to continue their training. There needs to be intern places in the region, junior doctor training places and registrar specialty training places in the region so that those medical student graduates can stay in the region and become the future medical workforce here.

Ms TRISH DOYLE: Excellent. Thank you for very clearly articulating that, Michelle.

Ms LIZA BUTLER: My question is for Professor Kay. We've heard a lot about workforce. Your submission states that a smaller, isolated district would struggle to attract and retain clinical and research expertise. Can you comment on how splitting the district might affect the medical workforce in each region even further?

FRANCES KAY: Certainly it's difficult to attract really high-quality, world-class researchers as well as clinicians to outside capital cities, where there is such a critical mass of excellence of resources and of infrastructure and, I guess, of promotion. Pharmaceutical companies and other sorts of sponsors, industry sponsors, will automatically come to a capital city to talk about research and innovation, and medical research institutes are the conduit to that. We often find difficulties in attracting and encouraging really high-class, world-leading researchers to come and then to stay, because there's not access to the same sorts of opportunities always that they might get in a capital city by virtue of that location.

What we've done really well across our district is work hard to talk about what our competitive advantage is here. Further to Dr Guppy's point, it's in these new and innovative models of care that we research and test and are able to roll out, in partnership with the university and the health district, that make a different kind of academic and research and clinical workforce available and supported and thus attractive to people who come to our region. I think, for us, not having that footprint across the whole of the rural and remote region limits our ability to scale up those sorts of connected clinician and scientist work packages, because it's often sometimes that capacity to

co-fund and to build some research time into a clinician's busy schedule that can also be a bit more of a carrot to come into the regions as well. It's a way that we sell what the strengths are of our region that would be further limited if the districts were split, because we couldn't necessarily offer that same reach and funding and infrastructure and resource out across the regions.

Ms LIZA BUTLER: And then they'd stay in Hunter hospital rather than going out—

FRANCES KAY: I think they would, yes—where the precinct is located.

The CHAIR: Can I just ask a question off the back of that? Could you give an example of some of the research that is happening through HMRI that extends up and into the reaches of the New England area in particular, and how that benefits the communities because you're doing some of your research into those areas?

FRANCES KAY: Indeed. It is because of our model of health and medical research that does set us and this region apart. One example is the Diabetes Alliance project, which started as a clinical innovation in the John Hunter Hospital as a way for our specialist endocrinologists to provide some specialist support to general practitioners in and around Newcastle who couldn't come in and access the specialist clinic. It was a way of extending the stretch and the reach of those specialists. What we were finding in the health district at John Hunter was we were getting a high proportion of presentations to the emergency departments for diabetes-related complications that really didn't need to get to that stage. We also noticed that there were inflows from the emergency departments from farther out in the region because the only option for people without a specialist consultant and without access to their GP was to come to the emergency department in the middle of the night for things that could very well be managed in place.

The specialists in the endocrinology unit within the John Hunter worked with HMRI to create a new service model, which doesn't sound very sophisticated, but it essentially puts specialists on a bus—fits out a MediBus with the equipment that's needed to properly measure and detect and screen for all sorts of diabetes-related complications. We have a team of DAP+ nurses and a workforce that hops on the bus and goes out to our regions, across all areas of the regions, and offers GP specialist access clinics, community engagement and awareness building activities at the same time around diabetes education and prevention, and also in-place career development and training opportunities for nurses and other allied health staff in those regions and in those regional communities that might not be able to travel to Newcastle to get that sort of access.

HMRI's role in that was to wrap the research and the evaluation around that model of care, to bring in philanthropic investment and funding to stand up and fund the clinicians and also the scientists and the training and the nurses that make up that big package, and then look at the health economics and the other sorts of efficiencies and savings that occur from being able to roll out that model of care. We're not doing anything differently—we're not discovering new treatments for diabetes—but it is a way to rapidly improve that supply chain or that bridge between what we know and do in the hospital and what we're able to take out into the regions. We now have every single general practice in the region engaged with the DAP+ project[1] who've received training in intervention and specialist clinics, and we've gone out to all corners of this district with the DAP+ MediBus. We're going back out to do that again over the coming years, and we're now looking to scale that up across New South Wales.

The CHAIR: If you've been successful in getting philanthropic funding because this is a research trial—I don't know how long it takes. Let's call it five years—theory, proof and then write it up. What happens then? In this instance, it sounds like you've seen so much success that across New South Wales this is going to be adopted, because a dollar spent on prevention has got to save us $100 on treatment.

FRANCES KAY: Absolutely. You're exactly right. Also, it's very hard to get money and funding and governments to invest in prevention because the impacts are often seen much, much further down the track. But what we've been able to do is demonstrate within a five-year period—actually, within a three-year period—that we can have service efficiencies and cost-benefit savings in terms of reduced emergency department presentations, and we've got health economists sitting at HMRI who are able to cost out those savings associated with this service model. The philanthropic funding and the grant funding helped us unlock and mobilise those savings. That's a very compelling argument to the state government to say, "It might be an initial outlay, but if you do, you will realise these benefits and these dollar savings in these areas within this three-year period." The person who was responsible for that service innovation locally is now working at the ministry level to help understand how we might scale and roll that out.

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[1] The Committee received correspondence from Professor Frances Kay clarifying this statement. The correspondence is published on the Committee's webpage.

Ms DONNA DAVIS: My first question is in relation to the School of Rural Medicine. Can the School of Rural Medicine provide more information on centres of excellence in medical training? I know you've mentioned the Riverland Academy of Clinical Excellence, but can you just expand a bit more on what that would mean, potentially, to assist with our need for more professionals?

MICHELLE GUPPY: Yes. This is a plan at the moment which has not yet been funded, but it's a plan that has been developed between the Hunter New England LHD, the University of New England and the University of Newcastle, as well as the Inverell Shire Council and, I believe, the Gwydir Shire Council as well. It's to develop a model, based on the Riverland Academy, where we see Inverell being a centre of training excellence, where Inverell Hospital is sufficiently staffed with rural generalists in order to train the pipeline of clinicians in Inverell who can then train rural generalists in the smaller towns like Moree, Narrabri, Warialda and Glen Innes.

It's about having a well-staffed hospital that acts as a bit of a hub-and-spoke model to then have rural generalist trainees, registrars and medical students in each of those small towns. In order to support Inverell, though, Armidale Hospital also then needs to be fully staffed with the full complement of obstetricians, paediatricians and specialist surgeons so that they can support the rural generalist workforce in those smaller towns as well. It's the development of a whole suite of adequate staffing at each of those sites.

Ms DONNA DAVIS: What is the School of Rural Medicine and UNE in general doing to attract international students to study particularly medicine, more so than nursing and any of those ancillary health—I never get that right—professions? If you are doing work in that field, are you finding that that's more going to Parramatta, or have you got a strong presence in Armidale?

MICHELLE GUPPY: In our medical program, we have no international students.

Ms DONNA DAVIS: Why is that?

MICHELLE GUPPY: The reason is because we are allocating our medical student training places to Australian trainees because they are likely to stay as Australian workforce, whereas it's a bit of a hard ask, asking our local clinicians to support the training of international medical students who are likely to then go back to their home country to work. In an already stretched workforce, we feel it's a big ask to ask doctors to train students who are not going to stay. In the nursing space, UNE has a very large cohort of international nursing students. I don't have the numbers but, if you would like to know them, I can find them out. Our nursing works on the basis of online training and then intensive schools, which are in both Armidale and in Parramatta. The nurses will study online, and then several times a year they'll come to either Armidale or Parramatta to do their simulation and hands-on training. Then they go to clinical placements across the region.

Ms DONNA DAVIS: That is a simulation centre. That's very good. Can I ask a further question? I would like to find out how many international students you have and whether you've got any statistics or data on the number of those students staying. I know you don't have doctors in training that are international students, but it'd be good to know what percentage do stay here after. If there is a higher percentage, maybe that's something we could be—

The CHAIR: I have that written down as a question I was going to ask.

MICHELLE GUPPY: I can let you know that the University of Newcastle does have 30 international students each year. That's 150 altogether. Most of those students do actually apply for an intern training position within an Australian hospital. They're not guaranteed a job though. To date, most who have wanted an Australian intern place have managed to get one. I don't have the data on how many of them then continue to stay in Australia, but I can certainly find that out.

Ms DONNA DAVIS: And that would be something that would need to be done with the Federal Government, isn't it? I know it's a bit of a controversial topic at the moment—international students—but they're the ones that—

MICHELLE GUPPY: The problem is that we've not been able to admit as many international students this year as previously because they've been denied visas because of the restriction on visa numbers.

The CHAIR: I too was going to ask about the number in training and the number that actually stay. Can I just start by clarifying—I think you mentioned this earlier and it escaped me—that the University of New England also trains nurses and other allied health professions. Is that correct?

MICHELLE GUPPY: Not all other allied health professions, but we train psychologists, social workers, counsellors, pharmacists and nurses.

The CHAIR: No speech pathologists?

MICHELLE GUPPY: No. The University of Newcastle trains speech pathologists.

The CHAIR: Yes, they do. I was also going to ask about whether or not you had any statistics around how many of them stay in regions. The whole genesis of the University of New England training medical staff, I thought, was that if they trained in regions, we'd have a better chance of keeping them in regions. I thought that was one of the bases for the argument.

MICHELLE GUPPY: Yes, it is. We are just about to publish a paper that is looking at the first 10 years of our joint medical program and where our students are. As part of that data, it shows that if we're recruiting students from rural and regional areas, that's where they tend to end up again when they've completed their training, whereas if we're recruiting students from metro, they go back metro. It's very strong data to show that where they originally come from, they're likely to go back to a similar environment. They don't go back necessarily to where they're from, but they're more likely to go back to a regional or rural community if that's where they're from.

The CHAIR: If they grow up in the country and they're comfortable in the country, they're more likely to end up working in the country.

MICHELLE GUPPY: Yes, that's right.

The CHAIR: One of our witnesses earlier today suggested that the University of New England doesn't take on enough health students. Is it possible for you to just increase the number by 50 per cent if that's what you're going to want to do? Is that really an option or is there a limitation?

MICHELLE GUPPY: It depends on what you mean by "health students". The Federal Government has a cap on nursing places and it has a cap on medical student places. At the moment, we are only allowed to train 60 medical students per year. That's all the Federal Government gives us funding for. The Government is intending to release an additional 100 medical school places, commencing next year, but that hasn't come out yet. We will be intending to apply for some more. It is the Federal Government that determines the number of both nursing and medical student places.

The CHAIR: I feel like we've strayed way off topic, so I'm going to come back. Professor Kay, we talked earlier and you gave the excellent example about the diabetes bus on the road and things like that. If we had an arbitrary line somewhere separating New England from the Hunter, I think your submission suggests that you would concentrate your work in the Hunter area, which would then mean that your research and projects would be limited into that area instead of extending out. Am I interpreting that correctly?

FRANCES KAY: Yes. It certainly would be much easier and cost effective to do that. The minute you go into a different district with different governance, clinical pathways and ways of working, it involves different and new ethics applications and different and new strategies and funding. It wouldn't be as straightforward, easy or timely to be able to scale up across the whole region if it was split into two. It's not impossible, but it certainly would take much more time, much more money and much more ethics and governance processes to be able to do that.

The CHAIR: In terms of seeking philanthropic funding for the research and things like that, what are the origins of some of that money? Could you give me a rough—

FRANCES KAY: Absolutely. We have a lot of bequests that come in. For HMRI, the Hunter Medical Research Institute, we bring in around $15 million to $20 million of philanthropic donations and investments per year. That's one of the highest in the state. It has often come from national regular givers and donors, but also really key are a lot of people who donate via bequests and via other areas of interest, having been personally impacted by different areas of medicine and medical challenges, who are within our community. We also have big trusts, like the Colonial Foundation, which funded the diabetes alliance project, but that started with seed funding from a local anonymous donor. It was seed funding of around $100,000 to get that started. There are lots of examples of that. We also have lots of support throughout the Hunter Valley business community and people who have made their start here in the Hunter and want to invest back into the Hunter and New England areas.

The CHAIR: The question I want to ask is the flip side of that: Do you ever get funding sources that specifically insist that the research must take place in regional and remote communities?

FRANCES KAY: Yes, we do. In fact, it's becoming more and more of a priority and area of interest. It's certainly a target of some of the big groups, like the Colonial Foundation and the Ramsay health foundation. They are really concerned with equity of access and innovative models of care, whether that be prevention, early intervention or service innovation that can reach out to people who are not typically in the remit of a capital city catchment.

The CHAIR: So, again, if there was a line dividing the New England from the Hunter, if they were going to chase a regional philanthropic dollar to set up a research project that specifically is in the region, that would be the task of your researchers. Is that right?

FRANCES KAY: Absolutely, it would be. It would be really hard for us to set up another HMRI base from which they could work in another region without significant additional cost. So the model that we have now of being able to take what we have in our building and in our research and academic and clinical community and put it on a bus and drive it around the region is made possible by the fact that we all are under the one governance footprint. To have to do that across another couple of regions, we wouldn't have those same permissions and relationships and network in place, and we would have to essentially set up probably another building, another place, in order for that to happen. It's also really hard—I'm sure we all know—to do really good research and translation in isolation. You need teams, and so we wouldn't want to send individual researchers out, just like you wouldn't want to send individual clinicians out to work in community areas without that other support and access to expertise around them.

The CHAIR: I've been to your magnificent facility, and my estimate would be that there must be tens of millions of dollars invested into that facility and all the equipment that's in there.

FRANCES KAY: Indeed, yes.

The CHAIR: And it's quite a large cohort of researchers across a range of interests that work from there.

FRANCES KAY: Yes. It's 1,600 strong. We are a comprehensive medical research institute. We don't specialise in cancer or in cardiovascular disease, and it's actually because of our footprint that we don't do that. We could focus all of our efforts and become totally excellent in cancer, for example; although, we are very excellent in stroke and other sorts of disorders. But it's because we are an MRI for our community that we think it's incumbent on us to develop streams of research, innovation and delivery that is across the wide range of general medical needs of our community.

The CHAIR: Dr Guppy, if I can just come back to you, I think that you were talking earlier about when your students go out into placements—it sounds to me like the majority of them stay within the Hunter New England health district but also that some of them went into the Central Coast. The district boundary isn't necessarily a limiter for your students. Is that correct?

MICHELLE GUPPY: That's correct. They can go to different LHDs, but I guess each LHD at the moment is associated with a university, so the Central Coast LHD is associated with the Joint Medical Program and the current Hunter New England is associated with the Joint Medical Program. They're really the only two LHDs where our students do hospital placements.

The CHAIR: Would they not be able to jump across to the Northern Rivers or the Mid Coast health district?

MICHELLE GUPPY: It's very difficult for that to happen. We actually don't have an arrangement with those LHDs to take our students in the hospitals in those regions, and so it's only by exception if the students go to those locations at the moment. We would need to negotiate clinical placements with those regions if we wanted to expand the footprint for our students.

The CHAIR: So in many ways it's simpler and easier to stay inside your health district, other than the arrangement you have with Central Coast, which, to be fair, I think Newcastle university has footprints in the Central Coast anyway so they have to have an ongoing arrangement. Is that right?

MICHELLE GUPPY: We have four partners in the Joint Medical Program, and the Central Coast LHD is one of the partners.

The CHAIR: Would either of you like to venture some positive outcomes that might come from separating? I know the strength of your submission is that, no, there aren't particularly. The local feeling on the ground is the decision-making needs to be closer to the service delivery and that that's not taking place at the moment. Putting aside all the workforce issues and the financial issues et cetera, the suggestion is the decision-making is happening too far away by people who don't understand the regions. Did either of you want to comment on what might help overcome that and how a line in the sand might produce that if it's real? Dr Guppy?

MICHELLE GUPPY: I think the rationale for splitting the health districts is to return decision-making to the New England region. Certainly I think if decisions are made locally, they are better informed decisions and they can take into account the specific issues that rural communities face, whereas if decisions are made down in Newcastle, they are made with a metro focus. People based in Newcastle do not necessarily have a full understanding of what the issues are. From the perspective of splitting the health district, if that did mean decisions

were made locally, that would be a positive effect. However, I don't think that's going to solve the medical workforce issues, which is sort of one of the main reasons people want this to occur. If the health service remained as one entity, I think there would definitely need to be some sort of outcome where there is a set-up for more local decision-making.

The CHAIR: Professor Kay, did you have any comment you'd like to make on that?

FRANCES KAY: I do. I think it's a really good question, and certainly that place-based research and place-based clinical services is a really critical issue. I do understand where the proponents of this bill are coming from in that respect. But I think there are lots of ways to achieve that outcome, of course. I think there would be benefits to have people in place in communities setting and driving research agendas, for example, of issues that are related and relevant to those communities. My concern is that because there's not already the track record or the status or the visibility of those regions necessarily in and of themselves without being associated with a medical research institute or a bigger university, then those issues will get a bit lost.

We have a situation where the costs to do research and the costs to support health and medical research from an infrastructure perspective are rising. Whether that be for cybersecurity, other sorts of costs of skills, laboratories and utilities and things like that, it's rising. I think by splitting the district and having to establish that all again rather than having people being able to capitalise and draw on the resources that already exist in the region would only make that situation worse. The way that MHRI is trying to address that very real and important issue is by spending more time out in the communities and co-designing a research agenda and then funding research that is actually relevant and connected to people's needs.

One example in doing this rounding that we've been doing over the past six months, particularly to understand what the needs of our entire region are in and around the health and medical research needs, is that we've also heard the story about how not having access to an MRI really has an impact on people's ability to stay in care in place when they could otherwise do that. We're currently negotiating for an investment to put an MRI on a bus and to be able to use that as a model of care. We wouldn't have known that and wouldn't have been able to innovate in that way. We have the scientists then working on the algorithms and the analysis, so how do you then interpret images? It might be a low field with a mobile and portable MRI, but we can do this when we listen to the community and then offer a little wraparound service evaluation and project that meets the needs directly like that.

The CHAIR: An MRI on a bus on the road?

FRANCES KAY: Yes.

The CHAIR: Wow! I hope that's a success.

FRANCES KAY: We have a partnership with a group who are developing this technology at an Indian university, so by our networks we have access to this information that we can then bring and attract to the region once we know what the needs are.

The CHAIR: One final question to you and then we'll tidy things up. Is there any exciting research into the health needs and outcomes for our Aboriginal communities? One of the arguments also around the pros for splitting the district is potentially greater opportunity for Aboriginal people to be able to stay on country, particularly for birthing but also for other treatments et cetera. Is HMRI doing any exciting, or has done any exciting, research into health outcomes for Aboriginal communities in our regional areas?

FRANCES KAY: We absolutely have, standing on the shoulders of giants like Professor Kelvin Kong and Professor Michelle Kennedy. What's wonderful about Michelle and Kelvin's work is not only that it's connected to and driven by Aboriginal communities in our region but it is world-class and world-quality, and it's attracting huge investments from the NHMRC and the MRFF, really competitive grant funding schemes, but also philanthropic investors. I think what's wonderful about Michelle's work, particularly with smoking and pregnancy and those sorts of activities, and Kelvin's with great ear health is that they're taking this same kind of regional concept of care, so putting things on a bus, going out to communities, providing education, which is very empowering, but also health care in place, which is actually changing the trajectory of, particularly, our young Aboriginal children who might miss out on schooling and other sorts of educational opportunities because they can't hear properly or they're not having those needs met.

In those two examples, we are getting huge gains and benefits by having local Aboriginal people develop research and clinical profiles in our local health district, which they've been taking back to their communities to solve problems that the communities themselves are identifying. Along with that, we are working with our Aboriginal communities, the university and the health districts to establish an Aboriginal health community panel. Now every piece of research that comes through in our ecosystem that has an impact on, an implication for or an

involvement of an Aboriginal First Nations researcher or community needs to go through this community panel for evaluation and advice to make sure that it is actually meeting the needs of, is relevant to and will have an impact on our First Nations people here.

The CHAIR: Would I be correct to assume that those two examples of research that you did happened inside the Hunter New England health district?

FRANCES KAY: No. They were far-reaching across the whole region. Both Michelle and Kelvin are from Awabakal and Worimi lands, and they're very committed and passionate about making sure their research impacts their communities as well. So it starts here and then it grows.

Ms DONNA DAVIS: This question is to both of you. In light of that research—and I have just done a quick google of some of that work about trying to reduce smoking in Indigenous populations, and pregnant women particularly—is there more that we could be doing as a government, as HMRI, with local government areas and with others in the community to promote the great work that you are doing? Likewise, UNE, is there more that all of us could be doing to promote the incentives and subsidies that we are offering as a government for nurses to go into nursing and allied health professions so that not only are we attracting more people into these professions but also we are informing our communities about the good work that is happening? It's so easy for people to latch onto negative things, especially when somebody has a negative—I grew up in a country town, so I know how the bush telegraph works. Is there more that we should be doing?

FRANCES KAY: I work in mental health, so I can absolutely relate to that experience. There absolutely is. Our selling point, or the major competitive advantage or attraction, is the million people across the whole Hunter New England region. We are a perfect testbed and a snapshot, socially, demographically and medical condition-wise, of everywhere else in Australia. If you come and do your clinical work here or if you come and live here, or if you innovate here or you invest here, it's much quicker to translate what you discover here to anywhere else in Australia.

For us as an ecosystem, our mission is to create the healthiest million people here— through research, through clinical innovation, through education and so forth—because we know it's much quicker to then make us the healthiest 26 million than if you do the research and innovation anywhere else. I guess the whole reason we're here is because proximity often equals attention, and we are at a disadvantage because we're not as proximal here to Sydney. But you're absolutely right. It doesn't undermine the impact and the quality— particularly the impact— of the work that we're doing, if we were given a chance to raise the profile around that.

Ms DONNA DAVIS: Would you say that's the same for you, Dr Guppy?

MICHELLE GUPPY: I might give you an example from last night. I ran a GP education session across the region. At that session we had GP obstetricians from Gunnedah, Inverell and Armidale. On the call we also had specialist obstetricians from Tamworth, Armidale and then the director of obstetrics from the John Hunter Hospital. What we were discussing last night was how you keep a woman in their hometown to be able to deliver their baby. We need a structure of obstetric care support where the GP obstetricians have good staffing. For example, in Inverell or Gunnedah hospitals, we have sufficient staffing for midwives so that they can have safe birthing in those small communities.

We need adequate obstetric cover in Tamworth and Armidale so that the specialist obstetricians there can provide the telehealth support or the consulting support to the GP obstetricians in those smaller communities to keep women on country. Then we need to have the backup of a big tertiary hospital like John Hunter so that if a woman has a very high-risk situation, they can be transferred down to Newcastle as a last resort. What we were discussing last night was something called a virtual high-risk clinic, which is essentially that: a virtual clinic where anybody can refer a woman and have a conversation around where is the safest place for this woman to give birth to her baby and who needs to be involved in her care across that spectrum. I think at every level of staffing that needs to be supported, with investment for staff in each of those locations, to be able to keep women on country.

The CHAIR: I thank both of our witnesses for appearing before us today. You will be provided with a copy of the transcript of your evidence for corrections. Committee staff will email questions taken on notice. I don't think there were any. We as a committee may develop supplementary questions that we wish to send to you following the hearings today. We ask that you turn those around in seven days, if that's possible. If it's not, please talk to us about that. Thank you for spending some of your precious, valuable, important time with us, both in making submissions and appearing before the Committee today. I appreciate that.

(The witnesses withdrew.)

(Luncheon adjournment)

Dr DAVID SCOTT, Chair, Tamworth Medical Staff Council, before the Committee via videoconference, sworn and examined

The CHAIR: We thank you for your precious time today. It's greatly appreciated. Let's get straight into it. First of all, I just remind you that during the course of proceedings today we will have access to photos and videos that might be used for social media and website purposes. If you don't want your image used, please let us know and we'll make sure that we adhere to that. Before we start, do you have any questions about the hearing process?

DAVID SCOTT: No, I don't.

The CHAIR: We obviously have your submission, but would you like to make a short, two-minute opening statement before we start on the questions?

DAVID SCOTT: No, I'm happy to hear the questions that you have.

The CHAIR: I thought that might be the case. We have a number of absences today from the Committee. Joining me today is Ms Liza Butler, the member for South Coast, and Ms Donna Davis, the member for Parramatta. Liza and I were both on the Select Committee on Remote, Rural and Regional Health that looked at the implementation of the 44 recommendations that came from the upper House inquiry a few years back—you refer to both of them in your submission—so we have crossed paths before. Importantly, the work that has been done historically is that it is acknowledged and accepted that delivery of health services across our regional, rural and remote areas is difficult and leads to lower life expectancy, for a whole bunch of reasons, for our communities out there.

We're not looking to re-prosecute that case. What we are trying to specifically understand in this instance is whether the New England area would be better serviced by separating from the Hunter, or whether the outcomes would more likely be worse for the New England area as a result of separation. That's really the focus for us. We already accept that there are difficulties in delivering the same levels of health in metro and regional areas. This might be a little bit different in terms of other commentary and evidence you've given previously. I appreciate the Tamworth Medical Staff Council haven't taken a specific position.

I want to start by asking this question: If the Hunter and New England were to split, we have been advised by Hunter New England Health that as much as $111 million would be required to set up an entire new level of administration. That would present itself as being delivered from Tamworth. We don't exactly know that; we're making some guesstimates. Would the Tamworth facility and the Tamworth medical fraternity be prepared and have the human assets to set up an entire new level of bureaucracy? Is that a skill set that's in and around Tamworth that you know of or that you have a familiarity with?

DAVID SCOTT: As you know, a number of years ago Tamworth used to be the hub for the New England health district—or whatever the terminology was—so it did have its own board and its own self-contained management, and it seemed to be adequate in that setting. As you also know, when the health districts merged and then de-merged throughout the state, places like Wagga, Orange, Dubbo, Lismore and other regional centres seem to have been able to take up the administrative and bureaucratic requirements to run their areas. So it would seem theoretically possible that could happen and that Tamworth could run it. But after years of being combined with the Hunter district, I have heard—and I would imagine more than I know of—that the administrative roles have been merged, relocated or rationalised such that now there are not the staff in Tamworth that we would need. If the split happened today, we would be very deficient in terms of bureaucratic and administrative staff. I don't know whether we could, but we certainly used to—and other places seem to do it—so I imagine it's possible.

The CHAIR: Earlier today we were told by another witness that there was an internal restructure within Hunter New England Health about 12 months ago which essentially created two areas, one being the New England and the other being Hunter and lower mid coast. Since that time, has the autonomy, decision-making and empowerment of the New England area been increased or realised?

DAVID SCOTT: I can't say that I've noticed a difference either positive or negative, possibly because our general manager reports now to the same person that she used to report to in the old structure. The person that she reports to has a new role and new title. I don't understand how that's influencing us and whether that does influence what our general manager can do. But the names of the people that are responsible for decision-making and the information haven't changed that much. So on the ground, at the coalface, we haven't noticed much difference with the new structure.

The CHAIR: Do you believe that you have enough autonomy and decision-making empowerment there at Tamworth or within the New England district, or do you believe that could be improved?

DAVID SCOTT: I believe it could be improved. As you said in the introduction, I don't pretend to think that having more autonomy would fix all the issues that we face. But I feel like when we want to get new medical staff positions, which is what I'm familiar with, or new protocols or access to, say, pilot services that might be rolled out—whether the state government might roll them out into each health district—we don't get first dibs on that. I think there would be improvements if we could have more decision-making capability locally, because the issues we face are local.

One example is not the current but the previous marketing campaign looking for new anaesthetists. It was a combined district campaign combining the Hunter and New England so the advertisement clearly said we're looking for people to go anywhere in the district. But of course the people that applied and the people that were selected wanted to and were best suited to go to Newcastle, so there were no appointments for new anaesthetists outside Newcastle. So although it was a combined whole-of-area program, it really only helped Newcastle. I think having the ability to run things more independently and just be more flexible would suit us.

The CHAIR: By the same token, in an advertising campaign like that looking for staff, Hunter New England Health could have run a specific campaign looking for anaesthetists that want to work in the Tamworth area or the Armidale area.

DAVID SCOTT: Yes, as they are now. They've run a specific campaign for Tamworth with some novel ideas, which is great. But the fact that it took us to say they needed to do that, to push for that and to invent a campaign around that, shows that it's not easy to get local decision-making in Tamworth.

The CHAIR: Dr Scott, do you work at multiple hospital sites across the Hunter New England or specifically just Tamworth?

DAVID SCOTT: Tamworth and Gunnedah hospitals, personally. But, as you would be aware, we take calls from all around the region: Armidale, Glen Innes in the last 24 hours and Moree recently—all around the region. So we're quite familiar with the way this part of the world works, medically.

The CHAIR: Those calls to assist the medical treatment that's on the ground at that time, wherever it's coming from—are they calling you to get a second set of eyes, a second opinion, or is it calling you because they need to do a transfer, or a referral through or something?

DAVID SCOTT: Often it's both. Often the doctor onsite, or the My GP doctor not onsite, feels that the patient has exceeded the capability of the local hospital, so they think a transfer is appropriate. Mostly it is—although, obviously, because we're specialists, we might have a slightly more nuanced approach to that situation. Advice is part of it, but mostly the patient needs to be transferred.

The CHAIR: Because those hospitals and medical centres are making those calls to you, I presume, number one, they're within the health district. If that's true, my question is are you able to say no or do you have to accept them under the rules and conditions of all being in the same health district?

DAVID SCOTT: I don't know if there are rules or, if there are, what they are. I guess we can say no, but normally you would have to explain and work with the doctor on the other end of the phone as to why that's the decision. You wouldn't hang up until you both agree on why a transfer is not needed or in the patient's best interest. Maybe it's needed, but not to your hospital. You wouldn't just say no and hang up.

The CHAIR: Sorry, I worded that poorly. If you thought you didn't have bed space, could you say—

DAVID SCOTT: That's a different question. My job is not to work out whether there are beds and what sort of beds there are, because there are beds and there are beds. My job is to work out whether the patient needs a transfer and the timing of that transfer, and then it's up to the bed manager's patient flow unit to work out how and when and where that patient goes. Sometimes the patient needs to come quickly, but there is just no space. Mostly, patient flow do an excellent job using the emergency department here to get them over here. At least they're closer to where they need to be. But sometimes it doesn't work if the beds are tight everywhere.

The CHAIR: What happens then? If you make the decision saying, "Yes, this person needs to escalate and come in from out there to Tamworth", and then the person is on the way and someone is looking for a bed but there's no bed available, what happens then?

DAVID SCOTT: If the patient has to stay at the smaller hospital, ideally the doctor there would talk to us day by day. We would monitor progress and see whether it's okay. Occasionally the patient has to go downstream further, maybe to John Hunter. But that happens very rarely, in my experience. Mostly they just have to wait, to be honest, and we monitor their condition while they wait.

Ms DONNA DAVIS: Thank you for appearing. If the bill was not to pass, what services do you think should be provided in Tamworth as a more localised base hospital to support the surrounding district hospitals?

DAVID SCOTT: If we didn't split, lots of things—

Ms DONNA DAVIS: If you didn't split, what could we do to improve Hunter New England in Tamworth?

DAVID SCOTT: Maybe I'll step back just a second to say the main thing I wanted to say, which helps answer that question. I think the reason this bill has come up is because our district is unique. As you know, regional areas are mostly looked after by regional base hospitals, and metropolitan areas by metropolitan hospitals. Each hospital is the tower and then has the smaller towns and hospitals around it—geographically smaller in the city and bigger in Wagga or Orange or Lismore. Ours is unique. Our district is shaped a bit like a water drop, where the major hospital—the big tower—is right down in the very far corner and services a huge area that's a long way away, of which it's not the centre. And also, population wise, it has to deal with a large urban population. The majority of the district is urban, but there is also a large, very remote rural population of people who live a long way from any health service, let alone a major one.

If we don't split—which, as I said, I don't have a strong opinion on because that's not my area of expertise—I think at least there has to be some recognition that this is an exceptional health district and therefore some special policies or considerations given to how we're going to manage a health district that is so diverse geographically and socially. For us in Tamworth, we feel that putting more resources into Tamworth, even if that's at the expense of the more metropolitan centres, would be advantageous. We would need more theatre time. That would be a big one. By theatre time, I mean we would have more theatres that are funded and therefore staffed with nurses and anaesthetists, so that the proceduralists here can do their work and, should emergencies come in from the district, we have more capacity to deal with them here.

We would like to see a diversity of specialities available. We don't expect every single neurosurgeon to live here and have a neurosurgery roster for Tamworth, but it would be nice if there was an agreement that, within the same health district, we need to prop up Tamworth. We can't expect people to drive from Moree and Glen Innes and Tenterfield all the way to Newcastle for a five-minute neurosurgery appointment. The neurosurgeon should be required, as part of their contract, to come up here. I'm just giving that as one example. They should come and spend some time in Tamworth, not necessarily to do on call here or even to operate here but to at least provide a service from Tamworth rather than from Newcastle. There are many other examples like that. We just like to see that the capability of Tamworth increased so we can prevent people having to go all the way to the corner of the health district and to a very different world than the one they know. They can have their treatment done locally. By locally, I mean still three or 3½ hours from where they live in Tamworth.

Ms DONNA DAVIS: Are there any models in other parts of New South Wales or other states of Australia—or even overseas that you're aware of—that have more mobile services? I'm thinking not of theatre but of cancer support and preventative medicine that don't happen already and that could be adopted to support the regional and remote areas.

DAVID SCOTT: I don't know the details. I know that Dubbo, for a number of years, had a lot of its specialists come from Sydney, and on regular rotations. It was the same people coming regularly but not living in Dubbo. That has advantages and certainly disadvantages as well. But for some specialities that might be a good step and might support the specialists that are here. And then, as people see that there's more facility and more capability in Tamworth, they may be encouraged to stay. Lismore has a lot of specialists, comparatively, to the inland centres. I'm not sure if they have a technique to make that service like that. I'm not sure.

Ms DONNA DAVIS: Close to the coast, I would suggest. I have one other question. Do you think that the quality of housing and lifestyle plays a part in retaining medical professionals in these regional and remote areas, and is there anything that we could be doing as a government to improve that?

DAVID SCOTT: I think it's a good question. To the previous response, some people just love being near the beach, and good on them. Some people don't, and that's fine. Some people are happy just to do it for a holiday. You can't change that. Some people have family that are in Sydney or on the coast, and they can only be a certain distance from family. That's okay. That's the way it is. But traditionally, campaigns have tried to emphasise big blue skies and outdoors, and that's nice.

In our experience, most doctors don't come for the bushwalks and the mountain biking. They come because the medicine is really good and they can raise their family there and have a really interesting, fulfilling and rewarding career while their family has lots of opportunities to do all the things that kids and families want to do. The Government could, if they wanted to help, show how good the career is in Tamworth and not just the

lifestyle. I think that would attract more people than just saying the lifestyle is good and you have to put up with your job, because that's not the case for most of us.

Ms DONNA DAVIS: So maybe focus on case studies. Have people like you as the ad.

DAVID SCOTT: There are plenty of better heads and stories than mine. That is being done. Part of our recent push for anaesthetists is to emphasise the quality of the work they'll be doing, not just the quality of the lifestyle. Although, for most of us, both are excellent. That's the sort of thing that is happening but needs to happen more.

Ms LIZA BUTLER: Thank you for joining us this afternoon. I want to go back to that example you provided of the neurologist going out there on a regular basis. Have you been able to put that idea to the area health service, and how did they respond?

DAVID SCOTT: Not personally, but the reason it won't happen is because there's no incentive for the relevant specialty. I don't want to pick on one specialty, but there's no interest, there's no need for them to come up here. From their point of view, they've got a full-time job and some, you know, 20 minutes from their home. Why would they travel to Tamworth to do it? The only way that's going to happen is if there's some area-wide decision that, if you work for our district—because of the unique geography of our district—you need to go do some time, sure, in Newcastle, but also you need to spend some time in Tamworth. That's only going to come about as part of a contractual administrative process. There are the occasional ones, but no reliable service is going to be set up just from people's goodwill of wanting to come to the country, which has traditionally been the way it's been done.

Ms LIZA BUTLER: So there's no mechanism for you to be able to feed that back. Is that correct?

DAVID SCOTT: To?

Ms LIZA BUTLER: To the area health service, to the powers that be, to managers.

DAVID SCOTT: We have and we can. We have contact with the management of the district as well as locally. But they're in a difficult situation between trying to attract people to Newcastle and keep them in Newcastle. If they have to enforce something like time outside of Newcastle, then that may make their position look less attractive compared to the Sydney position. I haven't sensed any interest from management in that as being a model to go forwards with. But I think it's doable. I know Queensland has a system more like that, where there's an assumption that you'll spend some time away from your home hospital servicing smaller areas. I just don't think it's part of the culture here. It's certainly not part of the contracts.

Ms LIZA BUTLER: Back to the last question from Ms Davis about retaining staff, in the rural, regional and remote committee that we're on, we heard that a lot of doctors who are not long out of their training go to a regional area and they feel very isolated and alone and not supported, especially because you'd never know whether it'll be a farm accident or a major highway accident that will come through, and they end up going back to the city where they have every specialty around them. Are you finding that in your area?

DAVID SCOTT: Absolutely. I'm privileged I work at Tamworth, which is a reasonably large hospital. I have lots of colleagues—we work well together—and I have my little specialty. The real heroes medically are the GPs or the general physicians and surgeons that staff the smaller hospitals north and west of here who, like you say, have to go from sick babies to car crashes to deliveries to all sorts of things. Yes, that's a high level of training to be able to feel confident doing that. I think they're reasonably well supported—sorry, the support's not easy. But the reason they're going is because there aren't a dozen highly qualified GPs in the same town. The reason they're going is because there's no-one else or there's one other person, so getting that support is difficult when there's no-one else or not many other people onsite. I think any efforts to try and help them and support them would be useful. Once again, if Tamworth could play a role in that, if there was some way we could help them with training—I don't know whether we'd need to split to do that but, once again, trying to boost the profile of Tamworth to help GPs maintain and increase their skills.

Ms LIZA BUTLER: Because once they are trained and are capable and confident, then it could be very rewarding careerwise.

DAVID SCOTT: I gather that's the case. The ones that stay at it love it and have just done such a fantastic service. Every town around here has—you could name a couple of GPs who've been there for decades and have just done so much good work in that time. That must be a wonderfully fulfilling career to do that.

Ms LIZA BUTLER: Your submission notes that you'd like more detail before being able to say whether it's a good thing or a bad thing. If we did enact the bill, what could be the consequences if we haven't looked at all the issues involved?

DAVID SCOTT: So, two things: Firstly, I'm not an administrator, so I won't pretend to understand how hospitals and health services are governed and the intricacies there and how it would change. I can't pretend to know the most important reasons for splitting. I can't pretend to understand. Secondly, obviously, if I was in charge of the split—I mean, I'm sure we could make do. But I'd hate to go through the process, agree there needs to be a split and then be told, "Well, you're only a quarter of the population. You're going to get a quarter of the funding," or something like that, or, "And by the way, all the staff that you used to have that are now at Newcastle—well, you'll just have to find your own staff," and, "All these outreach programs and the fact that every single patient needs to be transported to have anything done—you can just take care of all that yourself." If someone else gave us that as a deal, then that would be a bad deal. They're the concerns I'd have: that I don't understand the issues and that I wouldn't be in charge of how the money would be split.

Ms LIZA BUTLER: Throughout the hearings we've heard that referral pathways could be more difficult if we were to split the health districts. Do you have any comments on that?

DAVID SCOTT: I don't think so. Referral pathways exist across districts already. Newcastle people will tell you they get a lot of business from the North Coast, which is not their district. If you go to Wagga and you have a neurosurgical problem, there's no neurosurgeon at Wagga so they've got to transfer you to a different district. The referral pathway still exists. We may need to finesse them or formalise them or whatever, should a split go ahead. But, no, I think the health system, both between states and within states, works across boundaries reasonably well as it is.

Ms LIZA BUTLER: We also heard that we'd lose that training hospital of John Hunter. What is your comment on that? Because you'd no longer have a training hospital located in the western district.

DAVID SCOTT: Likewise, so therefore no-one would have a training hospital outside Newcastle, Sydney and Wollongong. We train lots and lots of people in Tamworth. We are a training centre, like all the regional centres are. There may be advantages. People may say, "Well, I wouldn't mind going to Tamworth, but I don't want to go to John Hunter." Or they go to John Hunter but get disappointed by how many non-Newcastle terms they get in their training. We wouldn't need to worry about that. We'd say, "Come to Tamworth and this will be where you'll be." I think there could be advantages and disadvantages in being distant to John Hunter as a training hospital.

The CHAIR: That's interesting. What type of students do you get coming through to do their training at Tamworth at the moment?

DAVID SCOTT: Training for us is medical students, but it's also what we call JMOs—

The CHAIR: Junior medical officers.

DAVID SCOTT: —so the first year or two after you become a doctor. Then we have the registrars, who are training in a certain specialty, including GP. So training is the whole package. The students come from the two main universities, which is University of New England and University of Newcastle. Some of them are based here for a year or more. Other ones just come on rotation from elsewhere. For the junior doctors, we have some that are based here, some that come on rotation and then, with the registrars, the same. There are all the different specialties. There's a choice. Some specialties you can do entirely outside metropolitan areas. You can do all your training in hospitals like Tamworth—maybe not only Tamworth but like Tamworth. Other specialties you certainly have to do some time in the major metropolitan centres, but those normally expect you to do some time in the country as part of that metropolitan-based education. It really varies a lot, the types of students and doctors we train.

The CHAIR: I might not be able to ask you a question about VMOs. Do you have any experience or—because Tamworth has their own set of doctors, right? You don't rely on VMOs, is that correct?

DAVID SCOTT: No, I'm a VMO. We have a lot of VMOs, yes.

The CHAIR: Is the process of getting signed on to be a VMO particularly difficult or complex? Are the negotiations hard? We are hearing anecdotally that, in some areas, local GPs want to be VMOs but Hunter New England Health just makes it too hard. Do you have a comment about whether or not it's just way too hard to get signed on by Hunter New England Health?

DAVID SCOTT: The GP side of things I can't really comment on. Once again, as I said before, I think anything we can do to help those guys stay and keep doing what they're doing should be considered. For the hospital for most of us these days, if there's a position for a specialist then they'll ask you, "Do you want to be staff here or a VMO?" Normally there's a choice but not always. There was a time when they really wanted staff specialists and not VMOs but, when they realised that was hindering their recruitment, I think there was a

relaxation of that policy. I don't think it's as big a problem in the bigger hospitals, but for the GPs it might be—I wouldn't know.

The CHAIR: Could you just describe to us in practice what's the difference, then, between being a staff specialist or a VMO for someone like yourself or other people like you?

DAVID SCOTT: Yes. So, if I was a staff specialist—I am a VMO. So I go to the hospital to do my ward rounds. I go to the public hospital to do my procedures. I do one clinic a fortnight in the public hospital, for liver disease. That's that. But when I'm not at the public hospital, I'm down in my private rooms, which are just down the street, and I see people there. But those people might go up to hospital, have procedures in hospital. So it's a very fluid situation. And therefore I'm paid by the hospital for what I do there. When I'm not doing anything there, they're not paying me. When you're a staff specialist, you have your office inside the hospital. You're paid a wage per day. And then, no matter what you're doing, you're being paid by the hour to be there and do that. There are advantages and disadvantages to both, both from my point of view and the hospital's point of view, depending on your situation.

The CHAIR: Thank you so much for that. Am I correct to call Tamworth Hospital a base hospital? Is that the correct term?

DAVID SCOTT: It used to be called a base hospital. Now it's called a rural referral hospital. Armidale is also a—

The CHAIR: What's the difference?

DAVID SCOTT: The name, probably.

Ms LIZA BUTLER: The name. They've changed names in some places to try and attract doctors from overseas, because it's all in the name.

The CHAIR: I was going to ask if Tamworth is as well resourced as other base hospitals, but that might be technically an incorrect question now.

DAVID SCOTT: Yes. Are we well resourced? Once again I don't have the data. I know one of the cardiologists here was pretty thorough in looking at the cardiology resources across similar-sized hospitals in regional New South Wales, and we are either on par or below par for those sort of resources. I couldn't really give you an easy answer to that question without going into the detail.

The CHAIR: Have you experienced events where equipment has broken or become faulty and it's taken a long time to get that through the processes of Hunter New England Health, once it's referred down the chain and gets approved and then gets purchased and then finally arrives back in the hospital? Is that an experience that you're familiar with?

DAVID SCOTT: Yes, it is. Whether that's avoidable, whether that would be improved by a split, I don't know, though. That's just bureaucracies, I assume. But, yes, there certainly are some delays. Things are slower than they seem to need to be.

The CHAIR: Earlier you described the opportunity, I guess, for specialists to rotate in and rotate out et cetera. Do you see any of that happening now?

DAVID SCOTT: It happens privately. Some specialists from the city come up to a private medical practice here and see patients and that sort of thing or go to the private hospital and do surgeries there—like hand surgeons or bariatric surgeons, more specialty sort of stuff. They would go to the private practice or a private hospital. It doesn't involve the public system. For paediatrics, they certainly get some urologists and cardiologists and maybe other people. Endocrinologists come up here from Newcastle to do clinics here for paediatrics. I don't know of many other adult public clinics that come from Newcastle.

The CHAIR: I think that the Hunter New England Health submission is making the argument that they do send some specialist services out into the regional areas up through New England. Are you familiar with any of that?

DAVID SCOTT: Yes. There's some. For example, in Moree there's doctors that go from Newcastle to Moree to do a clinic, but it's monthly or something or at most fortnightly. Haematology is a bit of a hybrid model. The haematologists used to be here three days a week or maybe four days a week every week. They don't live here, but they are coming. There's isolated examples of it, but it's not a systematic, comprehensive plan to bring services to Tamworth, to upskill us here and to reduce patients' displacement when they go somewhere. It's very patchy.

The CHAIR: I think this is my final question, and I'm sorry if I missed it earlier. Did Tamworth Hospital use to offer a more extensive set of services? And did that start to deteriorate and erode once New England was joined with Hunter health?

DAVID SCOTT: I think we've grown in what we can do, but it's not in every way. We used to have a vascular surgery. We used to have ENT, which has only recently come back, but our other specialties were not as broad. But, at the same time, medicine was not quite as sub-specialised as it is now. So expectations of us, our colleagues in the community were probably different to what they are now. Other things have grown in the time since I was an intern here, in the year 2001. Some things are different. Some things are more. Some things are less. Whether that's attributable to the joining, I really couldn't say. I think there's too many other factors to attribute it to just that one thing.

The CHAIR: Could you just clarify to me? What does "sub-specialised" mean medically?

DAVID SCOTT: If you saw a physician, you'd say, "They can look after my heart and my lungs and my stroke", but now people expect to be looked after by neurologists for their stroke. And even more so, maybe, if you're in the city, you wouldn't be looked after by a neurologist for your stroke. You'd be looked after by a stroke neurologist for your stroke. So it gets smaller and smaller, the areas that we look after primarily, especially in the city.

The CHAIR: Thank you. I appreciate that.

Ms DONNA DAVIS: Just going back to the VMO question before, we heard earlier today that there was a specialist who prefers to go to a different health district because the requirements for just basic training, to be able to sign on as a VMO, are not as stringent as they are in Hunter New England. We were told that there's the compulsory training, so many—I suppose they're online—hours of training. Is that something that you've had experience of and think is right across the board? Or is it something Hunter New England require?

DAVID SCOTT: I don't know. I don't think our requirements would be any different, in terms of professional requirements. In terms of learning where the fire stairs are and that sort of stuff, I don't know ours would be much different there either. The difference in what they say you should do and what you actually need to do might be more than appreciated, as well. I can't say. I know other health districts have seemed to have provided quicker responses during recruitment. If someone wanted a job, they applied for us and somewhere else, but they were offered the other place first and pushed down the line quicker somewhere else than they have been here. I've heard that a number of times, which we're trying to address. But in terms of actual requirements, I can't say I know of any difference.

Ms DONNA DAVIS: We were talking about GPs in regional areas and specialists as well, that they feel unsupported. There is this anecdotal evidence that we've received, that there is a sense of finding it hard to retain people because there is a lack of support. But then we know that in other professions, particularly those that the Government is responsible for recruiting, like police, for example, paramedics, there is a very structured debriefing process in place these days for those professions, when they experience a road accident or were witness to a murder or whatever it is. Is there something that we should be looking at recommending, in terms of formalised debriefing and formalised support for medical professionals in regional and remote areas, that would assist them and help with retention?

DAVID SCOTT: I think it's a really good point. It's probably less required in Tamworth because we have quite a few people around. It sounds like and I imagine it would be required in the smaller centres, the two-, three-, four-GP towns. That sounds like that would be a really useful thing, but you'd have to ask them what would be most useful, and you have to find people to do it. It's a tricky one because, presumably, it'd need to be done by another doctor. But if you've got a doctor who can travel around the countryside, talking to doctors, then other people would say maybe that doctor should just be seeing patients. The people who would be willing and able to do that work, I imagine, would be relatively small, but it is something certainly worth considering. If that helps people to stay, I'd like to think we could provide some—even if it's just telephonic support from Tamworth, being receptive when they call us and helpful if they're in a tight spot. I'd like to think we could do that better as well—anything, because those guys need help. They do a lot of hard work and they need help.

Ms DONNA DAVIS: Given that we are sometimes quite reliant on doctors or medical professionals that are from other cultural backgrounds—English may not be their first language—is there more that we could be doing to support people that may feel isolated for those reasons as well?

DAVID SCOTT: Maybe. I think the majority of doctors in this region would have done their medical degree overseas. I don't think that would be—yes, I think that would be pretty close. Certainly the vast majority of new doctors to our region would have done their medical degree overseas and therefore come from a culture and possibly language which are somewhat foreign. To be fair, on the whole, they work with local people and

local people work with them very well. I'm always a bit reluctant to see a government having some sort of "This is how we're going to help you to assimilate" policy. That doesn't feel quite right. But, yes, it is a factor that needs to be taken into consideration. If there are special things that that group of professionals think they would benefit from, it should be something that we consider.

The CHAIR: They were an excellent couple of questions. I really liked that. We haven't touched on some of that stuff. Thank you so much for being available for us today. You will be provided with a copy of the transcript of your evidence today for corrections. If you think you might have been misheard or misquoted or taken out of context, you can make some suggestions for change.

Committee staff will also potentially be emailing to you any additional questions that we, as a committee, develop after the hearing today on the back of the evidence that you have given. We will send those out to you if that happens. We would ask, if possible, can you turn that around in seven days. If it's not possible, then please talk to us about any additional time that you might need. I understand, obviously, in your work and in your life you're very, very busy. Thank you again, Dr Scott, for being with us today.

(The witness withdrew.)

Dr PAUL CRAVEN, Executive Director for Children and Young People and Families, Hunter New England Local Health District, affirmed and examined

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

Mr MATTHEW DALY, Deputy Secretary of System Sustainability and Performance, NSW Health, sworn and examined

Mr ALFA D'AMATO, Deputy Secretary of Financial and Corporate Services, and Chief Financial Officer, NSW Health, sworn and examined

Ms TRACEY McCOSKER, Chief Executive, Hunter New England Local Health District, before the Committee via videoconference, affirmed and examined

Ms ELIZABETH GRIST, Executive Director of Clinical Services and Nursing and Midwifery, Hunter New England Local Health District, before the Committee via videoconference, sworn and examined

Ms SUSAN HEYMAN, Executive Director of Operations, Hunter New England Local Health District, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our final set of witnesses to our hearing into the proposal to separate Hunter New England Health into two separate health districts. Thank you all for appearing before the Committee today. Please note that photos and video footage will be taken and potentially used for social media and public engagement. If you would like your image to not be used, please let us know, and we will adhere to that. Before we start, do any of you have any questions about the hearing process?

TRACEY McCOSKER: No.

PAUL CRAVEN: No.

ELIZABETH GRIST: No.

SUSAN HEYMAN: No.

LUKE SLOANE: No.

MATTHEW DALY: No.

ALFA D'AMATO: No.

The CHAIR: Excellent. We have your submissions, which are greatly appreciated. Would any of you like to make a short two-minute opening statement? Before we begin the questions? I'll throw it to Hunter New England Health first and then come back to NSW Health second. Ms McCosker, would you like to make an opening statement?

TRACEY McCOSKER: Yes. I'd just like to apologise for not being there in person. I fully intended to, but I have been travelling in the north-west of the district and managed to get a head cold on my way home. I'm very sorry.

The CHAIR: Yes, you can keep that.

TRACEY McCOSKER: You didn't want to me to share it with you, though. Thank you for the opportunity to speak today. Since becoming chief executive in 2023, I have made it a priority for myself and my executive to be out in our communities regularly with clinicians, staff and our local leaders. Those conversations always remind us, as they did in this last week, of both the strength of our system and the challenges we face. We are committed to working together to leverage our strengths but also to resolve the challenges. I would like to be clear that Hunter New England Local Health District is not run solely out of Newcastle. Our board is spread across the region with members who come from Emmaville, Uralla, Repton, Inverell as well as Newcastle, ensuring that local perspectives directly shape governance and decision-making.

On the ground, our Executive Director of Clinical Operations, Susan Heyman, is normally based in Tamworth with all the general managers and health service managers in every local area who hold real authority over their budget, recruitment and day-to-day operations. Local leadership isn't an afterthought; it's built into how we operate and we actively support those leaders. We restructured our clinical operations over 12 months ago to ensure that our larger acute hospitals work more closely as one network, from Armidale and Tamworth right through to John Hunter. We have also created networks for the rural and regional hospitals across the district to work more collaboratively, while better coordinating our community and out-of-hospital services to improve access to health care for our regional and rural patients.

We've also invested in reinvigorating the local health advisory councils to ensure that we are working more closely with local communities and listening to their needs and concerns so that they can influence the decisions made and be more informed about what is happening in their local hospitals and why. While there is a view that the challenges in delivering health care in our rural and regional areas are due to how resources are allocated and where those decisions are made, the biggest issue impacting our ability to deliver the health service required is workforce. Workforce shortages are the biggest challenge we face here and nationally, and rural and regional areas are hardest hit. In fact, right now we have 150 active vacancies that are being advertised. We don't believe splitting the district would solve the workforce problem. Instead, it could fragment staffing, reduce flexibility and make it harder to recruit and retain health professionals.

Our position on whether the Hunter New England Local Health District should be split is based on a very considered lot of work that we've done on service delivery, workforce data, patient outcomes and financial modelling. Whilst we acknowledge there are always things that we can do better, we do believe splitting the district would cost more, deliver less and put services at risk. Right now, many patients in regional towns can access specialist care without always leaving their communities because we run integrated outreach and virtual services and break the network apart, and those linkages are compromised. I agree they won't disappear altogether, but they will be compromised in critical areas like oncology, maternity and Aboriginal health. It would also mean duplicating governance and corporate functions—funding that would be better spent on frontline health services.

We have been here before. The district was created in 2005, and when the large area health services split, Hunter New England Local Health District stayed intact because staff and communities understood the benefits of staying together, and we believe those reasons remain just as relevant today. It won't fix critical workforce shortages, it won't improve care and it will cost more. We feel that this service, this region in Hunter New England, does deserve a system that works together collaboratively and not in silos. Despite some of the views you've heard through this process, we are genuinely trying to achieve that. Keeping our district as one is the best way to protect and strengthen the care that the communities in our district rely on. I haven't got anything more to say on that, but the colleagues that I have with me will be able to answer more directly about workforce issues.

LUKE SLOANE: NSW Health is committed to ensuring patients in NSW Health and New South Wales, regardless of where they live, have access to high-quality health care as close to home as possible. The current model for the Hunter New England Local Health District and, in fact, all of our districts, enables that operational delivery of inpatient, community-based and population health services and ensures the effective delivery of these services are delivered in a cost-effective manner, but also promotes that staffing retention to deliver that high-quality, appropriate and, most importantly, timely patient care. Things that you've already heard in our submission—the total population size is comparable to a metropolitan local health district. Not to put it outside of what would be the norm in some of our other local health districts as well, this networking that we talk about through Hunter New England and, importantly, John Hunter supports the self-sufficiency that's upwards of 90 per cent for Hunter New England.

They're taking care of their own community, their own patients, within their own needs. The greatest strength of the New South Wales public health system, as has been seen through COVID but also, as we've come out of COVID and as we go forward, is its interconnectedness. We ensure every resident in regional, rural and remote New South Wales can access the health care they need as close to home as possible—being the pressing

point there—and we'll continue to work on improving that from a capacity and capability point of view. It remains one of our number one pressing priorities. Justice Richard Beasley, who led the Special Commission of Inquiry into Healthcare Funding, described NSW Health as, "Highly efficient and well managed, comprising healthcare workers who are highly trained, skilled and dedicated."

Hunter New England is no different. Whether we're talking about paramedics that work in the district, some of whom were described as glorified Uber drivers this morning—which I, on their behalf, take mild offence at, not only for them but also for the patients they transport. Every single individual patient that we treat matters. They're not a widget; they're not a passenger. They're one of our patients whom we care for deeply. The paramedics do an outstanding job of providing that clinical care, no matter what the acuity of that patient is. But we know that we put people in the transport that reflects the acuity that the patient needs to get to the right and most definitive care within the Hunter New England Local Health District but across New South Wales as well.

We'll only achieve these outcomes and this escalation in care and increased capacity if we continue to reinforce that well-networked system—we'll hear about that as I'm sure you work through some of your questions today—and around that integrated system across New South Wales, not only connecting us within New South Wales public health system, but also then to the primary health networks and, most importantly, to our GPs and other community healthcare providers and charities that support the work not only in Hunter New England but across the state. By connecting our smallest hospital services with the biggest hospitals, that's how we bring that latest technology to the bedside—for example, our most remote, like Tibooburra and Broken Hill, being able to connect directly with an intensive care unit, which I would say even 10 years ago probably wasn't practical or possible in many of our smaller facilities.

I don't want to suggest for any moment—and I've talked to many of you around the room about this—that the system is perfect. Anyone that claims that is probably shooting for the moon. We know it's not, but we'll continue to work on improving it, absolutely. The challenges we face really are many. One of the things I just really want to draw on after hearing some of the witness statements this morning is to point out the fact that many of the clinical leaders, if not all of them—management, local executive and executive—are part of the community. As you've heard from Tracey's statement, we have board members representative in Hunter New England across the whole footprint, similar to other districts down to the south and all around regional areas. We're trying to make sure that the boards are comprised of people, at the discretion of the Minister, that represent the community and that are working for the health district.

Many of the leaders, including Paul—we talk about bureaucrats and we use that in a terribly negative connotation. Paul is still a practising paediatrician and neonatal intensivist out there travelling all around the district, teaching and providing support to clinicians in every single part of Hunter New England. As public servants, we have to stand by integrity. We have to be objective. I have to present you with data and fact. Unfortunately, I don't have poetic licence around that. We are all clinicians. The Secretary of NSW Health is a nurse. I'm a registered nurse. I would say the predominance of all of our managers, leaders and executives in the system have come from some clinical background—albeit, by time, slightly disconnected from the clinical coalface, but we have some insight into how the system has grown and matured over that time.

I think, purposefully, we always need to do better with connecting with the communities and being able to work with and have a shared understanding of what good health care looks like. We heard this morning around the gaps in health care and availability. Some of the services talked about having had birthing services for more than 15 years, and when they did, they had maybe seven births per year, or they've been transferred. The view was that we would focus on aged care, and they've been transitioning to multipurpose services with aged-care facilities for the last 15 years.

We know that we're trying to bridge the gap around some of those primary healthcare gaps through things like the Rural Generalist Single Employer model, where the New South Wales Government and the health system sees its role in providing training support to primary healthcare clinicians that we know also support our hospital. But we need to balance that with the history of not burning out GPs. I know we heard from Dr Baker this morning. I really want to give him some kudos for still working while he's 75 and doing locum shifts. We love that, but we also need to recognise how that succession behind that is preserved, and how NSW Health contributes to that, especially for general practitioners in regional areas.

I'll finish off by saying that our health system connects every day through collaborative programs, many of which—telestroke, virtual ICU, the Virtual Rural Generalist Service and we're about to do some virtual ophthalmology in all eight of the districts, in conjunction with South Eastern Sydney Local Health District—are things that perhaps weren't available five or 10 years ago. We are continuing to build capacity and capability. We're bound by the health Act. We need to have governance structures in place across New South Wales that reflect appropriate governance in order to deal with our fiduciary responsibilities across the New South Wales

health system. Going back to Justice Richard Beasley's comments, we need to do that to be able to maintain and continue to be one of the best healthcare systems in the world.

With that, I'm happy to hand over and take some questions. I'm sorry to get so emotional about this, but I'm a staunch advocate for rural and regional health care at the moment. I think I've been to more facilities and met with more healthcare delivery people than anyone else in the state in the past two years. I'll continue to do so. I'll continue to engage with communities even though it was perhaps inferred that we haven't engaged with communities by some of the witnesses.

The CHAIR: Thank you very much, Mr Sloane. Ms McCosker, please correct me, because I think I've been making a terrible error. At 4.3 of your submission—I think it's on page 9—you talk about recruitment and retention. There are two dot points there: 1,773 hard-to-fill positions and 1,243 critical positions. I have taken them to mean that they are vacancies, and I have said on a number of occasions that you have 3,000 vacancies across Hunter New England Health. Have I completely stuffed that up?

TRACEY McCOSKER: I wouldn't say you've stuffed it up. I'm not sure where that number came from. Just let me pull this up. I had it. I've got Liz's problem where I had it a minute ago and it's just disappeared. I don't know, Paul, if you want to talk to any of the medical stuff.

PAUL CRAVEN: Were they the critical positions that have been—

The CHAIR: It talks about "the district supports recruitment and retention" et cetera, and then it has got four dot points: 1,773 hard-to-fill positions, 1,243 critical positions—

TRACEY McCOSKER: They're not vacancies.

PAUL CRAVEN: I think they're incentive positions.

TRACEY McCOSKER: They're the positions that qualify for incentive bonuses in those categories.

The CHAIR: My apologies.

TRACEY McCOSKER: It's to try to emphasise the ruralness, for want of a better word, and remoteness of some of those positions.

The CHAIR: I apologise to everybody that I've used that figure over the past four days of hearings. Could you just remind me: In your opening statement, you did put a figure around the number of—

TRACEY McCOSKER: There are 150 vacancies that we're actively recruiting for.

The CHAIR: I sincerely apologise. I can't apologise enough.

LUKE SLOANE: I should just clarify: They would be positions that are attached to the Rural Health Workforce Incentive Scheme and the incentives for being able to attract and retain staff. Each district would've had to go through and identify the critical and hard-to-fill vacancies in order to attract those incentive payments and apply them to the employees that gain a position or are in a position.

The CHAIR: Now that I re-read it, I can see that, Mr Sloane. I connected the word "recruitment" with the numbers. Let's kick off. I'm not sure who I'm going to ask this question to. We've had some feedback about simple things like IT—IT presenting telehealth services at some of the medical facilities that apparently doesn't provide a clear enough picture so that people can identify each other very well. We also had a suggestion about IT in terms of health worker accommodation not being available—so when a health worker comes into town to do that work, and then they can't even log on in their bedroom, that becomes a disincentive for them to stay. Who is responsible for IT? Do we have someone different responsible for IT inside of a hospital versus IT inside of a worker accommodation centre?

LUKE SLOANE: I'll perhaps throw that to Tracey. As we've travelled around all of the local health districts in New South Wales—particularly Tracey can answer for Hunter New England—we know there are several spots where access to wi-fi is one of the things that employees would like as part of their hospital-provided accommodation. If we were to be offering them a leased property that's offsite or outside of the hospital property, we wouldn't normally provide any sort of wi-fi because the leased property itself is part of the incentive or the thing that we're giving to the employee to come and work there. We know that the co-located key worker accommodation—the wi-fi and access to hospital wi-fi is one of those things that we'll be working through. eHealth is responsible for liaising with the district at a system level. Tracey, I don't know if you want to make comments about that across your sites and services in the Hunter.

TRACEY McCOSKER: There are some sites that are just difficult. You might be interested to know that the largest amount of complaints I get about wi-fi not working is actually from the John Hunter Hospital.

Some of these problems are everywhere. We do get specific reports. We got one recently that in Moree there were some issues. We've sent someone up to look up there. There is a program that regularly goes and checks all of these things because they are so critical. We're in the middle of rolling out SDPR, which is the Single Digital Patient Record. That's going to mean a lot of upgrading of a lot of systems and IT equipment. We're actually in the process of doing all of that. The Single Digital Patient Record, the Epic system, turns on in Hunter New England in March 2026. By that stage, we're going to have quite a lot of new equipment and quite a lot of upgraded facilities. I'm hoping that will go a long way to reducing a lot of those issues. If there was a complaint or concern, we would address it immediately, which we did in Moree.

PAUL CRAVEN: Can I just add that with the SDPR system that's being rolled out, as the first LHD in tranche A to roll it out, it was interesting because students were talking about what would attract them most in going to a local health district, and having an electronic medical record is really important to work in a district. I'm really pleased that we are first in that respect. Built into the Epic system, which we were all involved in building at the same time and rolling out, there is an automated messaging system where clinicians can contact each other, so it'll be much easier in the future to be able to contact each other. There's also a built-in videoconferencing platform in that system. It's an amazing program.

Ms LIZA BUTLER: On that model that you're talking about, we heard earlier today that one of the complaints from health workers was that some of the systems within the health district didn't talk to each other. Will that solve that problem?

PAUL CRAVEN: Obviously it has to roll out still, but my understanding is that it's going to be a huge upgrade of equipment and technology. Then all aspects of the system will be connected. Every patient will have a single record, and it will talk to the whole state, never mind the whole district as well. Wherever patients move in this district, we will have one record for that person and everybody can see that record at all times.

Ms LIZA BUTLER: Whether they're at Wee Waa or Tenterfield—

PAUL CRAVEN: Moree, John Hunter—absolutely.

MATTHEW DALY: The state currently runs about seven or eight medical records in groups of—

Ms LIZA BUTLER: Is that why they're referring to them not talking to each other?

MATTHEW DALY: Yes. Now, regardless of whether you turn up in Tumut or Tweed, clinicians will have access and a view of your medical record, regardless of where in the state.

The CHAIR: That's good to know, because one of the concerns we heard, even about within the Hunter New England Local Health District, was that even moving patients internally, inside the district, can be problematic at times because you feel like you have to repeat all the information or you have to send a paper copy as opposed to an electronic copy, and tracking a patient going into more of a tertiary service and then coming back out and getting their information. Just remind us, please: When are we expecting that to come online and live?

TRACEY McCOSKER: March 2026. It seems to be coming very quickly.

ALFA D'AMATO: Can I just add a comment? There is a significant investment from the state point of view to highlight the fact that the corporate infrastructure will have better leverage once we are all grouped together. There is the Single Digital Patient Record, and it is more than $500 million.

The CHAIR: So we will save or find an efficiency of around $500 million once everyone's—

ALFA D'AMATO: No, that's the investment. That's the cost of that. Hunter New England is the first LHD to be going live.

The CHAIR: While we're talking about numbers and dollars—Mr D'Amato, you might be the best person to answer this or perhaps you over there, Tracey—in your submission you quoted $111 million to set up a new layer of administration. That seems to me like a very, very large number. But also, Mr Sloane, in your opening remarks, you talked about the responsibility that we have about our administration process which supports our patient care. What would be the minimum services and layers of administration that would be required to set up a whole new district and a whole new administration arm for a new district? What are the must-haves? How do we get to a number of $111 million in it?

LUKE SLOANE: From a personnel point of view or from all of the other stuff?

The CHAIR: Let's start with personnel.

LUKE SLOANE: From personnel, you are required to have a board, a chief executive and an executive unit. There are slight variances to the executive teams across all the local health districts. However, you would

expect, as per any organisation, to have someone heading up operations, clinical governance, nursing and midwifery, medical services as well as some of the other facility, IT for example, to plug into that as well. From that point, you'd have the supports for them. It wouldn't be a direct transfer. It wouldn't change, I don't think, dependent on the size of the local health district.

Further to that—I don't know whether Alfa wants to comment—it would come down to the budgetary requirements for standing up all of the supporting systems like that. SDPR will obviously make a bit of a change with regards to the electronic medical record, but then of course you're going to have executive leads of clinical services, such as cardiology lead or a surgery lead or a medical lead or an obstetrics and gynaecology lead. You do need those heads of department or heads of both clinical and operational services in order to provide the correct governance and management of the services within the district. Alfa, I don't know whether you want to talk about some of the other costs associated with that.

ALFA D'AMATO: No, you covered the main areas. I feel that obviously we have to replicate at the very least all of the governance structure that we have in place currently to run the district—as Luke mentioned, the office of the CEs, all the executive teams, the boards and what goes with the boards at the very least. There will be other areas like the finance teams, the ICT team and those other areas that need to be replicated as a result of having to run an independent district.

LUKE SLOANE: Just to comment, Chair, also, I know that there were some assumptions made that we would just pop those from John Hunter or what's seen as Newcastle central over to New England Tableland to run that, but it would not be the case. We would have to maintain both services in both districts and the governance structures, and there's a whole governance compendium around what we're required to have from a NSW Health point of view in order to run each one of those health entities.

The CHAIR: I needed to hear that to offset the suggestion that this would be really simple, it'd be small and it would be cheap.

LUKE SLOANE: As for an exact dollar quantum, that was a rough estimate. But I heard you this morning. Even if we were to drop it down and everyone was running out of a $50 million price tag, we still have to have those structures in place to run whatever that number of facilities is. It's not going to be a new thing out of the box that we would have to create. I think those governance structures have been in place. Whether it be area health services that were previously in place, or prior to that the other iteration, or since the de-amalgamation of area health services to local health districts, the governance structure has to be in place in line with running the business.

Ms LIZA BUTLER: We went out west last week and we heard from different communities that there doesn't seem to be a connection between them and feedback from Hunter New England. Today we've heard from Inverell, and they say that that's working quite well. Then we heard from Narrabri and they're saying they haven't got one. Where is the community's perception coming that they're not being heard and they're not being listened to and that they can ask for things but nothing comes?

LUKE SLOANE: I think it's very valid.

The CHAIR: Is this specifically about Hunter New England Health?

Ms LIZA BUTLER: Yes.

The CHAIR: Would this be one maybe for Ms McCosker?

LUKE SLOANE: I'm happy just to give a bit of an overview. The Regional Health Division since being created has focused on this as being one of our number one priorities as well and the development of the guiding principles for local health committees—different to a board; I don't want to conflate those two issues. We know that there are some districts that do this better. I think I've spoken about that before. We know Murrumbidgee has very sound efforts for the local health committees to be able to escalate issues all the way through to the board. We know from work that we've done with Hunter New England there are various spots where it works really well. Inverell was one of those great spots where a couple of years ago there was a lot of tension, some of the likes we're seeing play out in other communities at the moment.

The mayor and I met. We had a really great and candid discussion about how to work together better. Hunter New England absolutely bought into that process, and then they've worked on setting up this other committee to make sure that there is constant and ongoing dialogue as well as the council providing an extremely supportive environment to health workers within the town, whether they're new or they've been working at the hospital there for quite a long time. That has resulted in the exchange of ideas and also some very good dialogue that's transparent around what can and can't be done as well as created a really positive environment in the

community to attract workforce and have more people come in and work there. There are always challenges, but Tracey might be able to talk to what they're doing more so about that within the district.

The CHAIR: Sorry, Luke, what was the location of that?

LUKE SLOANE: That was Inverell I was just talking about.

The CHAIR: Tracey, over to you now about this?

TRACEY McCOSKER: I might just call on Susan in a minute too because we've currently got—I suppose local health advisory councils really suffered in COVID and a lot of them sort of became dormant, so what we're trying to do is reinvigorate those. We currently have 19 active local health advisory councils, and we have about three others in the pipeline of reinvigorating, and one of those is Wee Waa. I was at the Inverell local health forum that has really been sort of actively implemented by the local council and the different health clinicians on the ground.

Paul Craven has spent a lot of time talking to them, and they literally said to us, "The last 2½ years everything has changed. We feel like we've got a good relationship and we feel like we're on the same page and we're working on things together", which is great news and I think that they indicated that. Different communities have different personalities and different people. Susan, you might just want to say the things that we do to try and connect with the different communities across the district.

SUSAN HEYMAN: Thanks, Tracey. I think you're absolutely right. I think during COVID that did a disservice to a lot of our communities and people really retracted and services really retracted. I think what we're doing is now rebuilding those relationships and those connections and those opportunities for us to really hear from our communities and respond to communities. I think in some of our communities we're doing that really well and in other communities I think we still have work to do, and clearly Narrabri is one of those communities. I think we have to also be very careful that it's not the loudest or noisiest voice that we hear, because the rural communities are really diverse communities and some of them have quite vulnerable groups, and we just need to make sure that, whatever structures we set up, we really do hear from everyone in the community, all those representatives right across the community. That takes quite a lot of really thoughtful processes, I think.

Ms LIZA BUTLER: When we have these health advisory boards, how then do you relay that information back to the community so that you're taking the whole community along on the journey with you and not just the people on the advisory boards because then you may get misinformation in the community?

LUKE SLOANE: Hunter can talk to their experience, but I think across the board what we see is it's a really tricky situation. We've got to continue to run the health service, and then the leaders from that health service need to make sure that they're engaging with council, community or otherwise. And how to do that is going to differ from town to town. It is probably a little bit inferred that when we're making up representatives of the local health advisory committee, we ask them to be the envoys of what we're trying to communicate out to the community. There's proactive media and engagement through social media channels or other avenues around what's happening from a health district perspective that gets pushed out there.

But what's missing from some of those channels is the ability to have a critical conversation, which is not always nice or doesn't always feel good, about what can or can't be offered in a community, the reasons why, and perhaps putting to bed some of the myths around some of the issues that arise out of communities. That's the thing that we're still trying to negotiate through. We can't be having a town hall every other week—or maybe we can; maybe that's the solution to it—because many of our leaders need to get on with helping their frontline staff deliver the clinical care. One of those things is exactly how we utilise not only the local health board but also, as I said, the discussion with Inverell council, for example, and a few of our other councils that we work very well with, so that they act as a conduit to the rest of their community as well. But that relationship between the district and the councils has to be good, proactive and positive.

TRACEY McCOSKER: I have been asked to meet with a lot of mayors. Susan and I have been met with a lot of mayors. Most of the time we agree that we've got a shared problem and we talk about what we can do. The councils that get behind their health services and try to find accommodation for workers and try to make workers feel welcome when they come is where we really engage and explain the difficult challenges, as Luke said. We had a meeting not so long ago with three mayors who said, "Okay, now we understand it. Now we're in a position to tell our community what the challenge is." Invariably it comes back to workforce, and trying to provide a safe service without the workforce is sometimes not possible. So those opportunities have been good. We have tried to talk to Narrabri council. We had a very open and transparent meeting, and at the end of it we were thanked for being so transparent and honest about the discussions and the issues. But that's not how the media conference went afterwards, unfortunately. So we're trying very hard to work more closely with that community.

PAUL CRAVEN: I will talk a little bit about Inverell, on the back of what Tracey was talking about just then. Tracey said about the relationship we've built over the last few years as a team together by being out there in Inverell. It is a relationship, but it's not just health. It's health, it's university, it's a primary health network and it's the local community, at the end of the day. A lot of that is driven by the local council inviting us in and getting us all together to have that conversation. I would say that even though we've been out in Inverell very regularly, we've been to every other place as much as well. I think the model we're talking about in Inverell is absolutely generalisable to all those communities. It's a really superb way of sharing information.

A lot of what we have identified in conversation is sometimes we don't know what people are thinking and sometimes they might not know what we're doing. So it's a really good way of sharing that information at that stage as well. The work we're trying to do with Inverell and Armidale is not just about that area. We call it the New England north-west, but the work we're doing in training additional medical staff and making sure that we're training rural generalists and proceduralists is to benefit all the sites. So it's not just about one site; it's about all sites together.

Ms LIZA BUTLER: On the training of staff for rural areas, we heard in the rural, regional and remote committee as well—and we've heard it again today—that many GPs or medical training staff go out to a regional area and they feel quite isolated and they then cannot get wait to get back to a city, where they have every specialist around them. What are we doing to address that to help them feel supported so they then stay in a regional area?

PAUL CRAVEN: I can start, but my colleagues are online as well. I guess the first thing is we're trying to have a critical mass of people, because people don't want to be isolated. What we are doing at the moment in Armidale is trying to recruit two teams of people so they can support each other at that stage. We also recognise that there is more to it than just working. It is also about upskilling themselves with education, research, quality, writing guidelines and being a community in that region as well. We've actually had some local success recently in Armidale.

We've recruited about five new staff specialists, which is a fantastic achievement in that region. We've also just managed to recruit—because of some of the things that are occurring there—one of our first GPs back in Inverell Hospital as well. So, again, there's a flow-on effect. I've worked at Hunter New England for 21 years as a clinician. Whether it's just me as a neonatologist, it is a district that continuously goes out educating. It is important to maintain education. One thing we do very well is go out and educate, because you can't expect people to leave communities all the time to come in for education. It's just not possible.

Ms LIZA BUTLER: We heard that today.

PAUL CRAVEN: We have to go out and provide that education. We have some fantastic virtual support, whether it's clinical support in outreach clinics—and, I have to say, there are hundreds of outreach clinics within Hunter New England providing that local level of specialist support for people as well—and then obviously virtual care. I can speak from a virtualKIDS point of view, where if anyone rings Hunter New England and has a sick child, they can get specialist advice from a supporting paediatrician that might not be present in Moree, Narrabri, Inverell or Glen Innes at that stage. Whilst we have that virtual care for the whole state, the majority of its use comes from Hunter New England.

Ms LIZA BUTLER: Talking about virtual care, we have been onsite in hospitals all over the state and seen some camera technology that will pick up the smallest pore on your skin, yet we've heard in this inquiry that sometimes the screens are so blurry that it doesn't work. Does that range from hospital to hospital? And, if it does in those smaller hospitals, what are we doing about it to ensure that it is the best it can be for people that have to rely on that service?

LUKE SLOANE: I might use the Moree example. We had feedback not from a clinician but from a consumer about their experience of some IT, but when we checked that with the clinicians in the department on the ground, it was very much the opposite and there was no problem. I'm not saying that, again, this is why we need to go in and check and audit things. There are processes in place for clinicians to escalate, always effectively and across all of the state where we use this technology—again, this is not brand-new technology; we've been using this for many years. But if there are issues like that, we want to find out about them and be able to ratify them and make sure that staff are encouraged to escalate those issues so that the technology is working properly. The reliance on this is not going to go away in the foreseeable future. When I say "reliance", if we want to continue to deliver really high-end specialist care to our smaller sites, we will need to have this technology available in order to do it.

Ms DONNA DAVIS: I thought we didn't use the word "consumers" anymore but patients. When you say it is up to the staff to escalate, in terms of Wee Waa, we heard from many people that were patients that had had this experience. You may not all be aware, but several of you would be, that the telehealth service there is

their only option because they don't have any VMOs. Wouldn't it be a priority at your middle management level to do something to ensure that a hospital that doesn't have doctors has a very good telehealth service?

LUKE SLOANE: Absolutely.

TRACEY McCOSKER: Can we respond to that? Part of that is also how people are trained to use it. When we were talking about training and supporting staff, I was hoping that we could hear from Liz Grist, who is our director of nursing and midwifery, about all the support that we give the nursing staff. There are a lot of skills that need to go with using that equipment, which we're training people at Wee Waa to do. It's not straightforward and it's not necessarily about the technology. Sometimes it's just about people's experience and confidence with that technology.

Ms DONNA DAVIS: Again, it's over two years now that that hospital has only had telehealth. Wouldn't that be something you would expect may have been rectified by now?

SUSAN HEYMAN: Could I speak to that if you don't mind?

Ms DONNA DAVIS: I'm going just on what we've heard when we've been in Narrabri. We've had many witnesses that have said to us that, obviously there are nurses there, but in terms of having referrals to doctors.

SUSAN HEYMAN: We've got 28 small facilities across the local health district that rely on telehealth, as you call it, on a regular basis—daily, weekly and on demand, if you like. For example, if we've got a locum booked at a particular hospital and they don't show up because of the weather, plane flights can't get in, sickness or whatever, then we have the ability to transfer very quickly to video as medical support if we need to. We in fact do have a system to audit our video equipment on a really regular basis. That equipment is maintained at what is really quite a good senior level. But across the rural area the server doesn't always work, if you've got storms or other things going on. So irrespective of how good the equipment is or how well the staff may be trained, keeping in mind that we also have a lot of agency nurses and a lot of locums that come in and out—so different staff at different times—their skill level is variable. The equipment is maintained, and the staff in their orientation receive training. But we still have the issue of whether another event means that, at times, the connection is not perfect.

I drive around the district a lot. There are some days when I drive just from Tamworth to Armidale, which I do regularly, where I can get service the whole way; and then at other times it's a bit patchy. Some of that will be corrected with the SDPR, which Paul talked about. There's also network outages and improvements that are going on constantly across the rural area of New South Wales. That's the reality of it. I think most any reports of the systems not working are quickly escalated through. And IT, I must say, are really responsive in terms of responding to our small facilities and the nursing staff who are on there, to have the equipment repaired if it is at all faulty. I'll hand over to Liz, who might want to speak about some of the training that's provided with orientation, but also some of the remote supervision et cetera that's provided.

MATTHEW DALY: To that point, Susan—Chair, do you mind? I was almost going to make comment when you raised the issue, but I thought I'd leave Tracey's paper to rest on the table for the Committee. As the one with more grey hair than anyone on this table, I've lived through and led both the amalgamation of health services and the devolution of health services, which is exactly at the crux of the issue that the Committee is confronting itself with. I hark back to 2004 with the creation of the mega area health services, as we call them, that led to the creation of Hunter New England. Make no mistake, that was fundamentally about patient safety, because it came out of the tragedy of Camden—sorry. I worked there. It was to resolve the issues around Camden and Campbelltown Hospital. Make no mistake, we killed seven patients at that hospital.

What occurred from that was a realisation that developing health services, particularly in outer metropolitan and regional areas, needed the support of the big ivy league institutions and the immense clinical skills that reside in those big teaching hospitals. So it was no accident that the mega area health services were created by marrying the teaching hospitals—the big one in south-east Sydney, the Royal Prince Alfred Hospital, Royal North Shore Hospital and John Hunter Hospital—with their respective natural flow areas, and it was all because of patient safety. Coincidentally, it also released hundreds of millions of dollars through the administrative savings that fell that enabled the system, which had something like 18,000 or 20,000 patients at that point in time that had breached their overdue surgical status—it funded the immediate correction of that over the following 12 months. Actually, the recurrent nature of those savings funded it for some years, until population growth and costs subsequently eroded that benefit.

What we're seeing here is an identical set of circumstances, and I think we should look at it through a patient safety lens. Because in the next step, when I led the devolution of the creation of the local health districts, the networks that had been built up—and I'll give examples—between Prince of Wales Hospital supporting Wollongong Hospital, between St George Hospital supporting Shoalhaven Hospital, which took one to three years

to develop and get in place, the moment those administrative boundaries changed, those clinicians said, "You're on your own now. We have our own patients to look after," and all that work and the clinical networking, clinical support to those developing areas, often with greater population demands than the Prince of Wales and the RPAs of the world, disappeared overnight.

I can guarantee you that the goodwill that's being shown by the clinicians of John Hunter Hospital will similarly disappear. I cannot say that history will not repeat itself. At the end of the day, as public servants, we'll execute whatever decision government hands down, but we have an obligation to actually tell you the risks around it. Frankly, in my experience, that is exactly what will happen if you make this decision. But we will mitigate the risks if that's the decision of the Committee and government, and we'll do our utmost to protect patients as we do every single day.

The CHAIR: Before we go to another question, Liz Grist was going to give us some information about the training of the nurses to use the telehealth.

ELIZABETH GRIST: I believe that we've got a very robust education structure for all of our nurses across the district, particularly for our rural and remote nurses. All of our nurses in our hospitals, in the EDs and our small sites, have done the ECAT protocols, which is the emergency care assessment and treatment protocols. Everybody has been taught how to use the cameras and how to initiate care when a patient comes into one of our facilities. We regularly audit those skills. I feel really confident that the nurses that work in those areas do have those skills.

We do have a very robust support system in place as well if anybody feels they need to contact us, contact our larger sites and so forth, to get assistance at any time. Susan talked about the IT problems. That's something that I can't control—we can't control the weather and so forth—but I do feel really strongly that our team of educators monitors, audits and ensures that our nursing and midwifery staff do have the skills needed, particularly on our smaller sites. We're very focused on our smaller sites. I'm not sure if you've got a specific question about any of those things.

The CHAIR: No, I think it all stemmed from the fact that there'd been some unfortunate outcomes through the delivery of video medical assistance on one particular site. In part, that was blamed on poor connectivity and that swung us around to say that sometimes the connectivity is fine but it's the staff's ability to use the equipment.

LUKE SLOANE: Cutting through all of that, we want to make sure patient consumer experience is of the utmost importance. We have those processes in place. I'm sure intermittently it does fail, but we do need to make sure that patient experience is paramount, which I'm sure all of our clinicians aim to do every time they see someone. I'm not saying all of this—and I'm sure the team aren't saying all of that—negating actual patient experience on the ground as well. That's the most important thing to us.

Ms LIZA BUTLER: There were a number of issues raised by communities, but I think the catalyst for this proposed bill was the Wee Waa hospital. When we were out there last week, community members told us that there were up to four local GPs that were ready to do VMOs. Is that true or not true?

LUKE SLOANE: I'll let the Hunter New England talk about it. There are four GPs in town, I would say. There is one particular person who maintains a practice who the regional health division team and the recent independent review had the privilege of meeting and talking through the amazing work that they're doing in that town, from a primary care physician point of view. I note that NSW Health staff from the district also work out of that GP practice as well, which isn't a well-known thing. That shows the true integration of NSW Health and Wee Waa Health Service with that local GP's business and form and function from the town. I know that the Hunter New England have had negotiations with that GP.

I will just start their response off with saying that we have policy and rules around how much—and we have awards that govern how much—we can pay medical officers within the state. There's a significant amount of work being done at the national level to make sure that we are not cannibalising other states for any of our clinical workforce and that we are spending judiciously across it and trying to control locum rates across not only New South Wales but in conjunction with the other jurisdictions. We have award provisions as well as the Rural Doctors Association settlement package that govern exactly how much we should be offering people, commensurate with volume and the work that they do within our facilities. The reason why I say volume very firmly—and to get this on the record—is that I think we've done data all the way back to 2013. I think I mentioned this previously.

Per annum, there were around about 600 admissions to Wee Waa hospital, which is not many per day. Even less than that, emergency presentations dating back to the same period of time slowly decreased, which we acknowledge also would have decreased more rapidly in recent years since the temporary reduction in services.

To correct some of the terminology around closed services, the temporary reduction in services led to even less presentation. There's a bit of a tension for the district that we have observed externally for how much, perhaps, is looking to be negotiated. That's a bit of a commercial-in-confidence affair between the district and the GP, as I'm sure you would appreciate. But the district is also approaching other general practices and general practitioners in order to provide that service as well. I note that there was another VMO in recent years that also used to come on the weekends to Wee Waa that everyone seems to have forgotten about. I'll hand over to the district to make their comments.

PAUL CRAVEN: I don't know if Tracey wants to comment first, or I can comment.

TRACEY McCOSKER: You go, Paul. You are having the discussions.

PAUL CRAVEN: Yes, there are medical staff in town and, yes, they are interested in working in Wee Waa hospital. We're in negotiation. It's an ongoing process, and we have made that clear that it's an ongoing process at the moment. I guess there are lots of recommendations against the actual Wee Waa plan. When you're looking at the whole for Wee Waa and what that health service will look like in the future, we need to make sure that the medical component of that service matches what we want to create in that as well in Wee Waa. It is a small component of the workforce. We've got to get nursing correct, we've got to get our community services correct, we've got to get any allied health services correct and, obviously, we've got to get video services correct if they are being provided as well. We will continue to have those negotiations around what the medical cover will look like in Wee Waa hospital in future.

Ms LIZA BUTLER: Tracey, did you want to add anything to that?

TRACEY McCOSKER: Yes, just to say that we are committed to implementing the recommendations. That involves, obviously, opening some inpatient beds and having a medical presence onsite. I'm not sure we'll ever get to a 24/7 situation where we've got a medical presence onsite, but access to medical services is what we need, which we do have to a certain extent, obviously, with My Emergency Doctor. We are committed to that. We are looking at all the different models of care that could possibly help us deliver that. We have got some good irons in the fire. We're just working through those at the moment. I'm very hopeful that we'll be able to achieve what we need to achieve for Wee Waa hospital.

Ms LIZA BUTLER: Do you have a time frame on those negotiations?

TRACEY McCOSKER: I'm hoping that we'll know something in the next couple of months.

Ms LIZA BUTLER: Just for me to put on the record, with the number of presentations, we heard last week that people will just bypass Wee Waa now and will not even present there because they know that they will only get telehealth and it may or may not work. If you're basing your number of presentations to the hospital now when there are limited services, it's not reflective of what the community would like.

LUKE SLOANE: We're basing our information on presentations that go all the way back to 2011. Coming back to one of the comments earlier, this is one of the things that underpins that attraction and retention strategy. Clinicians need volume to maintain their skills and actually maintain their interest in working in a place. If they are only seeing two patients a day, it's really tricky to be able to then keep them gainfully employed, not only just from a pure—we know that there are many more presentations down the road, and 25 to 35 minutes down the road. I'm not saying that's exactly the answer, but they will vote with their feet also.

We know that when we've had recent flooding up in this area—of which we've had far too much this year. The reason why Tracey and the team have been able to then keep that facility open for 24 hours to support the local community during those times of flood—and I'm not suggesting that they can do that all the time—is because the people that usually work in Narrabri were actually trapped by floodwaters and able to work pretty significant overtime to maintain services and access to health care at Wee Waa. A similar thing goes for general practice. The doctor in town, as I said, is doing an absolutely fantastic job for that community in a primary care setting.

We're also quite conscious of the tension. It is a class D1b community hospital. It's not meant to offer surgery. It has been like that for a very long time. Its role delineation and its hospital classification has been like that for a very long time. It's not meant to offer anything except for augmentation and then deferral to other community centres. It has been like that since 2011. I think the last person to birth there was 2013, for example, and even then there were only seven births per annum leading up to that year as well. The volumes to attract general practice and general practice that then have rural generalist training and obstetrics around anaesthetics is very hard. We're also conscious that we don't want to move what will be normal primary care volume from the local GP surgery up to the hospital into a system that's essentially working for the local general practitioner as well. We want to make sure there is care available so that people don't have to bypass.

There's probably one other point I wanted to make that I heard this morning which I thought was quite dangerous if anyone was watching this at home, which is the concept of double and triple bypass of hospitals. I need the public to know that if they are being moved from a hospital to another hospital, it's for a higher delineation of care that's respective of their clinical acuity. Even Blacktown Hospital will sometimes send patients to Westmead Hospital or further afield in order to get the appropriate clinical care in a metro area. The same thing applies to the likes of Wee Waa, Narrabri and/or Tamworth. The fact that someone said this morning that John Hunter Hospital has been on bypass—I want to try and remain quite professional as a public servant here, but it was one of the most far-fetched things I've ever heard in my life. That person wouldn't have gone to John Hunter because we have a network of ICU beds across the state, and they would have been wanting to get that patient to a definitive ICU care bed that was available.

The other thing I want to mention is that when people are mentioning they are not going to hospital for any sort of reason, we want to reassure the public that they can present to any facility—obviously, in Wee Waa when there is no after-hours capacity, if they think that they're in any sort of emergency scenario, they are to dial 000. We don't want this messaging getting out that people that are getting bitten by snakes or falling off their tractors in the field shouldn't somehow be ringing 000 rather than qualifying whether or not they should be presenting to a hospital like Wee Waa. We want them to actually ring 000 and seek the care that they can get and will get from NSW Health.

Ms DONNA DAVIS: It's good that you finished on transport because I think it's a bit of an oversight that we haven't had NSW Ambulance here because we have heard about some of the challenges that they are facing as an incredible service. We know how important they are right across the state in delivering health care and emergency care. But we've also had people tell us about their experiences with ambulances being taken out of town to transport people, understandably, to other hospitals. They sometimes meet another ambulance on the side of the road and swap patients.

That can be a process if it's a long distance. But they can be taken away from that centre. I know that it's a concern for a lot of the local government areas that they can be, for extended periods of time, without an ambulance in town. I know it's not necessarily your area of expertise, but do you have any information you can give us on what could be done to try to improve that? What sort of funding could we be giving to alleviate this problem? Because it is obviously ongoing and it also links in with the very limited access to transport that people in regional and remote areas have.

LUKE SLOANE: I almost sound like the Commissioner saying there are three parts to my answer—if you saw him in budget estimates yesterday. But I will cover it off in three parts. Yes, you're correct. Sometimes paramedics, because of the clinical acuity of the patient, will be needed to provide it. In talking with the Commissioner for NSW Ambulance or Chief Executive, Dom Morgan, we have talked about this quite a lot. They use some pretty astute modelling to see what sort of case load each one of the regional areas actually needs in order to inform how they need to bolster the workforce or the vehicles that are available in those areas. We know that the ambulance is the one and only transportation method for a lot of patients because of their clinical acuity. We are rolling out also patient transport services across the state. Quite a few districts themselves manage their own patient transport services at the moment. As part of that, we'll be looking to use their intelligence to better utilise their transport function when there's not a clinical need for a nurse or a paramedic workforce to be doing that transportation.

Coming back to Matthew's comments about clinical safety and patient safety, in some circumstances, even if a patient has had chest pain in the preceding 24 hours, we will need to err on the side of caution and use the ambulance. But, in talking with Dom Morgan and NSW Ambulance, one of those things in rolling out the extra 500 paramedics across New South Wales is ensuring that we have that 24/7 shift coverage and we have the right amount of people that they provide back out from town to town or that is commensurate with their case load that we track across all of the ambulance services within New South Wales. The tyranny of distance in regional areas really plays a barrier for some of that stuff. But also we're not in a place where we can have—and rightfully so, so I doubt we do—paramedics sitting around just waiting for the emergency phone to ring to be sent out onto a job because, as I said before, the patient getting to their destination or the other hospital is probably on par with making sure that we can respond to the emergencies.

Ms DONNA DAVIS: We know that there are options for support for transport for people going to medical appointments, but the minimum kilometres is 100 kilometres. People that are travelling 50 or 60 kilometres are not eligible for that. What is the district doing, given that you are such a large district and you have an unusual situation where your major hospital is in one corner rather than in a central location? Is there more that could be done so that we can retain the health district as it is but support our communities better not only to get to appointments and to hospital but to get home into those remote areas? I know that it's something

that happens anywhere. In Parramatta, if somebody is discharged from Westmead, you've got to find your own way home. I appreciate that, but we're in a very different scenario in these districts.

LUKE SLOANE: From a system point of view, our team is working closely with Transport for NSW to review transport for health policy. In that, that captures things like availability of bus services, public transport, availabilities of taxi or private transport in regional areas, as well as other options. It's a pretty large policy review that we're doing at the moment. The reason why we are doing that is exactly because of that. We know that there's no availability of public transport like there is in metro areas. Even just for the healthy people going to get a medical check or something that's quite a long ways away, we know that the bus or train timetable isn't necessarily conducive to that.

In some of the districts we have—and most recently, we've just worked out sourcing one of the leftover buses from COVID that we used for patient transport services between Lightning Ridge and Goodooga, for example, to make sure the people of Goodooga can get to Lightning Ridge and access the health service there. Further to that, I think we've had an uplift in spend. I can't remember the exact percentage. I'd have to scroll through my notes, but last financial year we spent $55 million—I think it was, Alfa—on the Isolated Patients Travel and Accommodation Assistance Scheme. That's an uplift from around about $27 million, I think, in the previous couple of years.

The CHAIR: Statewide or Hunter New England?

LUKE SLOANE: Statewide.

Ms DONNA DAVIS: But that's for people travelling over 100 kilometres one way.

LUKE SLOANE: Yes. We have made exceptions below that. I know I was asked about this yesterday because it's not necessarily something that's incredibly efficient to go through every one and make exceptions where it's just up to. But in saying that, I'll probably throw to Paul and the district to talk about using the rural aerial health services grant that we maintain with the Royal Flying Doctor Service, as well as grants given to organisations like Little Wings, to then take clinical staff from the district central or from anywhere in the district actually to then outreach so that people don't actually have to travel at all.

The after hours discharge thing in regional areas, we're working through with them because we heard some stories about an 84-year-old being discharged very late in the night in one of the districts to our south. Of course, we never want that to be the patient experience. The district have followed up and are putting processes in place to make sure that they can do a safe discharge for vulnerable people going forward. I met with I think Hay council a couple of weeks ago to talk through how we're going to tackle that as well. But I'll let the district talk about what they might be doing locally.

PAUL CRAVEN: One of the best initiatives I can say is not leaving the home in the first place. If it's an appointment that you can actually do virtually, I think that is a phenomenal way of providing great service in a virtual capacity as well. So increasing virtual care is really important. I know it's our initiative in Hunter New England to increase virtual care at that stage. We provide a lot of virtual care already, but I think there is a greater capacity to provide that. I'm sure, with SDPR connecting the whole system, that is going to obviously ensure that we provide it even more succinctly in the future.

The other thing is taking services out to patients. Care close to home is really important from our point of view. Just from the children's services point of view, we do hundreds of outreach clinics per year. We do go out to communities so that we can actually provide it close to home at that stage, because obviously taking one person or two people out actually saves 15 families travelling. We've mapped out how much time it takes for a family to take to come to one appointment, for example. We do outreach across the whole district and beyond the district, as well as the tertiary children's hospital, but we do take a lot of care out at that stage as well.

As Luke says, we do use our aeromedical services as well. We have a very good relationship with RFDS but also with Little Wings, which is where we can bring patients in—again, not within the 100 kilometres but remote patients in for appointments that they need face to face or we can take medical teams out to patients as well. We fly, for example, regular—we have 27 cardiology outreaches a year around our district and we use Medical Wings for that so that we actually can take people out. We'll see up to 20 people per day when we take a team out to various communities in Hunter New England.

TRACEY McCOSKER: I'll just add, obviously why we're here is about splitting the district and none of this is going to change if we split the district. Transport is always going to be a problem. But one of the things that we are also looking at is local councils, what services they offer, what some of the Aboriginal medical services offer in regard to patient transport and what are some of the local initiatives. One of the advantages of working closely with the councils is that they often have suggestions in these areas of where we can help or they are

connected to voluntary organisations that can also help. They're the sort of things that I think are key in leveraging if we've got some effective local health advisory councils and also a good relationship with councils. But, yes, it's not going to change those sort of referral patterns.

Ms DONNA DAVIS: I know it's not going to change. I know that the question is, "Do you split the health district?" But if we can demonstrate that we are actively working to make it easier for people to get to the primary hospital in John Hunter and to make their lives easier—that's why we're here in the first place.

TRACEY McCOSKER: And we are looking at those options.

Ms DONNA DAVIS: Just touching on that, obviously we're very proud of and recognise the work that John Hunter does. We also acknowledge that there are particular health issues that are more common than others. Are there opportunities for us to expand those specialisations in Tamworth to better support the regional and remote communities so that there is less demand to travel? And obviously noting that you've got virtual care as an option, as well.

LUKE SLOANE: Ms Davis, can I make one comment. I'm sure Paul has a really great answer for that. One of the things I really want to push back—and I'm going to channel Dr Kerry Chant while I'm here—is that some of the major health issues are relevant not only in Hunter New England but in all rural, regional and remote areas. We need to work very closely with the communities themselves around how to reverse some of them.

Ms DONNA DAVIS: Preventative. Yes.

LUKE SLOANE: Diabetes, smoking cessation—we have higher smoking rates in all of the rural and regional areas. They're then preclusive to all of these. I'd be remiss not to actually mention, without Kerry being here, that a lot of those things are actually in our control from a promotion point of view and working closely with local council. We see that quite a few local councils are massively proactive in this space, as well as communities themselves that are actively trying to reduce their smoking rates, actually trying to exercise to reduce obesity rates. And then, before we even get to them, outreach clinics—which I'm sure Dr Craven will talk about with regard to chronic obstructive pulmonary disorder or cardiac problems or otherwise—and that's before we get into the complexity of the first 2,000 days.

PAUL CRAVEN: I was going to say that a lot of our services—I obviously know most about paediatrics and maternity or neonatal and all those related areas. We work in our service capability. So not everybody flows into John Hunter by any means or John Hunter Children's Hospital. Whereas we might be a level 6 centre, there's only certain patients that would ever need to come to there. Obviously we would make sure that Maitland, Taree, Armidale, Tamworth—they have a different service capability. If there are patients out in, maybe, Moree, we would never bring those patients directly to John Hunter. We would actually say, no, those patients in our service capability should actually be serviced by Tamworth.

Whereas we take some of our services out—we talk about outreach services—so does Tamworth as well. So they are very good also. Only in the last week we've had conversations about them taking their services out. So we'll provide specialist care to Tamworth. Tamworth will provide their specialist care out to Narrabri, Moree and Gunnedah. We talked only this week about doing that as well. There are certain things that are really specialised or that all sites need a little bit of help with at the same time. I guess the other thing is we have our networks as well. We have networks of services, and they work across the whole district. We have seven networks, and that's things like CancerNetwork and Urgent Care Network and procedural care, which is all our surgical services. All of those services network together to work together. So we actually provide a really consistent service across the whole district.

ELIZABETH GRIST: I'll jump in, just following on from the virtual care model and how things work. If I could just refer to the Menopause Hub, for example, which is at Wallsend in Newcastle, and it looks after the whole district. It's got endocrinologists, gynaecologists, physio. Women really like the virtual care. We're finding that even people that live in Wallsend prefer to book in virtually. We have high-risk maternity clinics right throughout the district that's virtual care. We have fetal maternal medicine specialists that actually fly to Moree to go where the need is. So we do try and ensure that, I guess, the way we deliver the care is what people want. Of course, there are always those critical incidents or situations where they've got to go to a higher-level facility, as we've discussed before. But the different modes that we provide, the care, treatments and so forth, I'm finding—I'm really amazed; particularly the menopause one was a great example—that women do like to have the virtual care. It's convenient for them and it's fantastic that we're able to provide for those that want that.

The CHAIR: Mr Daly, we have had some examples there of some wonderful work that Hunter New England Health is doing, spending time and resources to reach right out into the distances of the entire district. In your experience of devolutions in the past—if a line was drawn—is it your experience that those services would stop reaching so far and that they'd stop at their boundary?

MATTHEW DALY: Absolutely. All our clinicians, as some members of the Committee have observed, work under immense pressure and population pressure. They have to make priorities every single day about patients they see. They make clinical decisions as those they triage as 2 instead of 1, or 3 instead of 2, in order to ration time, to treat patients who come through the door. Having lived the experience, it started to occur within weeks of the administrative changes that saw that devolution. I know we're not here for money, because Government can allocate as much money as it chooses in order to implement its program. But just as it freed up hundreds of millions of dollars to clear the waiting list backlog that we had back then, it generated similar hundreds of millions of dollars across the system.

Government of the day actually told the public that it wouldn't cost another administrative dollar. But as the person responsible for setting up and appointing all those new chief executives, all those new board members, all the administrative support to support board members and chief executives and directors of finance, directors of nursing like Liz—that's just fundamentally not true. It just couldn't practically occur on this occasion. But Government has a right to invest taxpayers' money and it's accountable to the taxpayer. If it made that decision, we would implement it. But there are risks far greater to the expenditure of this state than the Treasury concerns. I'm here and I'm passionate. Excuse my momentary glitch at the beginning. It's because I'm passionate that I know the consequences of decisions like these. But nonetheless I, like I'm sure Susan Pearce and the rest of the executive and chief executives of the district, would work to implement it in the safest possible way. But I'm here to advise that that risk cannot be mitigated.

The CHAIR: Mr Daly, I don't think I can overvalue your contribution, because you have literally lived through both amalgamations and devolutions. I don't know that any of our other witnesses have offered those types of insights, so thank you. Mr D'Amato, obviously Hunter New England Health has that more metropolitan base but also the regional base. I want to ask you a question about delivery of services. I don't want to pick a service. But if each service is a widget, whether it's an X-ray or a night in hospital or a transport in an ambulance or whatever, I would guess that the delivery of each one of those medical events in a more metropolitan area must surely be cheaper than the delivery of each one of those medical events in a regional base.

ALFA D'AMATO: That's correct. From the data that we received from all the districts, we can actually see that the average cost of delivering these services from hospitals within the Hunter base versus the New England are significantly—I don't want to say "cheap"—just cost less, as a result of, obviously, the opportunities to have more volume, one being economy of scale. The other one is obviously distance. We try to accommodate for some of these variances in cost structure through our activity-based funding model. But obviously we can't mitigate all of these costs. As a result, we can actually see, even after having adjusted for these, the average cost for those hospitals in the New England tend to be more expensive than those in the Hunter. Again, this is not dissimilar to other regional areas—the southern area and the Far West. Far West is obviously, probably, the most exposed as a result of the fact that, effectively, they're one activity-based funded hospital and it is very regional. But we know one thing. Once some of these districts are exposed to this economies of scale, it's very hard to bring it to a level of efficiency.

The CHAIR: Thank you for that. I'm glad I got something right. Ms McCosker, can I ask about the make-up of your board? You mentioned a number of your board members who do come from across the regional and remote parts of the district. Is that by design? Are there a certain number of positions on your board that are allocated to the more regional areas?

TRACEY McCOSKER: The board was pretty much appointed before I got here 2½ years ago, but I believe that there was a deliberate attempt to try to make sure that the rural and regional areas in the north and north-west of our district were represented. Actually, you often find that people in those areas are much more keen to be involved in a board than people in metro areas, sometimes. They've been incredibly helpful and created some really good opportunities to discuss the issues. They're great advocates, but they understand governance as well. They've got a Hunter New England health district hat on, but they are clear advocates and share stories. We try to have board meetings around the district, and we had a board meeting in Inverell on Wednesday.

The CHAIR: Oh, very good.

TRACEY McCOSKER: Wherever we go, they do a tour of the hospital and meet the executive. On Wednesday they also met the local health advisory committee.

The CHAIR: But just at the minute you can't guarantee whether or not in your constitution the board make-up insists on a certain number of regional members?

TRACEY McCOSKER: Matthew Daly might know this better than me. I'm sorry, I don't know that.

MATTHEW DALY: No, I don't believe it is, Chair, but—

TRACEY McCOSKER: I don't think so.

MATTHEW DALY: —I guess all districts, in terms of the chair working with the secretary, by design, there is implicit bias to ensure representation of all communities, whether it be a large metropolitan community or a large rural, regional community. It's probably a reasonable outcome in terms of trying to get board representation. To mandate it I think you'd be overegging it and there could be some negative consequences to actually dictate, when I think those closest in those districts would have a better idea to ensure that there is representation from Narrabri or from Inverell or whatever part of this particular district. But I think it's great the way it has happened, explicitly or implicitly, because it sounds to me—the Committee members might be better placed—as though it's a fairly representative board for the population that it's serving. But there's no Health Services Act obligation to do so.

Ms DONNA DAVIS: We heard from UNE this morning about the training positions. I asked the question about whether or not—we were told that, statistically, if somebody stays in a regional area to train and they come from a regional area, they're more likely to not necessarily stay there but stay or move to another regional area. Given that, has NSW Health or the district advocated to increase the number of places at UNE for medical training? Secondly, have you done any active advocacy to try to get international students at that university for medicine?

PAUL CRAVEN: We work very closely with UNE at the moment. I know Professor Guppy, who appeared this morning, and we're working together. There are a couple of things that we have talked about together. One is an incentive for regional students to get into the university in the first place, which is fantastic. Because, as you say, up until recently most of the students attending UNE weren't from regions, so they were training and going back home again. The second one is also a program of flexible learning in place as well so that they will take health clinicians who would like to train as doctors in the future, and they will allow them to continue to work as clinicians in place in the regions to work for the first two years whilst they are doing remote study, and then have placements as well.

I know at the moment we have got a very large cohort of students in UNE. What we are doing—and this is in consultation with UNE—is we need to make sure that we have got enough people to train those students, because a lot of the teaching, and certainly all the clinical teaching, has to be done by our clinicians in the hospital. Obviously that is nursing, allied health and medicine at the end of the day. We've been working very hard to ensure that we have a really robust base of clinicians in Armidale, not only to train the students coming through but also to train the junior doctors coming through. We've just increased our junior doctor number in Armidale hospital as well. In Hunter New England, a lot of those junior doctors are from overseas. So whereas we might not advocate as much for the student population, because we're maybe not as involved in bringing the students in at that stage, we have brought in hundreds of overseas-trained doctors into our district as well.

What we're trying very hard to do is to ensure that they get the correct training in the system and that they also get accredited to progress with their training, because if we can get the junior doctors we bring in from overseas generally registered and training in Hunter New England, we know 70 per cent of them will stay within Hunter New England. We brought in something like 600 international medical graduates over the last three years. What we're busy trying to do now is get them all through their general registration. We have a training program in Newcastle called WBA, which has assessors all over the district, and we've got a hub in Tamworth, with assessors all over the district. Whilst most districts maybe have about five assessments per year—maybe even less at that stage, depending on the size of the district—we're assessing 60 people a year. Every one of those international medical graduates has to do 12 mini exams, 12 discussion exams and one 360. It's a lot of assessing, but we're doing 60 of them per year to make sure that we get all those internationally trained doctors generally registered and into their training programs. A lot of those are in the regions. It's investment.

TRACEY McCOSKER: Sorry, I know we must be out of time but, given the numbers of the nursing workforce, I think it might be good just to hear very quickly from Liz about the training in nursing as well.

ELIZABETH GRIST: Thanks, Tracey. Yes, we know our hospitals can't function at all without nurses and midwives. We've been really pleased that we've had a number of initiatives in recent times to actually bolster our training and education. A great example is, going to the point about regional people staying in regional areas, we've just opened a simulation lab at Tamworth Hospital in conjunction with Charles Darwin University. That was for midwives. It has now expanded for nursing students next year. At the end of the day, what used to happen is that people would do their online coursework, but they'd have to go to Sydney or Darwin or Newcastle or somewhere else to actually do their hands-on training and simulation.

We're really thrilled to have our first students for maternity services BMid this year—only a few weeks ago, actually—and all of those people were local people from Inverell, Tamworth, Narrabri, roundabout. It was a fantastic thing, and we're really excited about that. The other thing is that we did bring in 146 really, really highly

skilled nurses in our international recruitment, and almost 80 per cent of those people have bought houses in the rural and regional areas. We're really thrilled about how that will—and I could go on for a lot of other things. Nurse practitioners, for example, I think we've got the most in the state. We're nearly at 120[2], and almost half of those are in the rural and regional areas—similarly with our school-based trainees going into the schools and promoting nursing and midwifery. We're really confident that we feel that, I guess, build it and they'll come.

Ms DONNA DAVIS: That's great to hear. You need to sing that from the rooftops.

The CHAIR: Indeed. Thank you all for appearing before us today. Your time is incredibly valuable, and we greatly appreciate the service you provide to our communities. You will be provided with a copy of the transcript of the evidence today for any corrections. Committee staff will email questions taken on notice; I don't think there were any. We may develop supplementary questions that we send to you following this hearing as well. Again, a sincere thank you for all the work that you all do every single day for our communities. I would again like to thank the witnesses who appeared throughout the day. I also want to thank the Committee members, Hansard, the Committee staff, the audiovisual team and all the people at home who are watching. That concludes our public hearings. Thank you all so much.

(The witnesses withdrew.)

The Committee adjourned at 16:20.

[2] The Committee received correspondence from Ms Elizabeth Grist clarifying this statement. The correspondence is published on the Committee's webpage.