REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

CURRENT AND FUTURE PROVISION OF HEALTH SERVICES IN THE SOUTH-WEST SYDNEY GROWTH REGION

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Wednesday 15 July 2020

The Committee met at 09:40.

PRESENT

The Hon. Greg Donnelly (Chair)

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

PRESENT VIA TELECONFERENCE

The Hon. Lou Amato
The Hon. Wes Fang

The CHAIR: Good morning and welcome to the second hearing of the Portfolio Committee No. 2 - Health inquiry into the current and future provision of health services in the south-west Sydney growth region. Through this inquiry the Committee will examine the adequacy and efficacy of existing health services in the region and consider the future health infrastructure needs, including the feasibility of a new hospital to service the region's growing population. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of this land. I pay respects to the Elders past and present of the Eora nation and extend that respect to other Aboriginals who may be joining us on the internet. Today's hearing will include evidence from an expert panel for south-west Sydney local councils, a planning perspective and conclude with NSW Health.

Before we commence, I make some brief comments about procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. I remind media representatives who may join us later this morning that they must take responsibility for what they publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing, so I urge witnesses to be careful about any comments they may make to the media or to others after completing their evidence as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation.

The guidelines for the broadcast of proceedings are available from the secretariat. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that witnesses could answer only if they had more time or with certain documents to hand. In these circumstances, witnesses are advised that they can take a question on notice and provide an answer within 21 days.

JOHN WATSON, Senior Vice-Dean, Clinical Affairs, Faculty of Medicine, University of New South Wales, Sydney, affirmed and examined

ANNEMARIE HENNESSY, Dean, School of Medicine, Western Sydney University, affirmed and examined

LES BOKEY, Institute Director, Ingham Institute for Applied Medical Research, affirmed and examined

Professor HENNESSY: I too acknowledge the traditional owners of the land. I am the Pro-Vice-Chancellor for Health cluster at the Western Sydney University and I am a professor of medicine in the South Western Sydney Local Health District [LHD].

Professor BOKEY: I am also the Director of Surgery at Liverpool Hospital and the Clinical Dean of Western Sydney University.

The CHAIR: Thank you very much. It is great to start our second day of hearing with such a distinguished panel of experts and health professionals. I confirm for the record that with respect to your organisations, the submissions have been provided, received and processed. In the order of processing, with respect to Western Sydney University, its submission stands as submission No. 17 to the inquiry. It has been incorporated and is available via the webpage for the inquiry. With respect to the Ingham Institute for Applied Medical Research, it is submission No. 49. Thank you for that. That equally has been incorporated and is available via the inquiry's webpage. With respect to the University of New South Wales, its submission is submission No. 55 to the inquiry. It has been processed and sits as the submission to the inquiry and is available by the inquiry's webpage. Thank you very much for them. They have been very helpful for us thus far.

If you are agreeable, we have provision for an opening statement from the three of you. The submissions can be taken as read by the Committee members so you do not need to go into them into detail but perhaps rather set up your thoughts specifically about the inquiry's terms of reference and some particular comments you want to make. Once you have done that, if you are agreeable, we will open it up to questions from members of the Committee from the Government, Opposition and crossbench. We will share those questions around fairly for the duration of the hearing. Are people generally happy with that format?

Professor HENNESSY: Of course.

The CHAIR: I invite you to make your opening statement.

Professor WATSON: Thank you very much, Mr Chair. My remarks will be brief. The University of New South Wales has had a clinical school presence at the Liverpool Hospital site, part of what is now known as the South Western Sydney Local Health District for exactly 30 years. This is an important anniversary for us. If it had not been for the COVID-19 crisis, a whole program of celebrations and seminars was to be instituted; it is a little more tricky at the present. It is our largest clinical school in terms of student training. We have over 400 medical students there. We graduate the greatest proportion of our class of 300 medical students from this clinical school. It would be fair to say that when one looks back over the history of the various memorandums we feel we have been a very important part of a mutually beneficial transformation of the health service from what was when I was a medical student and resident a very large and under-resourced district general hospital to a hospital that truly is a major teaching hospital.

In recent times my colleagues from Western Sydney University have had the transformative experience of the Ingham Institute, which Professor Bokey will talk about. As it happens, we are all on that Board, I as the representative of the University of New South Wales and so on and so forth. There has been a significant evolution. Creating excellence takes time. We certainly believe we have helped to create excellence. We think and believe at the University that it is a very important area for the University of New South Wales to be in for a whole lot of reasons: the massive population growth; the very important, if not unique, sociocultural demographic features; the socio-economic status profile, which leads to very important challenges for health education and health literacy amongst the community; and also training a significant number of students who identify as either part of those cultural groups and/or coming from those areas, ultimately returning to practise as fully fledged practitioners in the region.

Professor HENNESSY: Western Sydney University has been the university for western Sydney with a clear commitment to regional growth and development. I wanted to speak to a couple of things just quickly in this opening statement and the first is about partnerships. We are very grateful to be able to present to you together today, because we work hand in glove together with the health department to deliver the partnership needs, the health planning needs, the workforce needs and, particularly from Western Sydney University's perspective, Aboriginal and Torres Strait Islander health needs within the region. From western Sydney's point of view, we have a comprehensive suite of health workforce training programs; thousands of nursing and midwifery students,

as the second biggest nursing university in the country; the medical school has been in place since 2007 and has now graduated about 1,200 doctors, many of whom have stayed and are working and training in the region; and we have paramedicine and a broad suite of allied health programs.

As Professor Watson has mentioned to you, our involvement with setting up tertiary-level education and workforce services in the region has been built on creating academic and scholarly work that works carefully with the local health district and the ministry in terms of meeting those needs by an evidence base. For example, recently around the bushfires which hit our region, the immediate response of the university, hand in glove with the Ingham Institute and with the University of New South Wales—through our partnership as the Sydney Health Partners under the title of Maridulu Budyari Gumal, which is a health research and education partnership—we have been able to step up to start to meet some of the evidence that we need to provide better health care after bushfires. Of course, as Professor Watson again alluded to, we have morphed that into an approach as to how we might get out of this mess that is COVID-19 with as much help as the university can provide in a scholarly way. I am happy to take questions from the Committee.

Professor BOKEY: The Ingham Institute was launched in 2012 with very strong local business support, support importantly from both Federal and State governments, from our universities, the University of New South Wales and Western Sydney University, and especially from the LHD. This is quite a unique institute in that the board members represent both universities and the LHD. They are all on the board of the Ingham Institute as well as very significant local business people who have been very philanthropic towards the Ingham Institute. Since 2012 we have established 43 research groups, we have 370 researchers, we have published over 1,800 publications in scientific journals and we are involved in more than 500 clinical trials. This has brought research to south-western Sydney, and a very important piece of research.

The institute is strongly supported by the South Western Sydney Local Health District and our translational research is closely aligned with the research and clinical strategies of the district. Again, that is quite unusual. Most medical research institutes have their own strategies that may not necessarily be aligned with the LHDs in which they reside, but ours is very closely aligned. The LHD in south-west Sydney has recognised the value of research and has provided significant resources. I will give you an example. They have supplied significant resources and funding to establish new academic units within south-western Sydney. This is unusual and quite unique. The initiative includes world-class academic leadership in diabetes and stroke, mental health, liver cancer and liver disease, women's health, paediatrics, gut and the microbiome and cancer. These have provided outstanding research and their presence, importantly, has attracted world-class researchers, trainees and opportunities.

I would just like to take a moment to inform you about the future plans of the Ingham Institute as it resides within south-western Sydney LHD. Funding and plans are now in place to build a $52 million Ingham Institute at the Macarthur site adjacent to the $630 million redevelopment plan at Campbelltown Hospital. There are significant plans to extend and expand the Liverpool Ingham Institute site to establish an education and research hub adjacent to the $740 million redevelopment at Liverpool Hospital. That will be two Ingham Institute centres. The third centre is being planned for the new Bankstown Hospital, a $1.3 billion new Bankstown Hospital. Within the New South Wales Government's $3 billion for new hospitals, extensions and redevelopments in the LHD, the Ingham Institute will have three individual centres under the one institute hat.

Interestingly and importantly enough, they will be coordinated and centralised. My colleagues have mentioned COVID-19, and I think it is important to inform you as to where the institute is going with COVID-19. We are in the process of directing and redirecting, in fact, our research strategies in line with the LHD to address the challenges and the opportunities—it is important to stress the opportunities—of the post-COVID-19 era, which will see major developments in digital health, remote sensing, remote diagnostics and interventional medicine, machine learning and robotics. In all of this we are closely partnered by our universities, which include UNSW, Western Sydney University, the University of Wollongong, Sydney University, the University of Tasmania and, of course, our very close partnership with the LHD.

The CHAIR: That was a very detailed and clear overview. Thank you very much. We will move to questioning now.

The Hon. WALT SECORD: Professor Watson, in your opening remarks you said that the University of New South Wales has had students on the Liverpool site for the last 30 years. Have you done studies on those students who remain or who returned to work in the region?

Professor WATSON: It is actually a little difficult to find the data out—you probably thought I would say that—for a whole lot of issues about tracking students after graduation and privacy and confidentiality. But if we do a first-pass analysis of where people's registration address is, and we are doing this at the moment in another

context with our rural graduates, there is a very significant proportion, somewhere between 20 per cent and 35 per cent. I could do better than that if I took that question on more detailed notice.

The CHAIR: Absolutely.

The Hon. WALT SECORD: I wrote this down from your introductory statement. It says "creating excellence takes time".

Professor WATSON: Yes.

The Hon. WALT SECORD: What did you actually mean by that? The University of New South Wales has been sending students to and from the Liverpool campus for 30 years. Yesterday we had doctor upon doctor talk about the difficulties at Liverpool, Fairfield, Camden and Campbelltown. As you say, creating excellence takes time. What do you say in the context of the evidence that you must have seen, read or heard this morning on radio or on television?

Professor WATSON: I did see a little bit on television last night. I was a medical student at Sydney Hospital when the Westmead Hospital was conceived. That was a difficult but important major project for the western part of Sydney. Now people would even argue Westmead is in Sydney's eastern suburbs!

The Hon. WALT SECORD: Or in the centre.

Professor WATSON: No-one would question the excellence of the service delivery, academic work and research of all the institutes, and even the newest developments in precincts with multi-university and multi-faculty engagement that is now happening in Westmead. Absolute excellence in almost every respect—there probably are exceptions, but they need not concern us. That takes time. That is an evolutionary project. It is actually not just the time taken for capital investment and the time taken for people investment, it is the time taken for the evolution of how people think. Teaching hospitals, which are what we are really talking about in the context of all these hospitals, deliver their health care with a way of thinking about how they deliver their health care, rather than just going through the motions. That is difficult. That is a cultural change, if you like. I am sure you appreciate fully that changing culture takes time. That is what I think I meant by talking about "achieving excellence takes time".

The Hon. WALT SECORD: Yesterday we heard from Professor Levy about the impact of underfunding, under-resourcing and difficulties in western Sydney and the impact on junior doctors. Now, that must be something that is of concern to you which comes across your plate, so to speak?

Professor WATSON: Well, the universities are responsible for medical students in our system. We are not responsible in our system for post-graduation education or even pastoral care. Having said that, we are all clinicians and we are all active clinicians. Wearing other hats, those issues are of concern and importance to us. I am not trying to get out of that responsibility, but the funding and establishment strength of junior medical officers, which I think is what Professor Levy was alluding to, only has an indirect impact on our efforts in teaching, cultural change, thinking and the pursuit of excellence. It is still a strong influence, but it is not something we can control. We have to work with that envelope. We have to make sure that there are enough opportunities for our medical students to learn from both junior and senior doctors. I believe there are. I believe there are enough opportunities for our medical students to learn usefully from the establishment of junior and senior doctors. My colleagues may also have insights.

The Hon. WALT SECORD: Professor Hennessy, in your opening remarks you said since 2007 that 1,200 doctors have graduated from Western Sydney University. How many of those doctors remain in western Sydney? You have to have done studies on that.

Professor HENNESSY: Yes, of course. We have been tracking those numbers as carefully as we can, given the constraints. I will just reiterate that our junior doctors and the early training parts of programs are highly networked. That is one of the strengths of New South Wales training. By being networked they are required to work in a big hospital, a small hospital, an outer metropolitan hospital and a rural hospital as part of their training. Tracking them is complicated. What we do know is that between 50 per cent and 70 per cent of our graduates have undertaken their training in the region. That is data that has been produced in our annual Australian Medical Council report, which is responsible for accreditation of a medical school. They are parts of the training where they may or may not end up living. Given that a training pipeline is about 12 years long, we are very keen—though we have only had graduating classes since 2011—and we are starting to land those graduates at the moment.

At Campbelltown in the last few weeks we now have Australia's first fully trained, female dermatologist of Aboriginal background. She is a Larrakia woman now working in Campbelltown, running the new service there. We are very proud of that moment. We have 30-odd Aboriginal graduates from our program, many of whom

are now general practitioners working in the region, who I see both in terms of the figures, which we are interested in, but in terms of my day-to-day clinical practice. At Westmead Hospital, which is a sister hospital in training for our students at Blacktown, we are seeing roughly 50 per cent of our medical registrar training, for example, being in those places. We are very happy that those figures are strong and representing our interest in workforce planning for south-west and western Sydney.

The Hon. WALT SECORD: If the Committee and the Government eventually decides to recommend or construct a new hospital down in the south-west, down in Campbelltown, Camden or a new growth area, would there be enough—this may be a silly question—doctors to staff it?

Professor HENNESSY: You ask a very complex question. I mean, manpower would depend entirely on the nature of the services that were being provided. A medical school is an important part. More importantly, in terms of the numbers or provision of nursing graduates, paramedicine graduates and allied health graduates which are needed for the services that you provide, that would need to be carefully planned. We certainly have the capacity to upskill enough nursing graduates, but the limitations around the doctor graduates that you are talking about are Federal constraints around caps, which were placed 10 years ago on the number of medical students that we can train.

I am confident that, given the current envelope, we can support excellent, high-quality training in the hospitals where students are currently training and accessing, as Professor Watson has indicated, the layers of medical training that they need from junior doctors, junior registrars and fellows up to consultants. In terms of staffing, it would depend on the services that were planned. Our mantra is that we will train and respond to what the health care needs are. What is right for you—which is what I say regularly to my chief executive, Amanda Larkin—will be right for the university, in terms of its planning around the nature, number and type of training that we would offer, again, given that there are some Federal constraints around those numbers.

The Hon. WALT SECORD: How about a paediatric hospital, a children's hospital, in the region?

Professor HENNESSY: Paediatric services are going to be increased in the newly planned Campbelltown Hospital.

The Hon. WALT SECORD: No, my question is specific. In the 2015 election there was a debate about whether there would be the creation of paediatric services or a paediatric hospital and there was debate that there would not be enough paediatric surgeons in Australia to actually support a paediatric hospital.

Professor HENNESSY: I am unable to speak to any direct evidence about the numbers and availability of paediatric surgeons.

The Hon. WALT SECORD: You must be able to tell me if you would be up to a paediatric hospital or a children's hospital in the south-west of Sydney.

Professor HENNESSY: I am unable to answer that question.

The Hon. WALT SECORD: Professor Watson, could you add any information or any light? There was quite a heated debate. I remember having discussions with paediatric surgeons, there were about 24 of them, and they said that there would not be enough paediatric surgeons in Australia to set up a paediatric hospital.

Professor WATSON: That is outside my skill set and expertise. I am a neurologist.

The Hon. WALT SECORD: But you train young doctors and give them pathways and you know—

Professor WATSON: We train thousands of young doctors. To train a paediatric surgeon you are required to have a pipeline of paediatric registrars and that is determined by Health Departments, by hospitals and LHDs and accredited by the Colleges. If those levers were thrown, I could imagine that you could create enough paediatric surgeons, but the pipeline would be 12 years—at least six to eight years after they leave our hands.

The Hon. WALT SECORD: Professor Bokey, do you have anything to add? I saw you nodding a couple of times. Are we in agreement or disagreement?

Professor BOKEY: I love nodding, but I just—

Professor WATSON: He is one of the most agreeable people you could work with.

Professor BOKEY: I just want to emphasise Ingham's role in teaching and training. The Ingham Institute does not operate in silo mode. Within the planned integrated education research hubs that I mentioned, there is going to be a free flow of medical students, residents, registrars, consultants and researchers within the one environment. This, again, is quite unique. You find most institutions work in silos. There is the Government, is there is the LHD, there are the universities and there are the medical research institutes. What we

are doing is combining all of these within the one centre. This has significant implications about how young doctors are attracted to south-west Sydney and how they would wish to train in various disciplines, because they would be exposed to the very rich tableau that we would be providing for them in our integrated centres.

These centres are not a pipe dream; they are actually being planned and they are going to be in place within five years. I think the Ingham Institute is not just a research institute. It is very much in partnership with the LHD, with Amanda Larkin who sits on our board, with the University of New South Wales and Western Sydney University to provide and promote education, teaching and training. We also include in these centres a schools space scientific curriculum as well as potentially a space for TAFE students.

The Hon. EMMA HURST: Professor Watson, I have a follow-up question from something the Hon. Walt Secord asked in regards to students. The Hon. Walt Secord was referring to underfunding in the hospital, as we heard in this inquiry yesterday. In your submission you state that 420 University of New South Wales medical undergraduate students undertake placements at the university. Do you have any concerns or have you heard of any incidences where there was inadequate supervision of the students?

Professor WATSON: I have not. We have an excellent set of academics, both paid and unpaid. They are known as Conjoint in our environment, as Clinical in other environments. We have scores if not hundreds of those. We have very good systems of pastoral care. I have a counterpart, Professor Velan, who is the Senior Vice Dean for Education, along with his team. I am not suggesting every day for every student is sweetness and light, but I am not aware of any systemic or systematic issues along those lines.

The Hon. EMMA HURST: In your submission you also state that the University of New South Wales believes that consideration should be given to invest in the existing facilities rather than a new hospital at this stage. Can you expand on that a bit further and why you think we should be investing in existing facilities?

Professor WATSON: Creating a whole new hospital is not easy and it is not cheap, and that is just the concrete. Then there is the human resources and then there is the way of thinking. For example—I am now going ex cathedra—to continue with the previous line of inquiry, for every paediatric surgeon you want to plonk there, you would need scores of medical staff, you would need excellent X-ray departments, pathology departments, you would need scores if not hundreds of nurses to run those wards, then you need the paraclinical people that Dr Hennessey has been talking about. It is easy in a way to look at the very point of a triangle and say, "We need two paediatric neurosurgeons."

To run a really good paediatric surgical service you need at least five, because there is always one on leave and you cannot just run it on two or three. The experience of trying to get a really good neurosurgery service going in a place like Penrith over many years has shown some of the difficulties. It is not just a single apex predator. You need a lot of them and then you need everything behind that to make it work, right down to stores and so on. If we had unlimited resources, one could map out how to create a brand-new hospital and recreate the growth to excellence that has already happened in places like Liverpool and in places like Westmead, but it would require a huge amount of resources.

The Hon. EMMA HURST: You also mention in your submission a transformative model which you describe as hospitals without beds. Can you give us a very short elevator pitch on what that is?

Professor WATSON: You might have an aged relative who might have cardiac arrhythmia called atrial fibrillation, which is actually a potent risk of causing stroke and also leads to other problems. There are plenty of people in Australia and around the world experimenting with wards that are based in your own home. A monitor can be placed on the wrist and the rhythm and rate of the heart can be picked up. Even my Apple Watch tells me if it thinks I have fallen over. It has been wrong every time so far. It says, "If you have fallen you can push this button". There are some hospitals already overseas where there is actually a control room that looks like a flight control centre, an air traffic control centre, where people are monitoring in real-time patients and keeping them out of the hospital. If something goes wrong, you bring them in, but you do not have to bring in 25 people who might not need hospital. You only need to bring in the three or four that you really want to bring in. There is a whole lot of stuff on big data and augmented intelligence to help predict those people. The Holy Grail would be to predict the fact that your aged grandmother needs to come in, but predict it a day before she really needs to come in. That is what is happening in that area.

Ms CATE FAEHRMANN: I just want to touch on the issue of workforce shortages that we heard so much about yesterday. Clearly we heard about really systemic issues both in terms of positions that cannot be filled as well as not enough allocated positions to begin with. You have all mentioned working with the LHD in terms of workforce planning. I just wondered if you could expand for the Committee on exactly the ways in which you are working with the LHD, not just to fill vacant positions, but around creating the numbers of positions that

are clearly needed, given the systemic health issues that the area faces—so, in terms of increasing the positions and getting enough people to fill vacant positions.

Professor HENNESSY: I might go first. In establishing a relatively new medical school, this was one of the chief pillars of whether we were going to be able to do it and what would be the nature of the kind of educators that we would need. I think the new medical school and the expansion in academic allied health and nursing in the region was really a response to that, in finding a way to bring talent in the region, but to do it in the way that you describe, and that was to create new and exciting opportunities, rather than just filling vacancies. The negotiation between the University of New South Wales and Western Sydney University at the time was one of the great joys of my professional life, in fact, and we sat down and said, "Well, look, a professor of haematology is going to fit best with an academic support environment that is related to some of the cancer activity that was happening at the University of New South Wales central and that was a nice growth opportunity for them."

But very clearly it was constructed around meeting the needs of the region. For whatever reason, in that negotiation, because of mainstream oncology or cancer treatment growth that was needed in Campbelltown and Liverpool, we elected to take that position. As a result of those negotiations, even as recently as this year, we have 12 professorial units, academic units—not to describe it quite like that, but not just the person at the top, or the leader of that tree as a named leader—a construct that provides a depth of service and a new way of working. I think this notion that we want to replicate and produce something like somewhere else is never the way that we have operated. We have tried to be responsive, listen to the community needs, talk to the hospital and say, "What can we do to make that work and what is the best construct of an academic unit that we can create to have that happen?"

That has meant that we have been able to bring in fellows who are very sophisticated, still quite late trainees, early consultants, bring in advanced trainees and bring in registrars. They are the multiple layers that we have been talking about that build a strength of service, and we have examples of that happening. The pathology chairs that we hold at Liverpool and at Campbelltown are responsible now for running virtual training and other real-life training that is the national standard. We have a course in pathology that we offer to the health sector that fills within 24 hours from Australia and South-East Asia. That is a good example of great academic medicine that has been able to be developed out of the strategy. We recognise the need and work with the sector to identify a way of funding. Those funding models are really complicated and they are often quite bespoke, depending on what it is we are trying to achieve. But it is a very strong partnership negotiation where we will all partner into that arrangement and then create that academic unit.

I do not want you to think that we have stopped here. We would like to table a document from the three of us, which is the Macarthur research centre. Although that is another building—I think with permission I sought to have that tabled for you today and it is alluded to in your papers—what is in there is actually some space and opportunity for the next tranche of academic units. While we have not put a name to them, I envisage them being the sorts of things that the LHD have spoken to me almost daily about what they need. Paediatric surgery is mentioned and paediatric services within an academic context would be very efficiently delivered in a model of service planning that we are going forward with. The other areas of academic endeavour that are uppermost in my mind, given the regional leads, and which are very clearly espoused in this document and in our negotiations with the universities and the LHD, are in Aboriginal health, adolescent mental health and drug and alcohol health. These are really critical to the needs of the community and I know have been addressed in the submissions provided to you. We have clear line of sight to working out ways of bringing, not just talent, but better evidence into the way that we do things, which I think is what institutes and universities bring to the partnership in terms of planning.

Professor BOKEY: In my role as director of surgery at Liverpool Hospital I can speak to your question as well. I took on that role in 2012 when I arrived at Liverpool Hospital. At that stage Liverpool was still a small teaching hospital. It served the community, it had some aspects of a tertiary institution, but not yet. Within the eight years that I have been there, we have been able to establish probably the second largest cardiothoracic surgical unit in the State. When I first got there it was difficult to attract applicants to the position, but now I literally get phone calls on a regular basis saying, "Have you got a position for me?" Only last month we appointed two new outstanding cardiothoracic surgeons, and I obviously cannot go into those details. The same thing with complex plastic surgery. We now have one of the largest complex plastic or surgical units in the State.

The same with my own discipline, which is in colorectal surgery, in particular colorectal cancer. When I first got there it was one or two surgeons. We now have an extensive colorectal cancer surgical unit, which is supported academically by pathology et cetera. Over the last eight years the department of surgery at Liverpool Hospital has become a very attractive place for trainees to come to, and for junior doctors too. We have established very significant mentorship programs, wellbeing programs and formal educational programs for our trainees. All of this happened in progression and in partnership with the LHD and with the universities. That is

how research and universities build a place. We have gone from where it was in 2012 to where it is now, an internationally acknowledged surgical unit.

The Hon. NATASHA MACLAREN-JONES: I just wanted to ask you about some of the comments made yesterday by some of the witnesses that painted quite a stark situation in south-western Sydney health care and painted a bleak future. Comments were made by some of the doctors and nurses saying that people do not want to work there. Professor Watson, you alluded to seeing some of the comments in the media. I am interested here what your view is in relation to the current situation, and also the future, bearing in mind obviously the Government is investing $6.5 billion across western Sydney and south-western Sydney to address health care in the future. I am interested in your views as to whether or not you think it is as bleak as it is being painted?

Professor HENNESSY: Who do you want to start?

The CHAIR: I think that was a handball.

Professor WATSON: A hospital pass.

Professor HENNESSY: We have stated our position about hospital training. Let us just pick medicine for a moment, although we are here to represent broadly the interests of the sector. There has been no growth in medical student training capacity, and with students comes money and an opportunity to do more in the teaching domain. But we have never had any systematic complaint or concern about our ability to train students in this environment. I agree with Professor Watson, we want them to aspire to the best qualities of training that are around. Many of the medical schools do move the students around a number of hospitals so they can see a comprehensive suite of mentor opportunities. In my time working in setting up the medical school, we have seen a growth in those opportunities, as Professor Bokey has indicated, and there are new opportunities coming online.

I think there are parts of those services, though, where we are very clear, as both clinicians and as leaders in medical education, but there are parts of that education that need to be dealt with as part of the planning. My feeling is that the planning is done in partnership, so that we are trying to work through that in ways together, whether it is around our capacity to support some financial incentives around research, as we have all alluded to, but how they interact with the ability to attract the kind of talent and training opportunities that we want. We see the long lag time between what might be an entry point into a medical program or a nursing program and the readiness to build your career, which is often 12 or 15 years later down the line. In terms of the immediacy of your question about the services there, I think we have all looked at the submissions carefully and we are seeing comparisons between x and y, a and b and "they have this number and we have that".

I think our job for you today and our job in general is to provide the evidence about the outcomes and the quality both of the service that we are providing and also for the quality of the training of the individuals that we care for. We think we have training well organised, but by a very detailed approach to looking at the suite of services and—this is our job—making sure there are no gaps in training. We work very hard to make that happen. My general feeling is that when we are identifying significant gaps, that they are considered, but they are considered in a holistic way across what the services in the sector need and in response to the capital investment that is occurring. Sometimes we wish things happened a bit quicker, I will admit that, yes.

The Hon. NATASHA MACLAREN-JONES: The next question I am interested in is the area of advancements in technology in particular. You have touched on the fact that with the COVID pandemic we have seen a lot more in telehealth, but there are also other advances in technology. I am interested to hear your opinion about how that is going to benefit hospital admissions and reducing the pressure on our hospitals moving forward?

Professor BOKEY: I think I can speak to that, because that is one of my research interests and has been for quite some time. I think the way that health is going to be delivered is forever changed. If we think we are going to go back to whatever it was, it is never going to go back, because there are going to be a multitude of technologies that are already in place in most other industries bar health. These technologies are in car manufacturing, clothing manufacturing, bread making and space et cetera. In surgery I am particularly interested in remote sensing, in remote interventional diagnostics, in remote interventional surgeries and interventional therapeutics. In a country like Australia, that is very important, where you can have an expert at Liverpool, let us say, remotely helping for the care of a patient in Wagga or what have you. The Ingham Institute in fact has now established a centre called RAMeT, Robotics and Applied Medical Technologies, in particular to look at how advanced technologies are going to change the way that we deliver health.

Professor Watson alluded to some of these advances, such as remote sensing and virtual hospitals. All of these are aimed at looking at health in a different way—keeping patients outside of hospitals and visiting patients in their homes via telehealth. In my own practice, most of my interviews are now done by telephone, which has existed for 150 years, I might add, and the patients love it. They say, "Thank you for visiting me at home, doctor. That is great." In our teaching, training and research, we have to look at the evidence behind these technologies,

we have to promote the research in these technologies and, importantly, we have to link up with industry and biomedical engineering centres within our universities to make them commercially viable. The Ingham Institute is very, very much involved in the post-COVID era. In fact, we are already in it.

The CHAIR: That has brought us to the conclusion of this session. It has been a most informative session. It has been great to be able to speak to you in person and articulate further beyond the points you made in your submission. On behalf of the Committee, thank you for the leadership that your institutions are respectively showing in their commitment to south-western Sydney. We appreciate very much your input to this inquiry.

(The witnesses withdrew.)

ALLY DENCH, Executive Director Community and Corporate, Wollondilly Shire Council, affirmed and examined

SUSAN GIBBESON, Manager Social Planning & Community Development City and Community Services Group, Fairfield City Council, affirmed and examined

KATE STARES, Partnerships Manager, Campbelltown City Council, affirmed and examined

SUE COLEMAN, Executive Officer, Western Parkland Councils, affirmed and examined

The CHAIR: Welcome and thank you all very much for making yourself available to come to the inquiry this morning. It is much appreciated. We know you have very busy workloads and commitments and taking time out is much appreciated. Before we go any further, I should acknowledge that two members of the Committee are participating in this inquiry remotely. You cannot see them but they can see and hear you. I am sure that if they do speak, they will be heard. Their questions will come to you through the Hon. Natasha Maclaren-Jones, who is a member of the Government. We apologise for that, but we have had to work with the circumstances.

The Hon. LOU AMATO: Chair, I am having a little bit of trouble hearing Kate Stares. She is breaking up a little bit. I also declare that Ms Dench and myself have known each other for many, many years and it was always a pleasure working with her when I was a councillor and deputy mayor at Wollondilly.

The CHAIR: Thank you, Mr Amato. I appreciate that acknowledgement. If you are agreeable, we will ask each of you to make an opening statement. Before I go any further, I should acknowledge the submissions from your respective organisations. The Wollondilly Shire Council submission is No. 24; that has been received and processed and is on the inquiry's webpage. The next one is the Campbelltown City Council submission, which is No. 39 and has been processed and is on the inquiry's webpage. We then have the Western Parklands Councils submission, which is No. 47. That has been processed and is on the webpage. Finally, the Fairfield City Council submission is No. 51. That has been processed and is on the inquiry's webpage. Thank you for those; they are all very informative. You can take them as read by Committee members. With respect to your opening statements, you do not have to examine in detail matters in your submissions, but rather set up the general points you wish to make. Once that is done across the four organisations, we will then move to questioning from Committee members. If that is agreeable, we will start with Ms Coleman.

Ms COLEMAN: Thank you for this opportunity to speak and for your keen interest in the growing communities of south-western Sydney. The Western Parkland Councils represent the eight councils that have partnered with the Australian and New South Wales governments to deliver the Western Sydney City Deal. That includes five councils that are part of the south-western Sydney area, as well as three others—the three that we have here today, and also Liverpool and Camden councils, which are part of that region. As you will have noted from our submission, the Western Parkland Councils believe there is an urgent need to not only plan for the unprecedented growth in this region, but also to address some of the existing deficit that results in inequitable health outcomes now for our current residents.

The geographical scale of the region and poor connectivity can make accessing health services and facilities quite difficult and time consuming, whether that be by public transport or by private vehicle, as is so often the case in the region. We favour having locally based services that are complemented by other facilities and services of a more specialist nature at that regional level at the strategic centres, such as Campbelltown and Liverpool. We also believe that fair and equitable resource allocation requires a really robust analysis of consistent and reliable data, including population projections. That is an area that has not always been achievable. People often underestimate the diversity in the region. I would really encourage you to consider the different demographic profiles throughout the area and the rates of chronic illness associated with different population groups—particularly those where there is significant social disadvantage.

We believe, for example, that specialised, culturally specific services may be required in order to be able to achieve equitable health outcomes for all. Importantly, we recommend that planning for health services needs to be done very much in conjunction with planning for other public infrastructure, whether that be transport, education and the sorts of facilities provided by local government. A very joined-up approach, we believe, is essential in order to achieve a very effective use of public resources and better health outcomes across the whole sector. Thank you. I welcome your questions.

Ms DENCH: Thank you very much for the opportunity to speak on behalf of Wollondilly Shire Council here today. Wollondilly Shire Council has two main concerns. The first is regarding the current provision of health services in the Wollondilly community, and the second concern is the future provision of health services to address

the needs of our growing community. Wollondilly is on the outskirts of the south-western Sydney area and covers a vast area of 2,500 square kilometres. Our current population estimate is 52,000 people. We are one of the seven local governments in the South Western Sydney Local Health District and the only local government area [LGA] in that health district that does not have a public hospital. We have two major growth areas located in Wollondilly, these being the Greater Macarthur Growth Area and the Wilton Growth Area.

Our population is expected to triple over the coming years up to 2036 with the growing population—an additional 54,000 people proposed in the Greater Macarthur area and 45,000 population estimate in the Wilton Growth Area. That is a projected extra 99,000 people on top of our current population of 52,000. As I said, it is going to triple our current population, with very little provision of essential infrastructure, non-essential infrastructure and public transport being planned to accommodate the shire's growing needs. It does not include any analysis of the shire's important prime geographic location. It is strategically placed, linking the Illawarra to the south-west and west metropolitan areas of Sydney. The strategic role of Wilton is terribly underestimated. It should be clearly noted that there will be a far greater impact than what I am attesting to today when adding the total population of Greater Macarthur, including the populations of Campbelltown and Camden.

We have three core issues that we are advocating for, and they are planning, access and equity. What we are seeking from the inquiry—what we are hoping for—is fair and equitable service provision; health planning for suitable, well-managed growth; and locally based health services, programs and facilities that are in place early and adaptable to the growing population, focusing on preventative health. We are recommending to plan for tertiary-level services: that is, a hospital in the Wilton Growth Area. Council is a really great advocate for the models of care that the south-west local area health district is advocating for, and that is integrated community care. However, it is not seen as a silver bullet to solutions to health needs in our area. There still remains the need for tertiary and hospital services. Integrated care is a great model and works really well, particularly if you have a carer and someone invested in you to be able to speak out on your behalf. There is still the need for a public hospital and tertiary-level services in our area. As I said before, we are the only LGA that does not have a public hospital, and we are going to be growing to 150,000 people.

Based on our analysis, with the Wilton New Town, Appin and North Appin, it will generate another 224 hospital beds that are needed. The nearest hospitals in relation to Wilton are 25 kilometres away in Campbelltown, 35 kilometres away in Wollongong and 42 kilometres from Bowral Hospital, which is not close or accessible by any measure—particularly for a transport-disadvantaged community such as Wollondilly. We are one of the most transport-disadvantaged communities in New South Wales. Our issue, too, is in regards to the planning and future planning and the cumulative effect that is not taken into consideration. Growth plans, we believe, do not talk to each other. We do not believe that they are actually taking into consideration the needs in each of those areas. We have the Greater Macarthur Special Infrastructure Contribution [SIC] for the Greater Macarthur area, which proposes a levy of $1.5 million for community health facilities, which is predominantly for land, not for facilities to actually be built. The Wilton SIC proposes a levy of $750,000—lucky to buy two house blocks, if you are lucky.

We actually advocated, in the initial draft SIC, for 10 hectares to be put aside for a medical hub or a hub for where tertiary services and a mix of services could be provided. It was originally agreed to, based on planning assumptions at the time. However, south-west local area health and NSW Health have no plans to provide tertiary-level services at Wilton. The 10-hectare site has since been removed from the SIC, which is concerning for council. Really, all that is being proposed is floor space in regards to the provision of health services. The site was a perfect opportunity to leverage private facilities or public-private. By setting aside land, it opens up that opportunity for those needs to be met. We believe that it was removed based upon outdated planning assumptions, with the population projections only including part of the growth expected for the Wollondilly local government area. That is the growth that was already gazetted for; it did not take into account those areas that were not gazetted but is coming our way. The impact of a cumulative effect of two major growth areas closely located to the South West Growth Area, which incorporates Oran Park and Leppington, contributes to outdated planning assumptions.

The current public health service model is Liverpool-centric and the classification of Campbelltown public hospital as category B limits access to resourcing that will meet the current needs of our communities. If current needs are not being adequately met, how are our growing communities' needs going to be met? There is inequitable allocation of funding and services and opportunities at Campbelltown public hospital, which creates the need to travel long distances to Liverpool. Believe me—when you are in labour, you do not want to be travelling over 45 minutes to get to hospital. This also creates competition for limited resources based upon the categorisation of public hospitals because, as we know, specialist services and other services tend to congregate around hospital centres. This can also play out in community health and also home care and social support programs. This is about competition for limited resources. Wollondilly has not been viewed as a high-needs area,

particularly in terms of both population numbers and indicators of disadvantage. As I said, we are the most transport-disadvantaged community.

We also suffer from the "poor cousin" effect in the Macarthur sub-region, where programs and resources are allocated to Macarthur and are often based at Campbelltown and do not make it "over the hill". They do not often get over the Razorback to Wollondilly. When they do come over, they are often under threat of being withdrawn and pulled back to the parent service because someone is off sick or someone is on long service leave, and we tend to not have adequately provided services in our area. As I said before, the strategic role of Wilton needs to be considered in relation to its position to the Illawarra and connecting right up. The Greater Sydney region plan also talks about an aspirational goal of a 30-minute city. We believe that aspirational goal needs to also be for health care, not just for how we access services.

In summary, Wollondilly Shire Council would like to emphasise the need to ensure planning assumptions used are aligned across all State agencies, because quite often there are different planning assumptions and different numbers, which are very confusing. Often those planning assumptions in planning documents are quite outdated. The cumulative effect needs to be taken into account not just in growth areas, but also in infill and on the planning proposals. We have over 27 planning proposals on the table in Wollondilly—not just the two growth areas, but also other infill areas that are going to have an impact upon our health needs and the need for providing services. We also would like to emphasise the right to a certain level of access to health care in Wollondilly, rather than travelling long distances and extended time to access services. We need to plan for need; this will give certainty of health service provision, whether this be publicly or privately provided or in partnership. The appropriate allocation of land through the Special Infrastructure Contribution allows flexibility for this to happen. Thank you.

The CHAIR: That is a very comprehensive opening statement, so thank you very much for that.

Ms GIBBESON: I would like to thank the Committee for inviting me to the forum. I would also like to acknowledge that I am on the Gadigal land of the Eora Nation today. Fairfield's population is from immigration, not from development or birth rate. These are the indicators used in health planning. In 2½ years between 2016 and 2019, approximately 17,000 refugees settled in Fairfield. Since 1991 approximately 70,000 refugees and their families made Fairfield their first home. Fairfield is not part of the growth area. Many Fairfield residents have traumatic events in their past. Over 20 per cent of the population do not speak English well, or at all. Over 20 per cent do not have internet at home, so home schooling and telehealth are not viable alternatives for this cohort.

Fairfield has a Socio-Economic Indexes for Areas ranking that is the lowest in Sydney, with only Brewarrina, Central Darling and Walgett more disadvantaged in New South Wales. Fairfield's health outcomes are in the lowest quintile and are very poor. Fairfield Hospital was upgraded and rebuilt 32 years ago in 1988; that was 32 years after the previous hospital was opened in 1956. The population has increased in this time both in number and also complexity. Health services have not developed to reflect this growth in size and increasing health needs—including access to specialists and, particularly, psychiatrists. Many residents fall through the cracks because they have low health literacy and do not understand how to navigate a very complex system, and because they cannot afford private treatment and, at times, they distrust advice as it conflicts with beliefs in their own communities.

Fairfield and south-west Sydney need equity in health services. They do not need just the same level as the rest of Sydney; they need consideration of the complexity and needs of the community in the provision of services to achieve improved health outcomes. The complexity of the people needs to be considered, rather than just the number of people. COVID-19 provided a valuable lesson in culture, communication and health. It is not enough to provide interpreters or translation. Council's work to address the health impact of the high level of gambling in our area as well as mental health issues has taught us that some things cannot be translated. The concepts do not exist. We have one culture that has no words for "mental health".

I suggest that Fairfield Hospital be established as an innovative trial of a place-based hospital with high-level clinical offerings with wraparound support to provide culturally connected services and systems to address the unique challenges of a highly disadvantaged and diverse community with poor health and low health literacy. This would remove some pressure off Liverpool Hospital and would provide equitable health services to the community. I put this forward, as well as the human aspect, in terms of health economics because we all know that catching up afterwards and having the ambulance at the bottom of the cliff is far more expensive than building capacity and having good health built at the top. Thank you.

The CHAIR: Thank you, that was another excellent opening statement.

Ms STARES: Thank you for the opportunity to have me before you today. I am here to speak to the submission on behalf of Campbelltown City Council. In the hierarchy of centres established in the Greater Sydney Commission's Region and District Plans, Campbelltown-Macarthur is the metropolitan centre for Macarthur, which, together with Liverpool, Greater Penrith and the emerging aerotropolis, form the metropolitan cluster centre for the Western Parkland City. Campbelltown council itself has also recently undertaken a significant piece of strategic planning in its Reimagining Campbelltown City Centre Master Plan, which sets our city on a path to realising its metropolitan potential to create a much more sustainable and prosperous city centre serving not only the Macarthur region, but also beyond to the Southern Highlands and parts of the Illawarra. This plan has been developed alongside the Greater Sydney Commission-led Collaboration Area, which produced the Place Strategy where multi-agency stakeholders across government—from health, transport, sport, utilities, education, planning and others—are committed to develop a road map of actions required to enable the realisation of Campbelltown's vision, including local jobs, better amenity and improved economic outcomes for our city and our region.

We have formed the Campbelltown health and education partnership with other key stakeholders in the health and education sector to deliver a true health, knowledge and innovation district around Campbelltown Hospital and Western Sydney University's School of Medicine and clinical school. We are encouraged by the Macarthur Medical Research Centre's commitment to delivery in Campbelltown. In order to maximise efficiencies of investment, we would respectfully submit that investment should be targeted to the existing infrastructure within the south-west Sydney local area health district's existing network, as these are the centres that are supported by transport, research, education, sporting facilities and other social infrastructure in accordance with the metropolitan planning I have described. This high-level infrastructure may then be supported by integrated health hubs at strategic centres within the south-west Sydney area that are well served by transport connectivity—for example, Glenfield, in the northern side of our local government area, which is only 20 minutes from the planned aerotropolis and co-located with other services to provide that proactive healthcare support in an innovative way to support the hospital service that is offered.

That is not to suggest that our infrastructure that is existing presently is sufficient for our current or projected needs. There is a strain on health services in south-west Sydney. We have learned that the south-west Sydney LHD has one of the lowest total annualised expense budgets per resident by any LHD in Greater Sydney. This deficit in health spend has the potential, with growth, to exacerbate deficiencies in our region's health outcomes. We would respectfully submit that this deficit should be first met through investment in existing facilities—particularly Campbelltown Hospital, to enable it to better fulfil its metropolitan role in serving the Macarthur region and beyond to the Southern Highlands. It is our suggestion that significant investment in hospital infrastructure outside the existing infrastructure may dilute the impact of that investment. Thank you.

The CHAIR: Thank you, that is very good. They were four excellent opening statements that set up the questioning very nicely. Thank you for the time taken to prepare such good statements. We will move to the questioning now.

The Hon. WALT SECORD: I thank all four participants for your submissions and your opening statements. They were comprehensive. I do not actually know where to start. Yesterday was confronting and you have just come through and reinforced what we heard from the doctors and the need. Ms Dench, you are the only local government area in the region without a hospital?

Ms DENCH: Correct.

The Hon. WALT SECORD: Health facilities at the moment—if you need to get to an emergency department, what is the journey or the time?

Ms DENCH: As I said, from Wilton, which would roughly be about the centre of where we are in the shire, you are looking at—where was my figure here?—25 kilometres to Campbelltown. Like I said, there is no public transport. There is no train at Wilton. There is a diesel service. We do not have electrification lines; electrification of the rail finishes at Macarthur-Campbelltown, so we are dependent upon diesel services. We are a very highly car-dependent community, if you are lucky to afford a car. But if you are a very vulnerable person, it is very difficult to get yourself to a hospital. Bowral is 42 kilometres away. Wollongong is 35 kilometres away. There is a hospital at Camden, but its services are very downgraded. I personally have a son with severe disabilities. Seizure—straight to Camden hospital. They did not have the service; we had to be straightaway transferred to Campbelltown. It is very distressing when someone has very high support needs, needing medical care.

The Hon. WALT SECORD: When you said that services are Liverpool-centric, what does that mean?

Ms DENCH: Specialist services, definitely.

The Hon. WALT SECORD: Does that mean you would go right past Campbelltown Hospital and go straight to Liverpool?

Ms DENCH: A lot of people do, yes.

The Hon. WALT SECORD: What kind of hospital or level of service would Wollondilly need? You are not talking about a Campbelltown-size hospital?

Ms DENCH: Like I said, we are very much big supporters of integrated community care: care within the community. But as I said, it is not the silver bullet solution. We need tertiary-level services, which is a hospital—whether that be public, private or public-private partnership. We need land or something set aside to enable us to facilitate that to happen. You do not set aside land, it ain't going to happen. We need somewhere, whether that is provided by government or private providers. Again, the cost of care—if you are able to afford private care—is another big factor. But definitely we are looking at a mixture of services. Again, if you are lucky to have a carer or someone at home, as I said, who is vested in you and your needs, the integrated care and community care will work very well.

Actually, Wollondilly is very proud to say we have a Wollondilly Health Alliance, which works extremely well, which is with the primary health network [PHN] and the south-west Sydney LHD—looking at that telehealth services and telehealth conferencing. We have made some really great inroads in that regard and some great outcomes for our community. We also have a joint-funded health position in our planning department, which is looking at planning for health outcomes in our new growth areas. All of that is all great to plan, but if you ain't got the land and you have not got the money to provide those services or the infrastructure, it all falls in a heap.

The Hon. WALT SECORD: Thank you for your submission and for your opening statement. I think you have spelt out very clearly your position and I think we are in no doubt.

The CHAIR: Just quickly, in terms of the delisting of that parcel of land that had otherwise been set aside for future development of a health precinct, that seems to make no sense in the context. Probably the average person can see that growth is happening and will continue to happen that way in terms of the Sydney outgrowth. What would be the logic of delisting? Can you provide any insights into that?

Ms DENCH: I would point towards the upgrade of Campbelltown Hospital and the upgrade there being seen as sufficient to meet the needs, whereas we believe that is only just going to be sufficient to meet the needs of the here and the now, not the growing population.

The CHAIR: That is the point I am making. Looking ahead 50 years, one would have thought that is the sort of time frame one would be thinking is necessary.

Ms DENCH: We were advocating and we had agreement for 10 hectares of land to be set aside. The SIC only allows for $750,000 towards health facilities in Wilton. That is not enough for 10 hectares. There is an opportunity, possibly, for the voluntary planning agreements, which are being negotiated. We do not know what the outcome of that is, but we are continuing to advocate for the need to set aside land so there is certainty. Whilst there is no dedication of land, there is no certainty that this will happen or will be planned for for our future projected population.

The Hon. WALT SECORD: Ms Gibbeson from Fairfield, your view is a bit different to that of the other people at the table, because you would like to see an upgrade of Fairfield Hospital.

Ms GIBBESON: Firstly, we are not part of the growth centre but we are right beside the growth centre. Our people will put pressure—because our hospital is 32 years old; it has not kept up. So there has been a loss of confidence and so some people do not go to hospital. They avoid it.

The Hon. WALT SECORD: At all? They just do not go to hospital at all?

Ms GIBBESON: Yes, they avoid it.

The CHAIR: Do you have any evidence of that?

Ms GIBBESON: When you look at the—I suppose, anecdotally, we hear it all the time. They avoid Fairfield Hospital a little bit because there is a loss of confidence. Our community does not really travel well. We have got all the north-south—no public transport. It is just another barrier and it is difficult. Or they go to Liverpool Hospital and they put pressure on Liverpool Hospital because of all the things I spoke about. There is language; there is culture. So it then gets difficult there.

The Hon. WALT SECORD: How would you restore confidence in the hospital?

Ms GIBBESON: I know everybody thinks their area is unique, but we do take virtually—we take 80 per cent of refugees coming into New South Wales. We are in an unusual situation. I have worked in western Sydney for 25 years. I thought I understood western Sydney. Fairfield is quite different in that it is organised according to cultural groups, and so those cultural groups and those cultural beliefs have a much stronger influence over people's behaviour and attitude than, say, in Parramatta or other places. You might have a high culturally and linguistically diverse [CALD] community, but it is the combination of the refugee status, the background and the level of disadvantage. It is very self-supporting. The community supports itself, and so that is why sometimes old people—we have not got many aged care facilities, really, for our population. People like to keep people at home. We have got a high level of people who need care—disability. They are kept at home, because that is the cultural way of doing it.

So that is why I am saying I think there is a brilliant opportunity to address the needs of Fairfield, but also to try something different and new and get away from this hierarchical thing and really respond to quite an unusual place with unusual needs. If you look at what happened with COVID, the CALD communities—it was hard to get them to get testing. Our testing rates in Fairfield are the same as a lot of really rural areas, in the same as our level of disadvantage is, because they listen to the people they know. They listen to the people they trust. They listen to the local leaders, and then they listen to what is happening in their country of origin. So when those countries go bad—like when Chile goes bad—that is what they respond to.

The Hon. WALT SECORD: Ms Stares, I wanted to draw attention to the submission where it says that in cancer, respiratory and circulatory diseases, Campbelltown is ranked first in Sydney for potentially avoidable mortality; for hospitalisation for diabetes it is ranked third in Sydney; and in mother and baby health, it is ranked first in the south-west for hospitalisations. What recommendations or what changes would you like to see? Would you like to see more support for Campbelltown Hospital? I see the theme of "Yes, we would like a new hospital in the growth area, but we also need support for existing resources". Would that encapsulate your council's position?

Ms STARES: Absolutely. We would advocate for further investment in Campbelltown Hospital to right some of those wrongs of those deficiencies in health outcomes that are being achieved, but also in an integrated care model as well within other centres in Campbelltown local government area and elsewhere in the region. But certainly we would support further investment in Campbelltown Hospital because the stage two development that is currently underway, once completed, still will not support the demand that will be projected at the time of its completion.

The Hon. WALT SECORD: Ms Coleman, as a bit of a regional overview, we heard similar evidence involving Liverpool: that once the upgrade is finished, it will actually need to be upgraded. Would you agree with the view that there needs to be support for existing resources but also support for an additional hospital in the region?

Ms COLEMAN: Yes, certainly that appears to be the evidence at the moment. As I said, having a robust analysis of population projections and the like is really critical. But it is not just around the hospitals; it is also about then fully utilising those hospitals and facilities when they are established and also, as some have alluded to, putting in on the preventative side as well, given the number of different factors that contribute to poor health outcomes and the incidence. Ideally, as was commented, we would like to avoid people needing to go to the hospital if we can try to influence some of those factors as well. That really needs complementary investment in terms of education and other social and family services and the like to try to, as we said, affect the front end, not just in terms of the facilities. But from a growth point of view, yes, clearly there is going to be increased demand.

The Hon. WALT SECORD: How do you actually get messages into those communities, for example, you give the illustration of the Chilean community?

Ms GIBBESON: We have meetings with all the services, the different community organisations, some are funded but some are just very much grassroots community organisations. We put information out through them and we work with the faith leaders. We go to the community leaders and we have quite a strong social media presence and the mayor put things out on that and a lot of people will listen to that because he is a local leader.

The Hon. EMMA HURST: Ms Gibbeson, I wanted to go back to something you said about the fact that the hospital has not been upgraded for 32 years. Can you give us an understanding of what that means in terms of resourcing and infrastructure? I think in your submission you talked about electricity problems in the hospital.

Ms GIBBESON: Yes. They do not have enough electricity often and the internet is not adequate. I know you had a representative from Fairfield clinicians who I am sure detailed it a lot more. We, as local government, get the information from the community. Certainly internet—

The CHAIR: Both those issues.

Ms GIBBESON: Yes. Very, very basic things are missing.

The Hon. EMMA HURST: And that is why you have that anecdotal evidence that people are avoiding the hospital, because they are worried about those issues?

Ms GIBBESON: Yes. And people know there is no pathology. If it is something serious they are forced to go to Liverpool because they know they will get transferred to Liverpool anyway. Or they will try and deal with that within their own community. I want to refer back to the question earlier in terms of evidence, I know at one stage I looked at it and we have a very high rate of people attending short sessions of GPs. We had hospitalisations, but we had a high death rate in hospitals and it looked like people were delaying going to hospital until they were really critical. They miss out on early care because there are really no specialists around. We do have a lot of GPs but most of them are about to retire and we are facing a big problem there. They put off getting the right medical care, so by the time they get to hospital it is often too late.

The Hon. EMMA HURST: In your submission you said that Wollondilly had a ratio of one GP to 2,960 people, which is much worse than other areas even in South Western Sydney; what impact does that have on the local community to access some of that early health care?

Ms DENCH: Again, people put off or they cannot access GPs. There is even a lower level of specialists available. That is why we started with our telehealth monitoring in the home. We have 35 residents who are monitoring their health needs so as to indicate when they do need to get to hospital and they go straight to Campbelltown. Our GPs are very low and historically they have always been low. Again, you cannot get people to come over the razorback out to Wollondilly, they do not want to locate out that way.

The Hon. EMMA HURST: What do you think needs to happen to encourage them to relocate?

Ms DENCH: Services out our way, adequate infrastructure, it is very frustrating when you cannot access the right facilities to service your community and service those that are needing health care. We have one community health centre in Tahmoor for the whole area. People are referred back up to Rose Meadow quite often, the health centre up there. They may as well go straight to the hospital, that is why there is a very big presentation at the emergency department for people. Rather than going to the GP they go straight to the emergency department

The Hon. EMMA HURST: Ms Stares, you note in your submission that the health of the Campbelltown community is influenced not only by health services but by a complex interaction of socio-economic, demographic and cultural factors. Do you think that this unique combination of factors has been taken into account in the healthcare planning and, if not, what do you think needs to be done at this point?

Ms STARES: No, I do not think it has been adequately considered in the health planning. In order to do that it is not a basic population prediction in line with investment spend. It needs to be considered holistically. In line with all of those is considerations of the community that it is serving.

Ms CATE FAEHRMANN: I agree with the Hon. Walt Secord in terms of the very excellent presentations and statements in terms of how comprehensive they were. If you had one message for the Government today in terms of a recommendation, is it essentially to ensure that the health needs of the existing population are dealt with first before adding hundreds of thousands of people to our areas: is that what you are trying to get across?

Ms DENCH: I would say, yes. We have to meet the needs of our current population and to address the income. People have to have somewhere to live. And the peri-urban areas, of which Wollondilly is a peri-urban council, is a prime place for growth because it is reasonably priced, it is cheaper, affordable housing can be built our way, but it is not affordable if you cannot get to services and you have to travel many kilometres and long distances to get to services; it then becomes unaffordable. We then have what is happening in Fairfield with people not presenting to hospital and staying at home because you cannot get anywhere, you cannot afford to get anywhere. We need to address the current needs of our population and take into account and plan effectively where people are being placed to make sure adequate infrastructure is in place before people get there.

Ms STARES: If I could add to that. The growth is happening now and it is already underway, so if the Government were to plan for further investment in the Campbelltown Hospital, for example, following its completion, if planning commenced now for stage three of that redevelopment that is what we would propose so that it is a continual process that involves as the growth occurs. But, the deficit in existing health outcomes needs to be addressed urgently and then that additional investment and planning needs to occur now.

Ms COLEMAN: If I might add and put in a plug for that really joined up approach to planning with greater Parramatta and the aerotropolis. The Greater Sydney Commission is leading on what is called the

place-based infrastructure compact where a whole range of State agencies are at the table looking at their planning, looking at an evidence based approach, running scenarios for different growth outcomes so the development and the triggers for development can be aligned with the infrastructure delivery across a whole range of State agencies and other service providers. That is an approach that the councils would be advocating for other growth regions as well.

Ms GIBBESON: We need joined up. Ms Coleman is correct, we need that level of joining up, but we also need connection and that is why I am saying a place-based approach. You cannot just count the numbers, we clearly have a deficit. I saw some of the inquiry yesterday and I think the hospitals were all saying there is a clear deficit. We know we have the cheapest run health district and we combine that with probably the most disadvantaged group of people and people who are moving in. So in lots of ways you need to look at the correlation between DV, between children at risk and health services both clinical and community, and this has been on our agenda for a long time. For 25 years we have held a partnership with population health and we have recently set up a health alliance. Our health district is very proactive in working with local council and that is very good. But there are numbers and disadvantage, there is a deficit and we have growth.

Ms CATE FAEHRMANN: Is there a particular wish list when it comes to health programs or services that could be provided by your local councils that you have potentially approached government about, in terms of needing increased resources, that you wish to talk to us about that you may not have included in your submission? I understand that there are relationships with LHDs, but is there anything particularly from a local government perspective that you see as a role council could play to assist with health outcomes in your LGAs?

Ms DENCH: Certainly in the planning area and the built environment and making sure that health outcomes are addressed and planned for when new growth centres are being planned. Things like cycleways, open space, outcomes such as that are considered. It is not just about making sure you have a road in place but you have to make sure there are walking tracks and cycling tracks for that preventative side of health and that is a big role that local council can play, particularly in base placed solutions for each of our areas. Our areas are very different but we do have common regional issues and that is where we believe our health and planning role, which is jointly funded between the South Western Sydney health district and council, it is a 50/50 split funded position, to ensure that health outcomes are embedded in the built environment and when we are planning for future communities: To ensure that we do not make the mistakes that we have made in the past.

The Hon. NATASHA MACLAREN-JONES: Ms Dench, you talked about having 30-minute cities and 30-minute health care, particularly in relation to Wilton, and you use the example of maternity. With the Bowral Hospital redevelopment, which is a $124 million investment, and stage one will be complete at the end of this year, it will have maternity and birthing suites. Campbelltown is a $632 million redevelopment, again with the maternity and birthing suites and both of those are 30-minute drives, and I know that because I live in the area. There is a planning proposal before council in relation to a day surgery that has talked about Picton which is a 10-minute drive from Wilton. My question is, surely having the two major multimillion dollar investments at Bowral and Campbelltown and a day surgery, does that deliver the 30-minute health service that you were asking about?

Ms DENCH: Not for all our community, no. If you have a vehicle, yes, that is fine, you are able to access it. If you do not have a vehicle there is very poor public transport. Our bus service is virtually the school bus in and out of the area. We do not have a train line through a lot of those particular areas, we have a lot of rural residential residences in our area and is very difficult to get to those particular hospitals if you need to. If you have a child who is having a seizure or someone who is trying to give birth—I had my children at Camden Hospital and it was a good distance away. Since that has closed down now it is Campbelltown or Bowral.

The Hon. NATASHA MACLAREN-JONES: But you also have day surgery and you have 30 minutes for both major hospitals.

Ms DENCH: Would that be a birthing?

The Hon. NATASHA MACLAREN-JONES: I just said day surgery. I am not sure of the details but I am happy to provide that.

Ms DENCH: We are a growing area with a young population and will be having high birth rates and we need a birthing centre, not just a day surgery. We need something that will address the whole needs of our community.

The Hon. NATASHA MACLAREN-JONES: You wanted a 30-minute healthcare system and you have two major hospitals both providing birthing suites at your doorstep.

Ms DENCH: If you can access them.

The Hon. NATASHA MACLAREN-JONES: My next question is in relation to health literacy. That is probably more for Fairfield Council. South Western Sydney is a diverse community. Do you have any information or advice in relation to how we can improve health literacy for local communities?

Ms GIBBESON: How we are working on it at Wollondilly is we have partnerships with the PHNs and the LHD. We work on building capacity, we run training programs with community leaders, we run information sessions, you really have to get in and educate the community. There are a number of things that are really difficult. When you have communities that do not have concepts for things like mental health it is really tough because you have to go back and try and explain or find ways that we can explain mental health to these communities before you can say "maybe you need some help". Then you have to try and find a psychiatrist. There are hardly any publicly funded psychiatrists in our area. It is really hard.

Gambling, that is a public health issue. That is a major health issue for us. We are constantly trying to educate and say this is actually a public health issue, this is a health issue, and find ways around it. You have to get in at the grassroots level and work with the leaders and with as many community people as you can. We do that with the PHNs and the LHD, but the bottom line is that we have 211,000 people, so a couple of half funded positions hardly scratches the surface. There is the volume but there is the depth that you have to go to and it is quite hard.

The Hon. NATASHA MACLAREN-JONES: Do any of the other councils want to comment about or put forward strategies that you can put forward as recommendations to engage the CALD community?

Ms COLEMAN: It is a challenging issue and it is one that needs to be tackled in a way that acknowledges the differences between different CALD communities as well, as Ms Gibbeson alluded to. It starts with the fundamentals around the things that address social isolation, because you need to overcome those barriers in order to address the high level needs in terms of specific information around the health services and the like. Fundamental access to English language and those support services, such as connections through their schools and the community leaders become very important in influencing outcomes.

Ms DENCH: It is also about developing trust between the communities and that is about having culturally acceptable services in place and being able to respect and address those cultural needs. That may not necessarily be just about language but about practice and how things are approached and done in relation to people's cultural and religious beliefs.

Ms GIBBESON: The level of stigma: In the broader community we have signs up about mental health and it is quite acceptable to say "I have a mental health issue". We are dealing with communities where if it is suggested a young person might benefit from some mental health support, the stigma is huge. You have to get past all of that and that goes back to the cultural beliefs. It is not as simple as translation, it is about beliefs, it is about community standards, it is about how you are perceived in your community if you acknowledge something like mental health. For example, hepatitis C: We have a lot of hepatitis C and B, which are silent things. You can now cure hepatitis C, which is just amazing. But to get that word out to people because so many people do not get tested because they do not want to know or they are not prepared to admit that they have got it.

We have had to run programs just to tell people that there is a cure. You can be cured. If you go to your GP you can be cured. But, getting that word out is hard. If you look at tobacco, we have a number of hard to reach communities—they are called "hard to reach communities"—that do not respond to your normal health promotion messaging. Tobacco is a classic. We will run, with health funding, or health will run, specific anti-smoking programs for different communities to target them because the message just does not get through. You are looking at resourcing and you are looking at boots on the ground, but it is just not as simple as translation.

The CHAIR: Thank you for coming along today. You have provided us with some very rich evidence this morning which has added nicely to what was provided in the submissions. Thank you for making your time available and the great leadership work you are showing in your communities and the positions you hold. They are obviously thriving communities. We know that and we understand that and that is part of the reason why we are having this inquiry, because it is such an important part of New South Wales and specifically Sydney and Greater Western Sydney and South Western Sydney in particular.

Ms DENCH: We applaud the inquiry because it is well needed in our area when it comes to equitable service delivery.

(The witnesses withdrew.)

(Short adjournment)

TIMOTHY BRYAN, Chief Executive Officer, Greenfields Development Company No. 2 Pty Ltd, sworn and examined

MARK PERICH, Director, Greenfields Development Company No. 2 Pty Ltd, sworn and examined

The CHAIR: Just to confirm, the submission from the organisation has been received. It stands as submission number 28 to the inquiry. It has been received and incorporated into evidence and is available on the webpage. You are able to make an opening statement of a few minutes. It does not need to cover what is in the submission because you can take that as read. It will set up the opportunity to ask you some questions about the submission and related matters.

Mr PERICH: Thank you for accepting our submission and allowing us to give evidence. Greenfields is a privately owned firm in south-west Sydney. My family, the Perich family, have been in Sydney since the 1960s or earlier. My grandfather came over here in 1938. We have been members of the public in south-west Sydney for a long time. We are in a position, obviously, as large landowners to be able to master plan and deliver new communities in south-west Sydney. We are based as dairy farmers and still dairy farm and look after cows. We are well grounded and have been around for a long time.

One thing that we have been able to do is work with the local health district in the area to plan, I guess, as part of the strategic planning for Oran Park and other areas what needs to come in the future. It has been really useful that that has happened from day dot. The rezoning of Oran Park happened in December 2007. We were working with the local health district, it is a guess, but probably around 2005 we were having meetings with them to start working on what is required to make a community healthy. We have had a good working relationship with the local health district for a long time. It is not only health that we look at in a strategic master planned community.

We look at where people live, how people live, how they keep fit, what leisure activities are required, what buildings are needed like leisure centres and skate parks and that sort of thing. We have a strong civic presence with Camden Council that has now relocated into Oran Park, into the town centre. Oran Park is a strategic centre in south-west Sydney. It is the closest centre to the new aerotropolis core, to the new airport, and is seeing a huge demand because of that as well. It will grow to a population that will call Oran Park home of 50,000 people and it will have a catchment of 150,000 people over time. Like I said, there is a choice in housing ranging from all different size homes. There are terrace homes and we are about to bring on the market apartments at Oran Park that people are probably not aware of. There are housing choices that meet price points for all different people.

The trick is to create supply and to make affordability something that can happen in Sydney where people have somewhere to live, but not only where they have somewhere to live, they have somewhere where they can work. Jobs within the town centre is really important. We have started up a smart work hub within the first commercial building in Oran Park. It is very popular and has created a lot of new business. We have health, obviously, that we are talking about today, and we have transport links. We were very fortunate at Oran Park that we partnered with Landcom, a State Government organisation, that actually brought in transport early. We had bus services running within Oran Park before the first resident moved in.

You might say that is a waste of taxpayers' money but I would disagree with that because it shapes people's views in terms of what they need for their living arrangements. If you have a bus service, if you have public transport, you then do not need an extra car and you might then only need one garage instead of two or three. That might mean that you need a smaller house and that becomes now affordable. Creating and shaping people's views from day dot is really important. Landcom were there to actually help with that by bringing in public transport, by designing how wide streets should be and how the footpaths should work. It was a very good combination of a private family business who had a vested interest in the area, who still live in the area, and who want a good outcome for other residents that are moving into the area.

The other thing is that it is a large land holding, it was 1,300 hectares, the Oran Park site. We will be selling land for the next 30 years. What we do today and what we did 10 years ago will reflect in how people view and trust us in the future, so we want to get it right. I think Camden Council has come to understand that is what we try to do. I am not saying that we are an unusual developer, but we are probably a little bit different. The other things that make up the town centre are aged care facilities and education have been a strong focus. We have worked closely with the department of education in terms of supply. It has been a very good parallel looking at education and looking at health needs, they all relate on numbers and population. Unfortunately, I think the education side of things misread the explosive growth in numbers. It has become a political issue in the last State election. They are rectifying that.

They had a good go at trying to get it right in the first place. Oran Park had a public school there early. It was not envisaged that the number of primary school students would be double the amount that they expected

by now. The initial school was built for about 750 children in the first stage and that school was to grow into 3,000 pupils into a K to 12 school. At the moment there are 1,500 primary school students in that school. To the Government's credit they have now built the full high school and primary school. There are classrooms there that are empty in anticipation of those kids growing through to high school. They have come around and caught up. The thing is that we are selling lots in Oran Park every day. We know the numbers that are coming in, we know the houses that are starting to be built, we know the houses that are being moved into. We have a community run process where we actually greet and welcome every member that moves into Oran Park.

We are very familiar with the population growth and the numbers real time. The hard part for government is to try and understand what those numbers really are when they are trying to forecast them. Education and health are very similar in terms of the ratios of numbers of population, from what we have seen. We have tried to help both with education and health in terms of what is coming and what needs to be done. I guess with that as an introduction, the community focus of what we try to do is really important. We have worked with the local health district very closely to try to provide provision for health early in Oran Park. The submission explains the three different stages.

I might explain just one more thing. Through the process of the South West Growth Area, which originally was for 300,000 people and would be closer now to 500,000 people with the new Parkland City growing adjacent to that South West Growth Area, that everybody got into a room—councils, State Government, agencies, education, health—and worked out what needed to be there. That was a great thing. The set up and the start back in 2005-06 when all this kicked off it was a great thing that everybody got in the room and said this is what we need. Forget about all the strings and attachments that each agency has, they actually said this is what we need. It was worked out that the health system would have two hospitals, Liverpool and Campbelltown, as the main hospitals that would grow to fulfil the needs of this new population, but there would be three integrated primary health care centres or integrated health hubs, as in our report.

One to be based at Leppington, one to be based at Oran Park and one to be based at North Bringelly, which now is the new Western Parkland City. They are the three integrated primary health care centres, not new hospitals, but expanded hospitals and the three centres. The first one and the only one that is active in the South West Growth Area is the one in Oran Park. There are three stages that are to be delivered for that integrated health hub at Oran Park. The first is to bring GPs into Oran Park first up and community health. The good part was that the local health district, and this is probably unusual and probably not what they normally do—I am not a health expert, I must admit, but I have learnt a lot along the way—but they came in and leased space in the shopping centre that we built in Oran Park.

They have a 450 metre square facility within our shopping centre called Oran Park Podium. They actually went out and selected GPs through a tender system and put Myhealth in there. They have about 13 GPs operating out of there now and they are busting at the seams. They also brought in community health so that they can check babies and do all the stuff that community health do. That was stage one and that was set up relatively quickly in 2014. Stage two was to bring in allied health services and imaging. They set aside extra rooms for allied health and they also set aside a room for imaging. I could see in talking to the local health district that the imaging space was not big enough to cater for the needs of the growth. I actually suggested to the local health district why do we not build another commercial building that we need to grow jobs in Oran Park and incorporate the ground level with imaging. They were receptive to that and it saved them having to go through the tender system of trying to find out what operator they should put in because it was in the private system, it was under Greenfields leadership to try and find out who should go in to that space.

Instead of taking maybe another three years through a whole tender system that the local health district is forced to do, we were able to bring Shire Medical Imaging into Oran Park early as part of stage two of the integrated health hub. It is now fitting out that space and we should have imaging services in Oran Park by August and, hopefully, the MRI by September. That is a great benefit for Oran Park residents and the community in south-west Sydney, including Camden residents. By working together we are able to achieve a better outcome. The unfortunate thing is the rigidity of the government process, I guess, of having to go out to tender and to have to go and try and do so many things. Even with bringing the allied health services in, really it is only in the last 12 months that they have been able to have that working within Oran Park, and it was because they had to jump through all sorts of hoops to go out to tender and to get that process done—which they have done, to their credit, and they are operating there.

The third stage at Oran Park is a purpose-built building—and this is how I have always understood it, talking to the local health district—a purpose-built building about 6,000 square metres in size that is basically an outpatients hospital: anything that you can do outside of hospital to try and bring services that people go to Liverpool and Campbelltown for now and clog the system up, to move it somewhere else so they do not have to take up space or services out of those spaces, which are overloaded already. We have set aside space at Oran Park

for this building. Whether the local health district and State Government want to buy that land, build their own building and run stage three on their own, or whether they want a developer—which we are happy to do—to build that for them and lease it back, we are open to all different suggestions. We have always said we will do anything to help government achieve its objectives, and health is one of those. That is stage three.

Luckily at the moment the new commercial building that we have built is 10,000 square metres in size. It is now open. People are moving in there with all sorts of different occupations. But we are focusing to try to get specialists into that building at the moment and we are getting some interest from different specialists to move into that building now, which will support the integrated health hub. One thing that will happen is that when stage three comes on board—when the Government puts money into building that facility—we will have a lot of other private operators that will come on board to be part of that. We have also discussed the private operators, in terms of private hospital operators, who would come and co-locate next to that facility. I have even spoken to one particular private hospital operator that would be happy to actually run the public part of the outpatient hospital, as I call it, in Oran Park. They have had experience of doing that in other States. There is a lot of opportunity, and there are a lot of ways you can skin a cat, but there are a lot of services that are required at Oran Park. The current population of Oran Park in the development that we have built is 12,000, 13,000 people today. You will notice that in—and I am sorry if this introduction is running a bit long, but—

The CHAIR: Yes, we will get to questions soon if we can.

Mr PERICH: Yes. But I will just make it clear that, in our submission to this Committee, stage three requires greater than 18,000 registered patients. I actually am a patient of this integrated health hub myself and was there yesterday. I actually asked the director there, "How many registered patients do you have in this facility?" His response to me after checking was 23,084 as of yesterday. When you look through stages one, two and three, stage two is greater than 4,000 registered patients; stage three is greater than 18,000 registered patients. The numbers are already there for this stage three. By 2026 within a three-kilometre radius of Oran Park the population will be 37,000 people; within a five-kilometre radius, which is not that far, it will be 69,000 people. Within a 10-kilometre radius it will be 204,000 people in 2026—we are talking six years time. I think I have covered my introduction.

The CHAIR: Thank you very much, Mr Perich. It has been a very comprehensive opening statement. Mr Bryan, I understand there is a document that you brought along to assist the Committee that I think you are wanting to have presented to the Committee?

Mr BRYAN: That is right.

The CHAIR: Thank you very much. We will receive that now.

The Hon. WALT SECORD: Mr Perich, I would just like to touch on something that you just touched on at the very end of your opening remarks. You talked about a private hospital operator looking at or interested in the public provision. Is that very far advanced or is it just at the—where is it at the moment?

Mr PERICH: No, it is not really advanced far at all. It is just a discussion to, I guess, gain appetite of what the private providers would look at. This particular provider would look at running the public section as well as the private hospital.

The Hon. WALT SECORD: What size of operation would that be? Would that be like a hospital the size of Camden, a very small hospital?

Mr PERICH: I do not know what their plans would be. If they were to come in there without the public system stage three today they would be relying on, I guess, the existing population plus the aged-care component that is moving into Oran Park. Currently, we have Thompson Health Care building a 230-bed nursing home, which should be completed within 12 months. We have just had Anglicare complete 84 beds. We have got over 300 nursing home beds coming in at Oran Park within the next 12 months. That will create a demand for health services aside from the population that is moving in, the younger population.

The Hon. WALT SECORD: Are you familiar with a hospital called the Northern Beaches Hospital?

Mr PERICH: I have heard of it.

The Hon. WALT SECORD: You have heard of it, right? That is a private operator providing a public part of a hospital. Would you look at something like that down in Oran Park?

Mr PERICH: We would look at anything that is going to provide health services to our community. At the end of the day it is not up to us to make decisions for government in terms of how it would like to provide health, but all I can say is that we talk to both public health providers—the local health district—and private health

providers to try to spark interest, to tell them what the demand is that is coming so they can make decisions to move in.

The Hon. WALT SECORD: If you lived at Oran Park today and you needed paediatric surgery or chemotherapy, where would you go?

Mr PERICH: Campbelltown or Liverpool hospitals.

The Hon. WALT SECORD: How far a trip would that be by car?

Mr PERICH: Campbelltown Hospital by car, you could get there in 20 minutes.

The Hon. WALT SECORD: How many kilometres would that be?

Mr PERICH: I do not know. It is probably 15 kilometres away.

The Hon. WALT SECORD: If you needed to access an emergency department, where would you go?

Mr PERICH: I guess Camden Hospital is the closest if you wanted—

The Hon. WALT SECORD: Okay, but the emergency department—

Mr PERICH: But most people do not go to Camden, because they are only going to send you somewhere else. More than likely it would be Campbelltown Hospital.

The Hon. WALT SECORD: At the moment is Camden Hospital the closest government-provided health service?

Mr PERICH: Yes.

The Hon. WALT SECORD: How far away is Camden?

Mr PERICH: Camden is probably about 10 kilometres away.

The Hon. WALT SECORD: Is there still land available at Oran Park to actually build a hospital?

Mr PERICH: Yes.

The Hon. WALT SECORD: There is?

Mr PERICH: Yes.

The Hon. WALT SECORD: Who owns that land at the moment?

Mr PERICH: Leppington Pastoral Company.

The Hon. WALT SECORD: So it is farmland?

Mr PERICH: It is part of our dairy farm.

The Hon. WALT SECORD: Your dairy farm?

Mr PERICH: Yes.

The Hon. WALT SECORD: Okay. So there is space, there is land available in Oran Park?

Mr PERICH: There is.

The Hon. WALT SECORD: In your opinion, do you think that there would be enough demand or need for a hospital there?

Mr PERICH: I am not a health expert, like I said before. We have had a study—and this is what was handed around—in terms of what the demand needs are over time for health services.

The CHAIR: Thank you for the document. All members of the Committee have it. Could you just explain what this document is, the genesis of it and—

The Hon. WALT SECORD: Sorry, I did not know I had it.

The CHAIR: That is all right. Mr Perich, could you explain the genesis of it, who produced it and its purpose?

Mr PERICH: This document was requested by our company, Greenfields Development Company. It was prepared by a consultant, Linéaire Projects, who are experts in health provision and demographics. They put together this document as a high-level strategic health service need assessment summary report so that we could

actually put this in front of health specialists, doctors, this Committee—anybody who wants to understand what the demand for health services will be over time in the Oran Park area.

The CHAIR: That was their brief, to produce that job, but is this document in the public domain?

Mr PERICH: It is now.

The CHAIR: Sorry, silly question. It is now, but prior to now—this is essentially the presentation to a public group for the first time?

Mr BRYAN: That is right.

Mr PERICH: It is the first time it has been publicly presented. We have used it for private discussions with different individuals.

The CHAIR: What we would normally do with a document like this is that we would publish it as part of the evidence to the inquiry. Are you agreeable to that?

Mr PERICH: Yes, no problem.

The CHAIR: Thank you.

The Hon. EMMA HURST: Your position is that the timing of the integrated health hub in the area needs to be moved forward to meet the community needs. If this is not moved forward, what are some of the consequences, in your opinion?

Mr PERICH: I guess it just means that health services will have—people will have to travel further to access health services, which will cause issues with overloading at other places, such as Liverpool and Campbelltown, and that people will be disadvantaged in terms of access to equitable health care. What we are trying to do at Oran Park is to keep people out of hospitals. What we are looking at doing is trying to create an environment, firstly, where people can live and be healthy: walk to work, ride their bikes to work, leave their car at home, walk their kids to school.

I can talk for hours in terms of the design of Oran Park and what is being put in place for walkability, to try and keep people more healthy. Part of keeping people more healthy is to be able to have access to services to help them: to doctors, to specialists, to dieticians, psychologists, all those sorts of people who actually help people to live their lives in a better way which they do not understand. To have access to those people where it is easy access will help those people to make better life-living choices and to enact what the health system wants them to do to keep them healthy.

The Hon. EMMA HURST: In your submission you talk about the fact that developing a good public health service in Oran Park will also attract more private sectors as well. Can you explain how you think that would all work?

Mr PERICH: It is funny: Looking into the health system and understanding it more every day as I talk to more and more people, it is a bit of a club. Specialists will come when they know they are going to have plenty of referrals. There are plenty of people, there are plenty of GPs, there are plenty of referrals and they have lots of work. If it is a nice place to work—and the town centre that we are trying to develop will be a nice place to work and not only to live—they will actually feel comfortable working there and coming there. They will actually enjoy their experience while they are there. Therefore, they actually talk to each other and decide to come.

What I think is really important, and something that can be done today without spending any money, is to actually make people realise that this is coming to Oran Park. Stage three of the integrated health hub at Oran Park, most people have no idea that it is coming. What government needs to do and what Health needs to is they actually need to make the industry and the public aware that at some stage this stage three will occur, because then it starts putting the private sector people's investment caps on to start thinking, "Okay, I have got a choice whether I am going to move into a nearby area that has no potential future or into an area that has a future with government support". I think it is really important that those messages and those signals are very clear.

I think the reason why they are not made clear is obviously because funding needs to make these things happen. Sometimes promises that are made by government, if they come later than when promised, can be a problem to government. I guess the hesitation in terms of announcing stage three of an integrated health hub and what it is going to be at Oran Park can pose issues to the current Government. I understand why maybe that is not a priority, or why it is not put out in front, but I think it needs to be put out in front—with disclaimers, I guess, if there is a problem in terms of budgetary constraints or whatever else needs to happen.

Ms CATE FAEHRMANN: I am just trying to get my head around the responsibility here of the New South Wales Government versus the responsibility of developers to provide for health services in new suburbs. You pay a developer levy; is that correct?

Mr PERICH: Yes.

Ms CATE FAEHRMANN: That is the infrastructure levy as well?

Mr PERICH: Yes.

Ms CATE FAEHRMANN: Is there a part or a component of that that you know goes to health services?

Mr PERICH: I would have to take that on notice. I know that the special infrastructure levy is mostly for roads, transport, sewer connections and those sorts of things. In terms of health, I would have to take that on notice and check whether there is a component of the SIC levy that is for health or not. I am not sure.

The CHAIR: That is fine.

Ms CATE FAEHRMANN: Just going back to that, remind me of what that levy is again?

Mr PERICH: I guess in layman's terms, in really simple terms, for every house that is built at Oran Park there is about $15,000 that goes to the State infrastructure levy. There is approximately another $30,000 that goes to council for more local infrastructure. When you start adding these levies—

Ms CATE FAEHRMANN: That is approximately—when you are saying $15,000 and $30,000 that is based on what average for a house? You are obviously using an average there where you say $15,000.

Mr PERICH: Say for a 450 square metre block. These are—

Ms CATE FAEHRMANN: What is the figure, though?

Mr PERICH: These are only round figures.

Ms CATE FAEHRMANN: But what are you selling that for, then?

Mr PERICH: That land sells for $450,000, about $460,000 for a 450-square metre block.

Ms CATE FAEHRMANN: With something like this that you have produced, what has the local health district done—for the benefit of Hansard, this is the high-level strategic health assessment that a consultant has undertaken for you—how does this fit in with, for example, what I assume is a strategic plan by the local health district around the local health needs?

Mr PERICH: What happened was that Linéaire, the consultants there who are experts obviously in health, went through to the local health district and interviewed them. They went through all the documents that were available to understand the system and how the local health district were to set up health in south-west Sydney. They interviewed a whole range of different people, different practitioners and specialists and—I am not sure if there is a list in there, actually, of everyone that they interviewed, but there was a comprehensive list of people they went through and had a chat with to try to pull this together.

Ms CATE FAEHRMANN: Okay. As a developer of a suburb, are you required to come up with the health needs of that suburb, and not NSW Health?

Mr PERICH: No.

Mr BRYAN: No.

Mr PERICH: We are unusual, I guess. We are trying to put in place things that government should be doing—well, not saying "should be doing": we are trying to work with government to provide all sorts of facilities within Oran Park. Health is one of them. We are currently looking at a justice precinct in Oran Park.

Ms CATE FAEHRMANN: Is this because you are trying to be more attractive to residents than what other suburbs would be by offering more services than what NSW Health or the Government is providing usually?

Mr PERICH: I guess we would like to see provision of health services, education and retail uses—everything that a community will need when they require it. We are not trying to say, "Fast-forward this for us because we are special." We are wanting something here on time when people require it.

Ms CATE FAEHRMANN: So the Government is not providing the health services that it should and you are having to step in as a private—

Mr PERICH: What we are trying to do is we are trying to encourage the provision of these services at the right time. We have worked with the local health district and allowed them to be able to do what they need to do in Oran Park. I will say what a normal developer would do: A normal developer—

Ms CATE FAEHRMANN: Yes. That was almost going to be my next question.

The CHAIR: That gives us a comparative analysis. That would be useful.

Mr PERICH: A normal developer would build all the infrastructure to build houses so that you could sell lots to customers. Depending on how big the development is and what they can provide they might put a neighbourhood shopping centre in, so they might have a Woolworths or a Coles. Doing that, they would then probably try to source a private GP provider to come in with some doctors. If they were lucky, those doctors might actually bring an X-ray operation in or something, but it is all private. We could quite easily go out to the private sector and bring GPs in. We did not need the local health district to bring GPs into Oran Park. We could have done that ourselves. We have large providers of GP services knocking on our door every day. The difference is because we worked with the local health district we know that the community needs more than GPs.

The Hon. WALT SECORD: I do not want to put words in your mouth, but as an astute businessman or group you have realised that there is a need for health services in this community. It would make it more attractive to people who want to buy homes in that community. Therefore, you are working to encourage health services in there because they are not available at this moment.

Mr PERICH: Health is the same as every other thing. If you cannot go to see a doctor or you cannot go get an X-ray—

The Hon. WALT SECORD: You have recognised that there is a—

Mr PERICH: It is no different than not being able to go to get your groceries. They are essential services.

The Hon. WALT SECORD: What I am trying to say is that you have recognised, "Okay, this will make it more attractive"—

Mr BRYAN: Yes.

Mr PERICH: Yes.

The Hon. WALT SECORD: —"to someone with a young family to say, okay, there are no health services in this community but we are going to help provide it because it has not been provided."

Mr PERICH: We are encouraging that. Correct.

The Hon. WALT SECORD: I understand. I just wanted to get my mind around why you were doing it.

The CHAIR: I think Mr Bryan has got something to say.

Mr BRYAN: Yes, if I can just add to that to put it into perspective: Oran Park town is a new town. This is not a suburb we are talking about. This is not an isolated development.

The Hon. WALT SECORD: No, it is a community.

Mr BRYAN: It is a community. A lot of what Mr Perich shared with you is that we are building all the things that you would expect within a community and a town. When you drive in to a town you would want to see—now, there is a balance between what public services are but what a developer, in the sense of having a strategic plan, and us wanting to get the right community—

The Hon. WALT SECORD: But he has made a decision that more people will want to live here if we provide health services, because the Government is not doing that. I understand what you are doing.

Mr BRYAN: It is a balance between the strategy in the public system, in the sense of what government is planning, and how we complement that. What we are trying to do is get the parallels and the balance right of what we want to do in the private space, in the sense of commercial decisions, but certainly making sure that that is balanced by the community services that are available: back to the buses, back to some of the comments that were make earlier. The basis of our submission is around that stage three, which is just making sure that those parallels are running in the timetable that we feel is appropriate for the growing population of Oran Park and our knowledge of that population, which perhaps is not more broadly understood and, hence, in the sense of this inquiry, having the opportunity to voice for our community that in fact the numbers and the demand are what we believe and see every day.

The Hon. WALT SECORD: I understand what you are doing.

The Hon. NATASHA MACLAREN-JONES: Just following on from that, I am interested in the consultation process with the current community but also the community that you are looking to attract. How does that fit into the work that you do and your engagement, not just necessarily with health, but obviously you were talking about justice, education and others?

Mr PERICH: We work closely with our community. We have regular updates that our community is invited to come to sit on and we explain everything that we are trying to energise, what we are trying to create, the new buildings that are being built—the second stage of the shopping centre, the new commercial building. Anything that is new, we basically try and explain it to them: if there is a road change, if there are things that affect them, the new railway line and where the tunnelling starts and where it goes and that sort of stuff. We have had Department of Transport at these meetings trying to explain that we spent six months actually trying to stop Department of Transport putting a railway line through someone's brand-new house, which we had no idea about and obviously our community thought we did. We work very closely with our community.

We also have a welcoming committee. With every member who moves in, we have somebody physically go and give them a welcome pack and have a chat with them and tell them all the services that are available. We have a community partners meeting where we bring in the local health district and we bring in all the different types of services that—it might be disability services; it could be a skin cancer representative. We have all these people who come in to community partners meetings. They all tell us, "Hey, listen, have you thought of this? Have you thought about the psychology needs? Have you thought about this?" We actually put all that together and say, "Okay, well, we might be missing something." Then we will actually go and try to find who we need to talk to and work out how we try to provision—and we cannot do everything, but we actually try to listen and work out what we are missing and what needs to be added. The reason we do that is we want it to be a better place, at the end of the day.

The Hon. NATASHA MACLAREN-JONES: My other question—I am happy to have one more—is in relation to the actual integrated health hubs. Looking at how it currently operates and the stages you have gone through, how easy is it to adapt the model across all parts of western Sydney or elsewhere? Obviously western Sydney is quite a diverse community and we have heard you have got young populations, you have also got migrants, the older population and various groups. How easy is it to adapt that model across different communities, or are there lessons learnt from—

Mr PERICH: Sitting on the private side of the fence, it is very easy because we just get things done. I do not think it is too hard. I think the local health district knows what is needed in this health hub. They have a lot of arms being held behind their back in terms of how they can deliver these services. For example, GPs, from what I have learnt, are normally a Federal jurisdiction. In this case we have got State Government Health procuring GPs in Oran Park. There might have been a few GPs out there who got their noses out of joint, because why is the local health district playing around with what someone else should be doing? But at the end of the day, I think to provide the service and for them to coordinate GPs to come in there, to coordinate allied health, to try to coordinate to bring imaging in and to try to be a catalyst for specialists, and then to get to basically this outpatient hospital, I think it is only State Government that can do that.

The CHAIR: I just want to finish on this: Obviously your work from the very start with the local health district has been important. In terms of how that has operated in practice, has the local health district essentially established, dare I say, a core group of people or set of individuals who in effect you have worked with over these matters? If that has been the case, could you just describe what that sort of interface and interaction has been?

Mr PERICH: The initial planning side for master planning, they have strategic planning people in Health. I have forgotten the guy's name—a very colourful guy with a colourful bowtie who has now retired. He came out and was trying to plan and understand the population growth and expectations to try to I guess give us ideas in terms of how to try to make a better community, to have the cycleways and footpaths and to make us as a developer think about what we can do in the hard building blocks, I guess, of road layouts, of putting things in different places to try to make it a more healthy community. They have a department that looks after strategy.

The CHAIR: Yes.

Mr PERICH: The name escapes me of who does that—

The CHAIR: That is fine. I am just trying to understand the architecture of this interface.

Mr PERICH: In terms of delivery, Amanda Larkin is at the top of the south-west local health district. She has been instrumental in trying to make these things happen. But she is tied up and flat out with the expansions of Liverpool Hospital. I know she is really busy. Another fellow called Justin Duggan basically was put on to talk

and set up this integrated health hub, to set out tenders, to go out and procure GPs—to make it happen, in other words; to work with us as the developer to find space. That was a role that he, plus a few others—it was not him on his own, but that is the name that comes to my mind of who I have had many meetings with—played to make it actually happen. I guess the good part is that they had a very receptive developer that could help them make it happen. I think that is also very important.

The CHAIR: Thank you. That is very helpful. Gentlemen, thank you very much for coming along today. There may well be some questions arising from the opportunity for members to read *Hansard*, which will lead to some what we call supplementary questions. We will seek to provide you those through the secretariat to look at. We provide a 21-day turnaround time. It will be based on the questions we have had today. Once again, thank you very much for coming along and providing us with some very valuable insights into the particular project you have been working on.

Mr PERICH: Can I just add one thing?

The CHAIR: You certainly can.

Mr PERICH: One thing that I have missed that is really important too in new communities is the connection of fast internet speeds and fibre. With Oran Park being a new place we made sure that there were very good internet fibre connections there. If a facility needs to move in there, we have the capability of putting dark fibres in there for secure—

The CHAIR: Sorry, what fibres?

Mr PERICH: A dark fibre. Basically it is a secure fibre where nobody can hack in or do anything else. We are now about to turn on speeds of up to one gigabyte per second within Oran Park. Those sorts of technologies will enable eHealth to happen. I know that the local health district is working with new technologies, in terms of patients' information, that can connect from GPs to the public hospital systems. Currently one of their mandates is to work on that now, and I know they are doing that in this integrated health hub.

The CHAIR: Thank you very much. That is great. The issue of telehealth has been covered by previous witnesses, so that is just for today.

(The witnesses withdrew.)

(Luncheon adjournment)

SUSAN PEARCE, Deputy Secretary, Patient Experience and System Performance, sworn and examined

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning, sworn and examined

AMANDA LARKIN, Chief Executive, South Western Sydney Local Health District, sworn and examined

The CHAIR: Thank you very much for coming along this afternoon. I can confirm that the Government submission to this inquiry has been received and sits as submission No. 33 to the inquiry. The submission has been processed and now forms evidence to the inquiry. It has been uploaded to the webpage for the inquiry and can be accessed through there. Thank you for that. Witnesses should take submissions as read by members participating. In terms of your opening statements, which I will invite you to make shortly, you do not need to go through your submissions in detail but instead perhaps set some key points that you would like to elucidate. If you are agreeable, we would then like to share the questions between representatives of the Opposition, crossbench and the Government, and we will move through those questions in a pretty fluid way to complete the time allotted this afternoon. Is that an agreeable format, Dr Lyons?

Dr LYONS: Certainly.

The CHAIR: Thank you very much. I invite witnesses to make an opening statement.

Ms LARKIN: I will make the opening statement on behalf of us. The South Western Sydney Local Health District vision of "leading care, healthier communities" underpins the strategic direction of the organisation and drives our priorities. Our clinicians and staff are committed and dedicated, and continually identify innovative ways to provide consistent, safe and high-quality care to the growing community of the south-west. New South Wales operates one part of a comprehensive health system in Australia. All parts of the health system, including general practice and the private sector, play an important role in providing health services for our communities.

With respect to public health services provided by NSW Health, it is an exciting and historic time for development of health services in the south-west Sydney growth region and South Western Sydney Local Health District. The district is one of the largest local health districts in New South Wales, with an estimated population of over one million residents. South-western Sydney communities make up approximately 12 per cent of the New South Wales population and are as diverse as they are large, with around 51 per cent of residents speaking a language other than English at home and over 16,000 residents identifying as Aboriginal or Torres Strait Islander. Further, the district is home to a significant refugee population and a community with a high burden of disease.

There is substantial growth projected over the next 20 years, development of new housing estates in many parts of the district, urban infill in more developed local government areas, as well as the strategic planning for the greenfield land around the Western Sydney Aerotropolis. As a result of forecast growth in demand for a range of health services, the New South Wales Government has committed significant health infrastructure funding in south-west Sydney, with almost $3 billion committed to hospital redevelopments. This investment and the associated redevelopments will provide opportunities to improve the quality of health services, methods of service delivery, models of care and provision of care that is local and accessible to the community, and this is a very important issue.

Developing a diverse health infrastructure portfolio in the area will position South Western Sydney Local Health District to respond and adapt as clinical and service planning continues to evolve to include digitally enabled care strategies and virtual health, especially in new facilities, community-based care in local health centres, greater care in people's homes as well as the acute hospital setting. A commitment to research and clinical trials will also see more innovative healthcare practices, which will benefit the community by keeping people healthy and out of hospital as well as providing access to the most current treatments available. Providing quality health services in the South West Sydney Growth Region now and into the future is a key focus for both our district and NSW Health. Thank you.

The CHAIR: Thank you, Ms Larkin. That is a very good, clear opening statement, which has set up the questioning nicely. Are we okay to proceed with the questioning? As I indicated there are representatives from the Opposition, crossbench and the Government and we will share questioning around.

The Hon. WALT SECORD: Can we be flexible about the allocation of times, Chair?

Ms CATE FAEHRMANN: I am happy with flexibility.

The Hon. NATASHA MACLAREN-JONES: I am happy with that.

The CHAIR: Okay. That is fine. It is important that the three groups get their proportion of the questions. We will begin with the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you. I would like to direct my very first question to Ms Larkin. The current COVID testing taking place involving the Crossroads Hotel, is the local health district running that, or is that a NSW Health activity?

Ms LARKIN: It is being operated by South Western Sydney.

The Hon. WALT SECORD: So it is your local health district.

Ms LARKIN: Yes.

The Hon. WALT SECORD: Okay. So you are operating that. Are you overseeing or do you have knowledge of how it has occurred?

Ms LARKIN: Yes.

The Hon. WALT SECORD: Is it working properly?

Ms LARKIN: It is working extremely well.

The Hon. WALT SECORD: What is the current wait time in a vehicle to get tested?

Ms LARKIN: There is a period of wait time but can I just explain? Currently as of yesterday across the district we screened 3,296 people. With what we are experiencing in the south-west at the moment, the demand for screening is high. People are being incredibly responsive to the screening stations and they spread both from Liverpool down into Campbelltown across into Narellan, to Picton, and is today down into Bowral. We have got them set up in all the local hospitals and the pop-ups have been established to meet current community need. There is a period of wait time in the screening stations—it is the volume—but we are working through the volume and we are running now from 8.00 until 9.00 p.m.

The Hon. WALT SECORD: You have said twice periods of wait.

Ms LARKIN: Yes.

The Hon. WALT SECORD: What is the period of wait for tests?

Ms LARKIN: It varies depending on the time that people arrive, the volume that is there at any particular time—we are going from 8.00 until 9.00 p.m.—and the aim is to not turn people away, to continue swabbing for as long as we possibly can.

The Hon. WALT SECORD: Okay. You said there are variable times. A five-hour wait; is that the average wait to be tested?

Ms LARKIN: At Picton yesterday there was quite a long wait for people, so immediately by 3.00 p.m. yesterday afternoon to support the Picton clinic we set up Camden Hospital and diverted people from Picton across to Camden Hospital to reduce the wait time and ensure that they were seen. We extended that clinic until nine o'clock to make sure we saw the greatest volume we could.

The Hon. WALT SECORD: Has the region declared a hotspot yet?

Ms LARKIN: I might ask my colleagues to explain that.

The Hon. NATASHA MACLAREN-JONES: Point of order—

The Hon. WALT SECORD: No. This relates very specifically to the provision of health care in south-west Sydney.

The CHAIR: Okay. I understand that. The Hon. Natasha Maclaren-Jones has not even cited the point of order. A point of order has been taken.

The Hon. NATASHA MACLAREN-JONES: First of all I want to say it is not within the terms of reference.

The Hon. WALT SECORD: Yes, it is.

The Hon. NATASHA MACLAREN-JONES: However, this is very important overall and the information being provided is very important but I remind the Hon. Walt Secord that we are here to talk about growth in the region, not necessarily about specific things occurring today.

The Hon. WALT SECORD: To the point of order: The very last item of the terms of reference relate very specifically to this, "and related matters". This is something that is the subject of public policy and I in fact think that this highlights the lack of attention that south-west Sydney receives.

The Hon. NATASHA MACLAREN-JONES: Oh, come on, Walt!

The CHAIR: Order!

The Hon. NATASHA MACLAREN-JONES: We have staff that are working long hours in hospitals and in clinics around this State to do the right thing by the people. Do not dare sit here—

The Hon. WALT SECORD: I think your Government has dropped the ball.

The CHAIR: Order!

The Hon. NATASHA MACLAREN-JONES: Don't you dare!

The CHAIR: Order! Please!

The Hon. WALT SECORD: Your Government has neglected a part of Sydney.

The Hon. NATASHA MACLAREN-JONES: They have not.

The Hon. WALT SECORD: Completely neglected a part of Sydney!

The Hon. NATASHA MACLAREN-JONES: Have not! Stop the theatrics.

The CHAIR: Order!

The Hon. NATASHA MACLAREN-JONES: We know you love the arts, but come on, mate.

The CHAIR: Order! Please listen. I thought we got off to a reasonable start. I will rule on the point of order. This is a specific inquiry and we know what the terms of reference are. Yesterday I gave some attitude around questioning with respect to the matter of the COVID emergency and provided an opportunity for witnesses to provide some responses to give some immediate information which, through this inquiry, would be usefully passed on to the general public in New South Wales. I thought that was a reasonable thing to do.

The Hon. WALT SECORD: Thank you, Chair.

The CHAIR: Hang on. I did that yesterday. I do not want to regret doing that. I will permit some modest additional attitude, given what has just exploded in front of me to pursue the line of questioning to provide information through the health officials that they can usefully be passed on to the community at large. But once that is done, we then move on to exploration of the terms of reference. I will allow some attitude but please do not do that again.

The Hon. WALT SECORD: Thank you, Chair. Dr Lyons, how does the Government determine the criteria to declare a region or an area a hotspot, keeping in mind that the Northern Territory and Queensland have declared residents who live in south-west Sydney to be living in a hotspot?

Dr LYONS: I will preface my response by saying I am not the Chief Health Officer and public health is not in my area of responsibility, but to the best of my understanding what we are dealing with at the moment in south-west Sydney is a cluster around the Crossroads Hotel. My understanding from the briefings I have received from the public health side of things in the Ministry is that all of the COVID-positive cases can trace back to a contact at that hotel, even if it is by secondary or tertiary, which means a secondary contact or a third-person contact. It traces back to that initial outbreak. In that context it is seen to be an outbreak and a cluster around a specific infection that has occurred. At this stage it is not broader than that. What other States may declare it to be and what we declare to be, in our view it is defined as a cluster and an outbreak around one site at this point in time. Until there was more widespread community transmission from an unknown source that was not related to that particular cluster, then we would say that it is an outbreak and a cluster around one site.

The Hon. WALT SECORD: Okay. Just so that I get this correct: NSW Health says it is a cluster or an outbreak, but the Northern Territory and Queensland said it is hotspot. Ms Larkin, are you involved in discussions or recommendations in discussions with the Chief Health Officer involving the declaration of it as a hotspot, a cluster or—what was the third one?

Dr LYONS: It is an outbreak.

The Hon. WALT SECORD: —a hotspot?

Ms LARKIN: Ongoing daily discussions with the Chief Health Officer around the work that we are doing out there, et cetera, that discussion is specifically around it being a hotspot has not been raised at this point.

The Hon. WALT SECORD: It has not been raised?

Ms LARKIN: No.

The Hon. WALT SECORD: But it is in the public arena.

Ms LARKIN: A cluster—

The Hon. WALT SECORD: The Queensland and Northern Territory governments have declared it a hotspot. If an area is declared a hotspot, what occurs in that area?

Ms LARKIN: I cannot—

Dr LYONS: There would be further action taken. If there was widespread community transmission within a certain locality then it would raise the requirements for additional public health measures to be undertaken. I think the response that New South Wales is taking at this point, knowing that it is an outbreak around one site and can be linked back to that one site is to increase awareness of the importance of the public health measures and also rapidly increase the testing in the community on that site to ensure that, if there is any evidence of any further transmission, that is quickly identified and people can be isolated and ensure that the transmission is broken. That is the strategy that is underway at the moment.

The Hon. WALT SECORD: So 34 cases linked to the Crossroads Hotel is a cluster, is an outbreak, but not a hotspot?

Dr LYONS: Well, that is not the language we are using. A hotspot might have a certain connotation in other jurisdictions but in New South Wales it is a cluster around one specific outbreak.

The Hon. WALT SECORD: Ms Larkin, I read some data earlier this week about testing in south-west Sydney for COVID, which is half the per capita population that it is in Sydney's east. Is that still the case?

Ms LARKIN: Not in the current situation. Over the last couple of weeks as cases have been identified from the Friday from the Crossroads, it has significantly increased over that period of time. Yesterday would have been what of the largest we would have done over the last couple of weeks.

The Hon. WALT SECORD: You mentioned earlier that there is now a pop-up clinic in Bowral.

Ms LARKIN: Yes, there is.

The Hon. WALT SECORD: Is the cluster growing in size?

Ms LARKIN: There was a case identified linked to the Crossroads in Bowral last night and there will be a pop-up there tomorrow.

The Hon. WALT SECORD: How many testing sites are in there now in the south-west and in the Southern Highlands?

Ms LARKIN: The Southern Highlands is part of the South Western Sydney Local Health District so there is one at each of the six hospitals and now there are three pop-ups—one at Casula, one at Prestons one at Picton and tomorrow there will also be a further one at the showground at Moss Vale.

The Hon. WALT SECORD: By tomorrow there will be 10 sites.

Ms LARKIN: Yes.

The Hon. WALT SECORD: Right. How many staff will be at those sites?

Ms LARKIN: It varies based on whether they are static walk in or a drive through. At a drive through you need between about 16 and 18 staff for that so they will vary based on the location and the size and the throughput we can do. What is really important is that we ensure safety of people who present at the clinics and the staff who are working out of there, so it can vary.

The Hon. WALT SECORD: I think in the last hour so NSW Health has determined the person who was the source of the Crossroads Hotel. Is that correct?

Dr LYONS: There was a media conference about that around 11 o'clock today.

The Hon. WALT SECORD: So the source has been confirmed?

Dr LYONS: That is correct.

The Hon. WALT SECORD: Where is that source now?

Dr LYONS: At the press conference at 11 o'clock it was announced today that the genomic sequencing that had been undertaken of the virus that had been detected in the outbreak links back to the same genomic sequence that has been identified in Melbourne.

The Hon. WALT SECORD: How many staff are working or will be working at the 10 sites?

Ms LARKIN: I cannot tell you the total number because, as I said, it varies. The other thing is though depending on the demand we have increased staff so at Bankstown today we had some demands so we have increased that number, so it can vary, but we are putting the maximum staff possible to ensure that the quickest throughput for people.

The Hon. WALT SECORD: With your modelling and projections, are we through the worst of the Crossroads or is it just beginning? If you were to do a graft, where would we be in the cycle involving the Crossroads?

Ms LARKIN: Can I also reflect that I am not the Chief Health Officer in relation to that. I am responding to the cluster and to the cases that we are identifying. I am not aware of that at the moment in terms of where exactly that we are at.

Dr LYONS: I will give you some advice on what I know, which is that it appears that the first, from what the public health tracing has done, that the outbreak can be traced back to the presence of a number of people in the Crossroads Hotel on the evening of 3 July. With the incubation period of 14 days then you can assess that we are coming towards the end of that 14-day period from 3 July.

The Hon. WALT SECORD: So today is Wednesday?

Dr LYONS: The fifteenth.

The Hon. WALT SECORD: So Friday will be what you think to be the end of the incubation period.

Dr LYONS: I am not the public health expert. All I am indicating is that the outbreak was identified on 3 July and it is a 14-day incubation period.

The Hon. WALT SECORD: Outbreak, okay. It was identified on 3 July. When did the decision to expand the number of sites occur? Yesterday?

Ms LARKIN: No, no. On 3 July that was the Friday. A case was identified on the Monday. There was some tracing the following Friday. Within about three hours we had our additional clinic up at Casula and we have expanded since then as the cases have been identified.

Dr LYONS: The first it came to light that there were two cases that had a common place on the contract tracing of where they might have picked it up and it was last Friday. As a result of that then immediately there was a response in establishing the increased testing.

The Hon. WALT SECORD: Right. Okay.

The Hon. EMMA HURST: Liverpool Hospital noted in its submission and they gave evidence as well during this inquiry that children under 12 may have to travel up to an hour for emergency surgery because of a lack of facilities in the local area. I just want to know what your response to that is?

Ms LARKIN: The provision of paediatric surgery at Liverpool is up to the age of 12. In terms of more complex surgery that is required, those younger children would travel to the Children's Hospital. There are good relationships between the district and the network in terms of the provision of care at Westmead. We work closely together in terms of the provision of health services.

The Hon. EMMA HURST: Are you concerned about the length of travel and the stress on families if it is an hour's travelling?

Ms LARKIN: I think what we have to take into consideration is the appropriateness of the care to be provided at one of our places like Liverpool. Where is the expertise? Where can the best care be provided? I think we need to understand that both within the district and across New South Wales the networking of health care is a critical way services are provided. You see it with burns. You see it with a whole range of different services that that networking is essential in terms of the expertise, the knowledge and the facilities to provide that care.

The Hon. EMMA HURST: We also heard from Liverpool Hospital that they were unable to hire a head of birthing unit due to a lack of funds, despite it being highly recommended in a hospital report to avoid any further neonatal death. Is NSW Health doing anything to address these kinds of deficiencies?

Ms LARKIN: At the local level we have probably in the last two years appointed a very senior head of department for obstetrics, who is doing, I think, an excellent job for the area. The position I believe Liverpool are talking about is the head of birthing unit which, in conjunction with Liverpool Hospital, we are progressing at the moment.

The Hon. EMMA HURST: In your submission it says that NSW Health ensures access to professional healthcare interpreters when required. However, in a number of submissions and from a lot of evidence during this inquiry, people are complaining that they do not have timely access to interpreters and that this is actually impeding patient care, particularly in emergency situations. Is NSW Health doing anything to respond to that, or is that an issue that has come to your attention?

Ms LARKIN: Provision of interpreter services at South Western Sydney—and as I said in my opening statement, 51 per cent of people are from non English-speaking backgrounds—is a critical part of service delivery. We have provided a lot of the emergency care on a one-to-one basis but especially through COVID we have actually moved significantly towards telephone interpretive services, et cetera, in order to expand and to support families. From my point of view, as I said, interpreters are very critical. They are very central to care delivery. We look at different ways to provide interpreter services to support families at all levels of care, not only in emergency with prenatal—a whole range of areas. We have expanded the service but it is an important aspect for us.

The Hon. EMMA HURST: Do you think that that expanded telephone service will extend beyond COVID, if it is working?

Ms LARKIN: Absolutely, yes; and I would like to think we will also add virtual tele-videoconferencing for people because it can be easier. It is not easier with the older group of people of non English-speaking people. Is can be challenging so you have to provide a range of methods in order to best meet the needs of the family or the patients from a healthcare perspective.

The Hon. WALT SECORD: Excuse me, Chair, I was under a bit of a misunderstanding. I thought we were chopping and changing a bit. Is this my allocation of time?

The CHAIR: No. I am keeping people's times. You had 13 minutes and it is now the turn of the Deputy Chair.

The Hon. WALT SECORD: Okay, apologies.

The Hon. EMMA HURST: That is okay. In the evidence given by Campbelltown Hospital we heard that Campbelltown Hospital has more mental health patients spending greater than 24 hours in the emergency department [ED] per month than the entire Sydney health district per year. This is a really concerning statistic. Is NSW Health aware of this issue? Is anything being done to fix it?

Ms LARKIN: I will address it from a local perspective. The needs of mental health patients in South Western Sydney is an absolute priority, but it is challenging. But there are quite a lot of strategies in place to address that going further. As part of the Campbelltown redevelopment there will be a significant expansion of mental health services and the big demand is in the area of high dependency beds—high or acute beds—so that is what you will see in terms of our expansion of the next couple of years. But there is also, as part of the care for mental health patients, the aim to provide care in the community.

There are a number of strategies that are being developed in conjunction with the Ministry around services for people in the community, such as the Police, Ambulance and Clinical Early Response, or PACER, whereby in conjunction with ambulance people are maintained in the community. The Community Mental Health Emergency Team, or CoMHET, teams are seeing people very quickly after long-term inpatient care. There is a range of strategies that are in place to manage it but it is challenging at the moment and there can be long length of stay in the EDs.

Dr LYONS: If I could just add: Ms Larkin is the Chief Executive of the local health district and the mental health team in my division have regular contact about ensuring that the appropriate support is provided. We have had a lot of advocacy from Ms Larkin and her team about some of the challenges that are faced and they are issues around workforce, particularly around senior medical specialists in the public sector in south-western Sydney and the ability to attract and retain those psychiatrists in our workforce. We have had strategies in place to improve that and I think it has improved over the last 12 or 18 months.

Ms LARKIN: Significantly around medical staffing. Our medical staffing is probably the strongest it has been.

Dr LYONS: Yes. We have been very closely working to address those issues.

The Hon. EMMA HURST: Do you mean that the number of medical staff has increased?

Ms LARKIN: Increase, but we have retained them in terms of the health service and that is very important.

The Hon. EMMA HURST: How much have they increased by?

Ms LARKIN: I could not—

The Hon. EMMA HURST: You can take that on notice, of course.

Ms LARKIN: I am happy to do that.

Dr LYONS: I think the issues around the constraints in terms of beds is well recognised and we have planned for additional services. Ms Larkin has talked about the Campbelltown Hospital redevelopment. There will be a 33 per cent increase in the number of inpatient beds so there will be 62 extra inpatient beds when that redevelopment is complete. We recognise the need for us to continue to support those services in the interim, though, so the focus will be on how we can support better care in the community setting, given that the inpatient services are at capacity at the moment. That will be a continuing focus of investment over the years between now and when Campbelltown comes online.

The Hon. EMMA HURST: Can I put on notice any data around those retention rate changes as well? That would be really useful.

Ms LARKIN: Yes.

The Hon. EMMA HURST: I have just one more question in regards to the Camden area. We have heard that the Camden area is expected to grow significantly in population and even more so projected compared to other areas in south-west Sydney, but I understand that there are no plans to upgrade or invest in the Camden Hospitals. Is that correct?

Ms LARKIN: Camden Hospital is part of the governance of Camden and Campbelltown. The investment for that area is very much in the Campbelltown Hospital and very much part of clinical services planning. We have also established, though, and developed and delivered recently a care in the community plan, which is the development of integrated care hubs in that growth region. The integrated care hubs are about providing care close to the community in conjunction with primary care providers and a range of services that we trust will prevent people needing to come to hospital. But in relation to the overall growth and the need for acute services, that is very much tied to the Campbelltown Hospital, yes.

The Hon. WALT SECORD: Ms Larkin, why are patients at Liverpool Hospital waiting 300 days for hip replacements when they can get a similar procedure at the Royal Prince Alfred Hospital in 22 days?

Ms LARKIN: There is a significant volume of surgical activity in south-western Sydney. In relation to wait times, we have increased the amount of care that we have provided and that is obviously come about through growth, but there are wait times for particular surgeries in the south-west, yes.

The Hon. WALT SECORD: What are other wait times? For example, hip replacements is 300 days. What would be the average wait for cataract removal?

Ms LARKIN: Can take that on notice in terms of the specific wait times?

The Hon. WALT SECORD: Okay. If you are going to take that on notice, then could you also, when you take that on notice, show the average wait for cataract removal? When you are placed on the list, when does the meter start running in the sense of the wait? Is the wait from the referral to the specialist or when you meet your GP for the first time?

Ms LARKIN: The referral is when the referral comes in for you to go on the surgical waitlist. So you have seen the specialist and then you will be referred to the waitlist for your surgery to commence.

The Hon. WALT SECORD: So the 300 days for a hip replacement is actually in fact even longer than 300 days because there is the first meeting with the GP then there is a wait for a referral to a specialist and then when the specialist puts you on.

Ms LARKIN: Hip replacements and orthopaedic works are the important one to consider, though. In terms of referrals from GPs they have been some good programs implemented in terms of pre-surgery activities and work to support people who are on waitlists prior actually having their surgery.

The Hon. WALT SECORD: If you need a new hip, what would be the support that you would receive—a wheelchair?

Ms LARKIN: No, not a wheelchair, but some activities that may help you and improve your capabilities as you wait for that surgery to occur—very much so with knee surgery. We are putting in some good programs to support people who wait for knee replacement, et cetera.

The Hon. WALT SECORD: But—

The CHAIR: Hang on. The witness may answer the question. I do not think you had quite finished. Unless I am mistaken, I think you cut Ms Larkin off. You were in full flight as I was listening. Had you finished, or not?

Ms LARKIN: Thank you, Chair. What I am saying though is, yes, people wait period of time for orthopaedic surgery in the south-west but for things like knee surgery we have attempted to put in programs to support people while they are on the waitlist and put them in the best condition for their surgery once it is made available to them.

The Hon. WALT SECORD: Would it not be, instead of putting programs in place to deal with the wait, more efficient or better for the patient to actually simply conduct more procedures?

Ms LARKIN: But you do want patients to be in the best condition when they actually undertake this surgery.

Dr LYONS: Could I also support that. These osteoarthritis care programs are programs that we put in place for all districts across the State. It is about providing better quality care for people who have osteoarthritis and maybe on a waiting list for joint replacement. It is about keeping them active, reducing their pain and if there is an opportunity to lose weight, if that is an issue that might be causing pressure on their joints, the program supports that, improves their mobility and gets them in the best possible situation for surgery that is required. But there is also this advantage: Some of these people actually come off the waiting list because that program actually identifies that they can manage without the need for surgery. So it is actually a program. It is not just about biding time and waiting for surgery. It is actually about providing better quality of care.

The Hon. WALT SECORD: Ms Larkin, yesterday Professor Miriam Levy of the Liverpool Hospital said that the hospital was operating at 105 per cent of capacity. How does a hospital operate at 105 per cent capacity?

Ms LARKIN: The Liverpool Hospital is one of the busiest hospitals, without question, in New South Wales. The range of activities in the hospital varies. A statement of 105 per cent for the whole hospital at all times I think is probably not quite the picture. There are variations in terms of service delivery but places like the emergency department are very busy. There is no question about that. It is important that we understand that Liverpool operates in terms of the network of services in South Western Sydney and the move of patients between. It provides a large number of tertiary services. Patients move back to local hospitals once their surgery is completed so there is ongoing movement of patients across the district to manage the load of activity that Liverpool receives.

The Hon. WALT SECORD: If you are at 105 per cent does that mean that people are waiting in corridors outside or waiting in corridors and TV rooms and places like that?

Ms LARKIN: In terms of management of patients in our emergency department, it is an absolute priority for Liverpool Hospital and for the district to be managed in the safest possible way. The patients are moved through the hospital, especially in the emergency department, as quickly as possible so there is ongoing movement of patients to off-load from ambulances, to move into the emergency department and to move into inpatient beds. A significant amount of strategies have been put in place to ensure the flow of activity across the day and across the week.

The Hon. WALT SECORD: What is inpatient care?

Ms LARKIN: Inpatient care is when you require overnight care in a hospital bed.

The Hon. WALT SECORD: Okay, because yesterday Professor Levy said that 40 per cent of patients in the south-west of Sydney receive inpatient care outside the region. Does that mean 40 per cent of patients are forced to leave the region to get overnight care?

Ms LARKIN: There is a range of people who choose to undertake care in other hospitals around the State and that is the choice that people have. It may be in private hospitals. It may be in other public service and in other public hospitals in other districts. People live on the fringe. For example, people on the fringe of Western and Nepean may access Nepean Hospital, so there are lots of reasons why people access services outside of the district. There may be some services also that are not provided within South Western that may be required outside.

Ms PEARCE: Can I just make the point, Mr Secord, as well that that is not an uncommon situation. All of our health districts have flows in and out of their districts for various services so that is not a situation that is peculiar to South Western Sydney.

The Hon. WALT SECORD: Taking up Ms Pearce's comment, do you have other health districts that rationalise kidney dialysis? Yesterday they said that instead of having three treatments a week that in South Western Sydney you have it twice a week. It is rationalised. Does that occur in other health districts?

The Hon. NATASHA MACLAREN-JONES: You might want to clarify that Fairfield Hospital was the one that raised it and who used that term.

The Hon. WALT SECORD: Yes. When I posed the question afterwards, "Where does this also occur?" Professor Miriam Levy said, "Overseas in Pakistan."

The Hon. NATASHA MACLAREN-JONES: I think we all saw the media stunt that you did.

The CHAIR: Present the question and see what the answer is.

The Hon. WALT SECORD: Does rationing of kidney dialysis occur in other health districts, Ms Pearce?

Ms PEARCE: I have no particulars on that example, Mr Secord.

The Hon. WALT SECORD: Ms Larkin, yesterday there was quite a bit of interest in that. Is it good patient safety or good patient health to rationalise kidney dialysis?

Ms LARKIN: Earlier this year there were 14 patients who were receiving dialysis twice a week. The demand on dialysis in the south-west is significant. We organised for those patients to receive their third treatment on a Sunday so they are currently being appropriately treated. We are also purchasing some dialysis in the private. We are currently working with the clinicians, who are being very supportive around developing additional plans around how we can manage the load for those dialysis patients, which may be a third treatment in the day in chairs, some purchase in the private arena. We are looking at some home dialysis and a range of treatment services to ensure that all patients receive appropriate care.

The Hon. WALT SECORD: Ms Larkin, are you pleased that you have been able to bring the local health district in under budget?

Ms LARKIN: The financial performance of the organisation is my responsibility.

The Hon. WALT SECORD: No. Are you pleased that it is under budget?

Ms LARKIN: I am very comfortable that we are working within the budget envelope that the Government has given us, yes.

The Hon. WALT SECORD: Are you aware that other local health districts seem to put patients safety and patients care ahead of coming in under budget?

Ms LARKIN: Balancing the budget for the district and provision of high-quality care are both of my key responsibilities and ensuring the governance of the organisation and delivering the most appropriate care within the budget have been my responsibility for 10 years. I take both of those elements very seriously and both are most important.

The Hon. WALT SECORD: Are you confident that you are able to balance patient safety with financial responsibility?

Dr LYONS: Mr Secord, could I say that all of our chief executives have that responsibility.

The Hon. WALT SECORD: But my question was to Ms Larkin. Are you confident and comfortable that you balance patient safety with financial constraints?

Ms LARKIN: Safe high-quality care is an absolute priority for the board of South Western Sydney and for me as the Chief Executive.

Ms CATE FAEHRMANN: Sticking with budgets, Dr Lyons, I am assuming you have a very good handle on the different local health district budgets across the State.

Dr LYONS: Ms Pearce would have a better handle on it.

Ms CATE FAEHRMANN: Ms Pearce? Let's see then—either of you. In the submission made by the Campbelltown City Council—and we spoke to them this morning—included what they have said is an analysis, which I am assuming they have done of the local health district budget data from service agreements and financial statements and HealthStats NSW, which they suggest indicates that the South Western Sydney Local Health District is inequitably funded in comparison to other greater Sydney local health districts. Is that a correct statement?

Ms PEARCE: I have not heard that statement before now, Ms Faehrmann, but I can say that all of our local health districts are funded using the same funding formula, so there is no different treatment of local health districts across New South Wales at all. What I can say, for example, about South Western Sydney it is within our funding model we include what is called an equity adjuster and that equity adjuster—we have a very transparent funding model. We do not have any—you know, there is nothing to hide in terms of how our funding is allocated to districts.

The equity adjuster for South Western Sydney takes into account its population, the nature of that population in terms of its overall health, the fact that there are less private hospitals in the south-west than in other parts of the State. For example, in South Western Sydney's budget, they have 20 times the amount of that equity adjuster than a district like, say, the Sydney Local Health District. They have a very significant adjustment due to the nature of their population. I do not know or understand the work, obviously, of the Campbelltown council but health budgets and the funding formula attached to them obviously do have some complexity around them but there is an equitable distribution across the State based on those formulas.

Dr LYONS: If I could just add, in terms of the 2019-20 budget allocation, the two districts that received the highest growth in percentage terms were Western Sydney and South Western Sydney. Some of the districts that have the lowest growth were Northern Sydney and South Eastern Sydney. Those growth factors reflect the fact that, as a result of the demands on services, NSW Health purchases more activity from the districts where there is demand and growth and where there is a need to address equity issues. We redirect the resources more towards those districts that are seeing that growth.

Ms PEARCE: The South Western Sydney Local Health District has the highest budget of any local health district in the metropolitan area of Sydney.

Ms CATE FAEHRMANN: I am sure you heard the evidence yesterday by people at the Campbelltown Hospital, the Fairfield Hospital and the Liverpool Hospital and after hearing their evidence, you are coming here today with the suggestion that there are inequities in the funding and potentially a lack of transparency in the funding and that there is no substance to that evidence we heard yesterday?

Ms PEARCE: What we are saying is that in the Health budget, as is well documented to both in Australia and other countries, there is always pressure on health budgets and the request for more money to provide more for our patients. South Western Sydney has advocated strongly during our annual funding negotiations, which is why as Dr Lyons mentioned, their growth funding has been one of the highest in the State. Last year Western Sydney was 5 per cent growth and South Western Sydney was 4.9 per cent. Those discussions are held between district executive teams and clinicians who put forward funding requests year on year. We try to ensure, through a finite Health budget, that we are able to give effect to those requests the best that we can—and that is what we do, noting that the Health budget did increase last year by a billion dollars. For example, South Western Sydney since 2015-16 has had a $460 million increase in its budget over those years. So we are not suggesting our system is perfect—there is no perfect funding model in health systems anywhere in the world—but we do our best to have open and transparent discussions as to the allocation of our budget each year.

Dr LYONS: If I could just add, the other thing to reflect on, yes, no doubt there is pressure in the system and we will see certain parts of the State under more pressure than others, reflecting also the fact that we do not provide all of the health services to a community. We certainly provide a large proportion of them around the hospitals and community health services but there is also all of the other services that are provided outside of what NSW Health is responsible for. So issues like access to GPs will be an issue for communities. If they cannot access GPs they may well turn up for our services because they cannot access a GP. If there are not specialists in those districts, in those communities, providing services to the local community and referrals patients may not get that specialist care and end up in our hospitals as well. So there are a lot of factors—socioeconomic, private insurance rate, the provision of private hospital care—all of those factors can play into why certain parts of the State are under particular pressure. And then it is about how we are responding to that. As we say, we are responding by providing more resources into that district to more reflect that demand.

Ms CATE FAEHRMANN: The Committee received quite a detailed submission by the Campbelltown and Camden Emergency Department Executive. It said the key issue they see in terms of being able to address what many people said yesterday were inequities within the funding system that the Government has chosen to use is around transparency and reporting. It said in its submission:

> There is no way for services across different hospitals and across different LHD's can be compared with respect to their resourcing. That information is not made available.

What is being referred to?

Dr LYONS: I think they might be incorrect because that information is available. We have what is called the activity based management portal which has actually got a huge amount detail around the respective costs, activity, length of stay, performance of our services in hospitals right across the State. There is able to be a direct comparison between what it costs to provide care in one of our services and with another service. So that information is available and can be used by our management teams and our clinical teams to look at benchmarking their resources by comparison with others and what areas that they may need to focus on. That is available.

Ms CATE FAEHRMANN: It suggests that what is missing from all of this data to which you have just referred to is any reference to capacity. There is no reference to the capacity in terms of size, beds, staffing services or funding and all the focus is on how we deliver our services, none on our ability or capacity to deliver those services. Is that a fair argument?

Dr LYONS: They are two different things. The one thing is actually looking at what is being delivered, how it is being delivered, what cost it is to deliver that, what the level of performance is. Then there is the capacity which is actually where needs assessment and service planning comes into play. That is why as a result of the assessment that we made around what is required for supporting the population growth in south-western Sydney there is almost $3 billion worth of either completed or in-progress capital developments to reflected the need that there will be more services required over the next 10 years.

Ms CATE FAEHRMANN: Therefore in terms of capacity, how is that $3 billion compared to another district, say, around the North Shore or Northern Beaches? Do you have a comparison chart, for example, between assessing their capacity—you said they got $3 billion? What did the northern area of Sydney get? How many billions?

Dr LYONS: I think we could look at the distribution of capital across the State and let me say there has been record investment of capital for all services right across the State, rural, regional and metropolitan.

Ms CATE FAEHRMANN: But I think that is what they are getting at.

Dr LYONS: No, I think they are reflecting there that there is no mention in the measures that are looked around capacity. What I am saying is those factors are taken into account in terms of the service planning and the projections of then what is actually built. Then we provide the recurrent funds to operate those services which creates the extra capacity which is what they are concerned about. I would also say this, there is always a requirement for more hospital beds and more hospital services and more emergency departments. We are at the moment in the throes of thinking about how we can shift the whole focus of the health care system to be more focussed on what we can provide out-of-hospital, how we can provide more care in the community which means that we will not be required to build to that level and it could take some of the pressure off.

The CHAIR: Yesterday we had some good evidence from a number of expert witnesses and professionals, and submissions as well. I made the point later in the day that it surprised me that there had been very little in the content of submission or the oral evidence that touched on the important area of palliative care in the context of provision of health services. Once again we are working through another day of evidence. I know this is a general inquiry broadly into the provision of health care but within individual submissions some witnesses and organisations are highlighting particular things that deserve some emphasis. But on the matter of palliative care there is very little comment about it. Yesterday in exchange with one witness we made the point that, for example, in our nursing homes, in those places for our seniors, they are basically not equipped or set up to be able to palliate people at the end of life for a range of reasons but they do not currently do that.

Why is that not something that is being advanced with discussion with the Commonwealth, given that the Commonwealth is the provider essentially of funding for retirees and seniors and the provision of that senior care. I am also curious that time and time again we hear, survey after survey, of people saying if at all possible, and within the ability to have this provided care for them to die at home. In other words, instead of finding themselves entered in an emergency department in a hospital and ultimately passing away in the hospital, a preference commonly expressed, is to be able to be cared for to the end of life at home. I hear very little discourse and discussion about palliative care. You may take this question on notice. But in a Local Health District how does palliative care feature in your considerations in terms of the provision within what you have responsibility for? This is not a criticism I am trying to elucidate why it is not being more overtly discussed and considered.

Dr LYONS: I thank you for the question because sometimes the questions are not asked around it as well. Let me reassure you that we are very committed to improving access to palliative care for communities and residents right across the State. There has been significant investment by the Government to enhance palliative care services over the past few years.

The CHAIR: I am conscious of that, yes.

Dr LYONS: In addition to that, let me say, we are also advocating very strongly to the Commonwealth. There is a royal commission into the quality of aged care underway at the moment and our submissions have been very strongly around the need to enhance the level of medical and health care provided to residents in aged care facilities. We will continue to strongly support that. In relation to the specific things that the districts are doing I might ask Amanda Larkin to give that detail.

Ms LARKIN: I think we should also say that both Nigel Lyons and I actually chair the palliative care committee for the State.

The CHAIR: Wonderful.

Ms LARKIN: Honestly, the importance of palliative care in terms of the spread of care provision it is absolutely central, can I say to you? So at a local level there are palliative care beds—you would have heard that through Professor Friedbert Kohler yesterday—both at Camden and at Braeside. Those beds are well utilised but there is also a whole network of palliative care services through our community health centres where care is provided in the home. We really work very closely with families if care if someone wants to die at home to support them to do that .South Western Sydney also holds the contract for what we call the Peach Program.

The CHAIR: Yes, we heard that yesterday.

Ms LARKIN: You would have heard about the Peach Program yesterday. That is about specifically supporting families overnight because that is often when the critical issues can occur for families, when they feel frightened and when they just need that additional support. We do that in conjunction with Silver Chain. We provide that care in the home. Part of that is ensuring that people die where they want to die. Some people become frightened. Families become frightened and want to come into hospital. We have got the beds available but the care in the home is also available for people. The Peach Program has been really good in terms of that general support for people overnight. The program overall runs seven days a week, 24 hours, but the Peach gave the overnight care. Can I just reinforce to you all, palliative care is absolutely a central part of our care delivery and working with families at that critical stage is not just important but it is a privilege to be able to do it. What we do is we work to the very best of our ability to let people die where they want to die.

The CHAIR: That is very good to hear.

The Hon. NATASHA MACLAREN-JONES: I am aware that we are now in government time but I am happy, particularly in the current climate where it is extremely busy for NSW Health, to forfeit my time to allow them to leave and put my questions on notice or otherwise I can ask my questions now.

The CHAIR: Out of all of us I think Ms Cate Faehrmann was allocated a specific amount of time.

The Hon. NATASHA MACLAREN-JONES: I might just ask one. Some witnesses have raised the level of consultation in delivering services and rebuilding hospitals. Will you outline the process to engage with community and community organisations for a redevelopment and also the health needs for western Sydney?

Ms LARKIN: Can we do the health needs first?

The Hon. NATASHA MACLAREN-JONES: Yes.

Ms LARKIN: There was a really comprehensive needs assessment done in conjunction with the primary health network recently. It was a comprehensive piece of work that looked at identifying the health needs of the district, what were the critical issues and what were the things that we needed to focus on from a health care delivery perspective. There was extensive consultation internally within health, with GPs, stakeholders and other agencies. That was delivered back to the community at the end. There was very good discussion about that and very good input from groups around what were the critical issues in conjunction with good planning data, good health needs assessment data et cetera. So that was a really good one.

If we take a step back, prior to a redevelopment being considered there is the development of a clinical services plan that articulates clearly the critical service issues that need to be developed. There is extensive consultation, especially with clinicians around what are the priorities, what are the things that we need to focus on in conjunction with activity data, in conjunction with health needs data. That develops the clinical services plan and says "Look, these are the things that we need to focus on and these are the areas that a redevelopment would be focussed on in relation to the build and the requirements of the construction." Quite a lot of work is done both internally and externally around both of those areas.

Ms CATE FAEHRMANN: Just to get back to the request from health professionals working in the south-west, they particularly suggested that doing something like looking at the data, transparency and reporting would help address the historical inequalities in the system. They are referring specifically to, at the moment,

reporting in relation to activity but that is not reported against the capacity such as the number of staff of a hospital, the funding they get or what have you. Is that correct?

Dr LYONS: The activity based management portal actually has that activity and the inputs so the staffing levels and the other components that are actually used to provide that care are counted as a part of that. So it is used to assess the activity and the resources used in providing that activity.

Ms CATE FAEHRMANN: Is that publicly available when you compare the funding of hospitals, their resources, beds and the numbers of staff? Is that all readily available?

Dr LYONS: Yes it is, and length of stay and readmission rates, the performance through emergency departments—all of those things are available and are able to be compared.

Ms CATE FAEHRMANN: Dr Lyons why would there be this impassioned plea? We had many excellent submissions yesterday and many, by the way, consulted so much of their medical staff within the hospital to compile the submissions, so they are incredibly considered. This is the plea from the Campbelltown-Camden executive. If the Committee were only able to do one thing then it requested that a data set be developed and reported that allowed for comparison of resourcing alongside performance then we would be well placed to address the historical inequalities of resourcing that exists in South Western Sydney. Why do they say that? Have you read that submission? Do you suggest it is incorrect?

Dr LYONS: I have not read the submission, no.

Ms CATE FAEHRMANN: I suggest that you read the submission and address their concerns on notice? I find it very surprising that I am trying to get a response. I am not suggesting you are avoiding that but it is clearly something they have asked the Committee to look at and it would be good to get to the bottom of their issues.

Dr LYONS: Let me acknowledge that those clinicians are working extremely hard in an environment which is under extraordinary pressure activity wise. There is ongoing growth and activity as we have reflected and that we are providing more resources based on the fact that there is that pressure. They are very busy and are working very hard and I want to acknowledge the work that they do. You can also see that the growth in those hospitals is actually higher than some other hospitals. They would be looking at the fact that they are working hard and there is more work coming and comparing that to hospitals which may not be growing in activity as fast and feeling like they are under pressure—of course they are. But we are responding by putting more resources in and planning for the future when more capacity will be required. I just make those general comments and I am happy to take the additional on notice.

The CHAIR: Thank you for coming along. I appreciate you making the time available in what is an extremely busy period for you. On behalf of the Committee I thank you and your colleagues in the local health district and right down to the coalface with nurses, doctors and allied health workers who are doing very important work at this critical time. You have our best wishes in dealing with the challenges around coronavirus ahead.

Ms PEARCE: Can we also finally acknowledge the staff of the south west who are doing a wonderful job in this environment—none more so than recently with their response to the situation?

The CHAIR: Certainly we wish them well.

(The witnesses withdrew.)

(Short adjournment)

BRETT WHITWORTH, Deputy Secretary, Greater Sydney Place and Infrastructure, Department of Planning, Industry and Environment, before the Committee via teleconference, affirmed and examined

SAM SANGSTER, Chief Executive Officer, Western City & Aerotropolis Authority, affirmed and examined

The CHAIR: Mr Sangster or Mr Whitworth, do you want to make an opening statement?

Mr SANGSTER: No.

Mr WHITWORTH: I do not have an opening statement other than I obviously have read and familiarised myself with the NSW Health submission and I am more than happy to answer questions that are raised. The position of the Government has been articulated by that submission.

The Hon. WALT SECORD: Mr Sangster, to whom does the Western Sydney and Aerotropolis Authority report?

Mr SANGSTER: The Authority is constituted under an Act of Parliament and is constituted with a board. That board has a reporting relationship to the Minister for Jobs, Investment, Tourism and Western Sydney, Mr Ayres. We report to the Treasury cluster so we report to Michael Pratt.

The Hon. WALT SECORD: If questions are to be asked in Parliament they would be addressed to Minister Ayres?

Mr SANGSTER: Minister Ayres.

The Hon. WALT SECORD: The website talks about the purpose. The authority is working through a master planning process alongside local, State and Federal governments industry and the community. What does that planning extend to?

Mr SANGSTER: The master planning is a more detailed piece of planning that I am sure my colleague, Mr Whitworth, can expand on, such as the statutory planning; this is at a more granual level of planning about how the precinct planning then gets translated into development opportunities within the precincts within the defined area under our legislation. So there is a 11,200 hectare parcel that is defined under the legislation and we are working within that boundary.

The Hon. WALT SECORD: How far south does that go to?

Mr SANGSTER: That goes south and covers North Bringelly and runs across to the west to pick up the area that is called the Agribusiness Precinct.

The Hon. WALT SECORD: Does the planning responsibility solely relate to the aerotropolis or does it involve all land use activity within the confines of the area?

Mr SANGSTER: Our responsibilities are limited by schedule 1 to the Act and so that actually stipulates an area that is 11,200 hectares that sits basically around the airport.

The Hon. WALT SECORD: In relation to planning do you make recommendations to the State and Federal governments on what should occur within those confines?

Mr SANGSTER: Probably the best way to concede our role is that of a master developed community so more akin to a developer. So we are looking at all the different land uses and looking through that job plinth. So our primary focus, if you have read our website and looked at our strategy, is around economic development and bringing on development in that area. Our role is to actually look at what the right permutation and combinations of those building blocks are as any other main developer would do. We do not have planning powers though in terms of actually making those. We would be an applicant rather than an approver, is probably the best way to conceive of that.

The Hon. WALT SECORD: Your area of activity would be economic development?

Mr SANGSTER: Primarily our focus, and our main key performance indicator, is around looking at 200,000 jobs being created across the Western Parkland City and really bringing industry to bear around that, working with Foundation Partners that we have discussed publicly. Only this morning you may have seen the CSIRO has now committed to actually making a significant relocation out to the Aerotropolis and put a number of jobs into the Aerotropolis. Our work is attracting people and actually helping get that development away but we would be an applicant in the main process.

The Hon. WALT SECORD: Does NSW Health come into play into the planning or the activity of the Aerotropolis Authority?

Mr SANGSTER: Through the planning processes run by the Planning Partnership—and I am sure Mr Whitworth can explain the role of the Planning Partnership. Our functions are then to really take the outputs of those actually to understand how they could go in the various areas that we are looking at for master planning. So there are conversations that are going on around things such as if there are to be areas set aside for integrated health hubs, for example, in the Aerotropolis Core, where would that best be positioned vis-a-vis the other community asset, the open space where the station precincts would be and where the other developments would go. But we are not deciding what is required, we are really more responding to a requirement.

The Hon. WALT SECORD: Have the health needs of the region been taken into consideration as part of the aerotropolis?

Mr SANGSTER: So the Planning Partnership and the common planning assumption that are used by the Department of Planning, Industry and Environment are used in the broader precinct planning and other determinants. That need is really not a piece that we are determining. I understand where you are going with the question but it is not for us to determine the health needs. Once the health needs are determined we can then work with landowners and others to help understand where they may go.

Mr WHITWORTH: The land use planning and the infrastructure planning for the aerotropolis is being undertaken by the Western Sydney Planning Partnership. The Western Sydney Planning Partnership is a collaboration of the local councils in western Sydney with the State Government and a number of State Government agencies, including the Department of Planning, Industry and Environment, the Greater Sydney Commission, Transport for NSW and Infrastructure NSW. It also has the Commonwealth Government represented through the Department of Infrastructure, Transport, Regional Development and Communications as an observer.

Complementing the work of the Western Sydney Planning Partnership is the work being done by the department of planning and the Greater Sydney Commission on the infrastructure needs through both a place infrastructure compact that the Greater Sydney Commission has been developing and talking to all of the State agencies to enable them to understand what the development expectations will be in the area and then what their infrastructure needs will be based on their various servicing strategies and asset management strategies. And a piece of work that the Department of Planning, Industry and Environment is leading to ensure that there is an appropriate contribution from development for State infrastructure based on the policy principles that we have to all the collection of State infrastructure contributions that we have applied in the north-west and south-west of Sydney.

The Hon. WALT SECORD: Mr Whitworth, is NSW Health on any of those committees or bodies that you have referred to?

Mr WHITWORTH: NSW Health is not represented in the Western Sydney Planning Partnership but NSW Health has been engaged through the place infrastructure compact process that the Greater Sydney Commission has undertaken. It has been engaged via the ministry level and I understand that the ministry has engaged at the local health district level, given that there are effectively two local health districts that apply within the Western Sydney aerotropolis area.

The Hon. WALT SECORD: The two local health districts, would that be Western Sydney and South Western Sydney Local Health Districts?

Mr WHITWORTH: Yes, I believe it is. Again, I am not here representing the local health districts or NSW Health—

The CHAIR: We understand that.

Mr WHITWORTH: My understanding of their boundaries is that the South Western Local Health District incorporates the local government area of Liverpool, and the Western Sydney Local Health District incorporates the local government area of Penrith. Both Penrith and Liverpool have land that is within the western Sydney growth area planning frame.

Mr SANGSTER: The Nepean Blue Mountains Local Health District has coverage of the Penrith area. Western Sydney Local Health District's boundary includes places like Blacktown but is material because that network that operates between all three health districts—

The Hon. WALT SECORD: Okay, I hear you. Mr Whitworth, when NSW Planning is opening up an area or allowing construction or development to occur in an area, is it customary to involve the local health district or NSW Health into the planning or allocation of resources or future planning? For example, would you involve the Department of Education?

Mr WHITWORTH: Yes. We do involve both NSW Health, we involve New South Wales education, primarily both at the rezoning and the strategic planning phase to gauge the consequences and implications of the expansion of urban development into a new area and to enable those agencies to identify how they need to structure and adjust the services that they provide. And also to enable them to identify whether there is a need to take a contribution for any infrastructure that may need to be provided in that new growth area.

If I could just give a really quick example: The department has been undertaking work with Wollondilly Shire Council on the planning for the Wilton Growth Area and there is a draft State infrastructure contribution for the Wilton Growth Area. The department has been engaging with NSW Health and the local health district on its needs in that area. We have been discussing the potential for the identification of land by securing a site and a contribution for that site through the draft State infrastructure contributions. That gives you an example of the sorts of mechanisms that will be used to engage those agencies.

The Hon. WALT SECORD: I want you to cast your mind to Oran Park. This morning we heard from the Greenfields Development Company. It became quite apparent that planning for health was not taken into consideration because they were looking at private sector involvement and encouraging the private provision of health in the community down there—quite a large community. Was that an oversight or was that a policy that has been changed since Oran Park was approved?

Mr WHITWORTH: I would not characterise that there was no consideration on health. Oran Park was part of the identification of the South West Growth Centre, which was done in 2006. There have been various processes that were run by various previous organisations such as the Greater Sydney Commission and the department at the time that the South West Growth Centre was identified. We are talking about development not just at Oran Park, we are talking about Austral, Leppington, Catherine Field and Edmondson Park. The importance of the local health network and the importance of Liverpool Hospital was identified as being the primary deliverer of healthcare services in the area. That obviously was more than 15 years ago.

NSW Health and the local health district has, as you can see from their submission, started to talk about both the delivery of healthcare services in an integrated way by talking both about hospitals and starting to talk about the integrated health hubs, which operate as those primary health care style clinics and venues for community health services and so on. I think that what we are seeing is that the identification of an integrated health hub at Wilton, the potential identification of an integrated health hub at Glenfield, and the potential for an integrated health hub at the aerotropolis core is an example of how there is a shift in the way NSW Health delivers services. It recognises that you need to have a nuanced approach to the allocation of it services within its network.

The CHAIR: There has been criticism that has either been implicit or explicit from some of the witnesses thus far in this inquiry that the provision of healthcare services—and that is to be read in the broader sense, the hardware, the bricks and mortar, the buildings, right through to the community services, which are the more networked way of delivering the provision of health—that right through, from top to bottom, there has been hitherto a bit of a lag when it comes to the development of a new precinct. In other words, the buildings go in, the development has got underway and progressed.

The provision of health services comes in but it is somewhat lagged. It comes slower than otherwise the overall development of the precinct in terms of either the businesses that move in, commercial or residential, as the case may be. That in itself creates issues when there is this lag between the demand and the supply of health services in a growing area. What is being done with respect to this particular significant project in western Sydney to ensure that there is not a lag? In other words, to ensure that the health services are going to be delivered in such a way that they are making the contingent needs as they start off and grow and build over time on an ongoing basis?

Mr WHITWORTH: I am happy to start, Mr Sangster, and you can follow through. My perspective on that is that we have by using the place infrastructure compact. It is accompanied by a place focus to the preparation of business cases. Previously government agencies tended to identify the development of their assets and their infrastructure based on a sort of individual—how it fits within their asset management planning.

The place-based approach to the identification of infrastructure enables us to say, "As development proceeds within certain thresholds and certain benchmarks, there is an expectation that as these benchmarks get reached that there is a delivery, whether it be roads, whether it be schools or whether it be health infrastructure and health services." And because it is done in a coordinated, consolidated way, it is ensuring that the agency's mesh when they are planning and their provision of funding meshes together. This is an evolving process and it has been piloted both in the Greater Parramatta to Olympic Park area, as well as being piloted in the western Sydney area around the Western Sydney Aerotropolis.

Mr SANGSTER: Picking up on what Mr Whitworth said and echoing those comments, in the Aerotropolis Core and expanding on my earlier answer, the integrated health hub that I mentioned earlier is a good example of that. That requirement has been identified to us and we are now working with NSW health looking at what that would actually look like and at what point in the future of the back of that Place-based Infrastructure Compact work that is being done. That need has been identified. We are now working with them to understand how that might actually physically manifest and at what point in time. That is obviously a collaborative process that is underway.

The Hon. EMMA HURST: Thank you both for joining us this afternoon. You were talking to the Hon. Walt Secord about some of the conversations with the Western Sydney Planning Partnership and the consultation engaging NSW Health. Over the past couple of days we have heard from a lot of the people providing the services themselves and hearing their concerns around a dramatically growing population, particularly also with the aerotropolis coming in. Has there been any process to engage these hospitals or their services as part of the consultation directly?

Mr WHITWORTH: The standard process of the department is to work with the NSW Ministry of Health, and then through the Ministry of Health with the local health district, and then the local health district's managers through each network of hospitals and health services. We are flexible and adaptable depending on how the health districts want to then engage with us but obviously there is a degree of protocol. There is also the importance of working through those processes so that the NSW Ministry of Health is able to program any issues in services that might be arising out of a particular development [inaudible].

The CHAIR: Sorry about the interruption. Please proceed.

Mr WHITWORTH: In terms of addressing as part of the protocol and making sure that the Government is joined up to work for the health industry, but that does not mean that if the Health ministry through the health district says that they want us to talk directly with the hospitals, we are more than happy to do that.

The Hon. EMMA HURST: You detailed some of that structural process. I am not sure if you have seen any of the other submissions or heard any of the other evidence in this inquiry, but is the fact that there are such extreme concerns news to you? Is this process working and has that information about the concerns of the hospitals actually reached you in this planning stage?

Mr WHITWORTH: I suppose I have got to be really clear. There are certain, if we want to call them, "swing lanes," but you do not want me planning how you allocate the budget for the delivery of important healthcare services. I need to work within the government structures and see that there is a government agency that is responsible for planning for healthcare services. I need to make sure that that agency has the best information and the best knowledge about what the potential development in an area will be, just as that agency needs to provide us with its best understanding of the implications of what health implications and service delivery implications will be if a particular development area goes ahead. I am not quite sure what you mean in terms of—should I be listening to what the doctors in the hospital say, is that what you are asking?

The Hon. EMMA HURST: Sorry, no. Is this news to you that there are concerns or is this something that has been on the table for a long time and part of your planning process?

Mr WHITWORTH: My job is not to run the New South Wales South Western Sydney health service. My job as deputy secretary is to ensure that we have an ordered planning process that enables government agencies to flag and identify issues but also gives members of a community the opportunity to see and understand what our proposals are and for them to raise and flag issues of concern. During the exhibition of the Greater Macarthur 2040 plan, the Wilton 2040 plan and during the exhibition of the Western Sydney Aerotropolis plan we have received some commentary from people saying that they would like to see a hospital within the aerotropolis core.

We have to balance that against what NSW Health is advising in terms of its expected delivery of services but I have not seen community submissions flagging an issue with the way that healthcare services are being provided other than if they are not relating them to development activity. They are saying there would need to be an expectation that healthcare services are amplified or that they respond to the increase in development potential. That is certainly what NSW Health and the local health district identified to us in their submissions and commentary: That if there is an increase in population these are the things that we need to do in terms of responding to that. I think the submission flagged that in terms of investments that they have made and the hospital network in the area and their commentary about the investments that they intend to make in the integrated health hubs.

The CHAIR: I have one further question I thought I would raise just to see what the response was. There was an opportunity to provide a submission to the inquiry for the Western Sydney Aerotropolis Authority

and one was not forthcoming. As the Chair, I was a little bit surprised by that. I am wondering why it was deemed not appropriate to provide a submission to the inquiry?

Mr SANGSTER: Given the nature being very much in relation to health, and I guess particularly with what Mr Whitworth has just outlined in terms of the health planning processes and also hopefully being clear about our role of being an applicant and end consumer of the information that the planning system would then would produce, I am not sure that we can really add much into the discourse around how the planning for all of the different sorts of infrastructure we need. Once needs are determined then we can help lay them out. So on that basis we did not feel the need to do so.

The CHAIR: Thank you very much. There could be some supplementary questions that arise from evidence this afternoon. The secretariat will liaise with you directly over those supplementary questions. We have a turnaround time of 21 days for those to be returned and they will form part of your evidence to the inquiry. Thank you very much.

(The witnesses withdrew.)

The Committee adjourned at 15:30.