REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At The Winning Post Function Room, Manning Valley Race Club, Racecourse Drive, Taree NSW 2430 on Wednesday 16 June 2021

The Committee met at 2:55 pm

PRESENT

The Hon. Greg Donnelly (Chair)

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

The CHAIR: I welcome you all, both the witnesses on our first panel and a number of people from the public. It is good to see a number of people who have come along this afternoon to join us. This is the seventh hearing of Portfolio Committee No. 2 - Health and its inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. The inquiry is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales.

Before I commence I acknowledge the people of the Birpai nation who are the traditional custodians of this land. I pay my respects to Elders past, present and emerging and extend that respect to other Aboriginals present or who may be joining us on the internet. Today we are hearing from a number of stakeholders including local community groups, medical professionals, private citizens and the local health district. I thank everyone for making the time to give their evidence today to this important inquiry. Before I commence I will make some brief comments about the proceedings this afternoon. Today's hearing is being broadcast via the Parliament's website. A transcript of today's hearing will be placed on the Committee's webpage when it becomes available in a day or two. In accordance with broadcasting guidelines media representatives here or those who are about to join us are reminded that they must take responsibility for what they publish about the Committee's proceedings.

While parliamentary privilege applies to witnesses giving evidence today it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments they may make to the media or to others after they have completed their evidence this afternoon. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the Legislative Council in 2018. If witnesses are unable to answer a question today and want more time to respond they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days to the Committee secretariat.

If witnesses wish to hand up documents they should do so through the Committee staff. I note that already three documents have come forward and we will deal with those as we come to them shortly. With reference to the audibility of the hearing today I remind both Committee members and witnesses to speak into the microphones. There are two microphones before us. Those that are mounted are the microphones for the sound inside this room. They have been placed reasonably close to us because they need to pick up the clarity of the voice and project that. Witnesses do not need to push them back or bring them forward; they should be just in the right spot. Those that are mounted on a tripod are for Hansard—*Hansard* is the official record of the Parliament—who will be recording your contributions this afternoon. Finally, if you have not done so already could you turn your mobile phones to silent for the duration of the hearing.

EDDIE WOOD, President, Manning Great Lakes Community Health Action Group**,** sworn and examined

BREE KATSAMANGOS, Program Manager, Mission Australia and Convenor, Mid Coast 4 Kids, sworn and examined

MELISSA FOSTER, Aboriginal Project Worker and Playgroup Coordinator – Child Care Services Taree & Districts Inc., sworn and examined

JUDY HOLLINGWORTH, Founder and Deputy Chair, Manning Valley Push for Palliative, affirmed and examined

ROBYN JENKINS, Secretary, Manning Valley Push for Palliative, affirmed and examined

The CHAIR: I confirm that each of your respective organisations has made, and we have received and processed, your submissions to this inquiry. The Manning Great Lakes Community Health Action Group, your submission is No. 678 to this inquiry. Mid Coast 4 Kids, with respect to the Child Care Services Taree & Districts playgroup, is No. 166. The Manning Valley Push for Palliative submission is No. 167. They have all been received and they are all very helpful submissions to this inquiry. They have been processed and placed onto the Committee's webpage so they are in the public domain. In saying that you can take it as read that those submissions have been looked at and read by the Committee members. I will invite respective organisations to make an opening statement shortly. There is no need to go too deeply into what is contained in your submission; rather set it up within three or four minutes at the maximum and make mention of you want us to look at this afternoon. Once we have got through all of them, if you are agreeable, we will open up the inquiry to questions from various Committee members. Mr Wood, would you like to make an opening statement?

Mr WOOD: First of all, thank you for giving me the opportunity to appear before you today. Manning Great Lakes Community Health Action Group was formed five years ago by Alan Tickle in response to a serious accident here at this racecourse which resulted in our hospital, minutes away, being bypassed and five jockeys being transported to Port Macquarie Base Hospital, over 70 kilometres away, which outraged the community and impacted the golden hour of treatment. Our committee covers a broad spectrum of the community and comprises four nurses and two paramedics with a combined clinical experience of 231 years—a teacher, a financial planner with local government experience and an accountant. We have been lobbying since conception for extra funding for our hospital and for extra staffing and specialists whilst at all times supporting all categories of existing staff and have never been critical of them.

Manning Hospital's clinical services plan expired in 2017. A new clinical services plan [CSP] was completed in 2021 but has not yet been released. Local hospital, council and communities need to be involved in the annual review of the CSP and business plan. The Premier's plan for health service delivery should cascade down through the agencies bound by a chain of accountability with 12-monthly reviews. We are a 160-bed hospital yet the national bed allocation per 1,000 patient population is 2.5 and, based on this, Manning Hospital should be a 250-bed hospital with equitable and comparable resources. *The Heart of Inequality* study in 2017 clearly states that the Federal seat of Lyne has the worst cardiovascular outcomes in the whole of regional Australia.

We need to build and fit out a cardiac catheterisation lab at Manning Hospital supported by an adequate number of cardiologists, specially trained nursing staff, equipment and ongoing funding. We also need to increase our ICU beds in proportion to population, reflective of national standards. The emergency department [ED] needs to be fully funded and staffed for 16 beds instead of the current funding for nine. We need a 10-bedded short-stay unit to provide 48 hours comprehensive care to patients to ensure a safe and efficient admission process. Professor Zsolt Balogh states in his 2016 trauma review, "Manning Hospital needs to be brought up to the level of a primary acute care hospital such as Maitland Hospital or a level 3 trauma hospital such as Port Macquarie, Coffs Harbour or Tamworth."

Ear nose and throat services are extremely minimal with specialists only visiting two to three days per month. That is totally unacceptable. We need to have provision for eye surgery to be attended locally. Manning Hospital needs at least one more operating theatre. There are long wait times for elective surgery. There is a serious lack of specialists, doctors, nurses and ancillary staff in rural healthcare facilities compared to metropolitan areas, which leads to poor health outcomes. Bullying in the workplace is endemic in health and is not being adequately or appropriately addressed. Closure of the 16-bed T-BASIS dementia unit without warning has had a huge impact on the hospital and community.

This area requires increased funding for our ambulance service plus provision for on-call services. This area is a low socio-economic region with higher incidence of chronic disease in each person, which requires a significant loading for all hospital, medical and ancillary services. The incidence of cardiac and renal disease, diabetes, eye and ENT problems is much higher in our Indigenous community. Currently there is no oncology

radiation treatment available in the Manning-Great Lakes Area. A radiotherapy cancer centre needs to be funded and established locally. We feel that we require a standalone ward at Manning Base Hospital for palliative care patients, plus a hospice. Now that the 16-bed T-BASIS unit is idle, it would be an ideal spot for a hospice.

The CHAIR: Thank you very much for that detailed and comprehensive opening statement.

Ms HOLLINGWORTH: Mr Wood has covered quite a number of things that are relevant to us, which I will not pick up. I am just going to highlight what I think are the key themes coming out of the various submissions. It seems to me that the baseline is to fairly balance the allocation of resources in the health system across metropolitan, rural and those in regional. Most of what we are hearing or are about to hear today indicates that is not the case and has not been the case for a long time. So when you strip out local services and centralise things the cost for people like us goes way up, the health outcomes and the actual health services diminish, and the expertise flees the area.

Some key points and statistics from local government information are that 95,000 people are living in this area we believe at 2021 and 53 per cent of the population in 2016 was 50 years of age or older. So time has gone by since then. Health practitioners in the hospital and community health area estimate that now about 60 per cent of people they see are in the 60 years and older bracket. So you can predict what that means. This is the oldest electorate, I think, federally in the country and certainly it is one of the oldest in the State. We anticipate that by 2026 about 24 per cent of the population will be over 50 years of age. There is something else that has occurred recently that you might be aware of: the inrush of interest in real estate in non-metropolitan New South Wales. That has been occurring in this area and many others rurally and regionally and that means that there is now an affordability issue coming up for people about housing and being able to access things and being able to find somewhere to live.

The employment indicators are that 50 per cent of the population in our area are not in the paid workforce and that health care and social assistance sectors are the largest employers, which tells us some more about profile and the demographic of the population. Given the health incidents and trends are that 53 per cent of the population is over 50 years old, the need for health services is already high and will continue to increase into the future. We are expecting that and so is the health community. You will know about Socio-Economic Indexes for Areas [SEIFA] index disadvantage is 928, which placed us 107 out of 130 local government areas [LGAs] five years ago. I have a paper here that I would like to table that I do not have time to go through, obviously. I want to make six points, though.

The CHAIR: Could you just identify whether this is the one we have received or another one?

Ms HOLLINGWORTH: No, these are my notes for today.

The CHAIR: That is fine.

Ms HOLLINGWORTH: It is really thematic rather than specific.

The CHAIR: That is fine. I am just conscious of the time for the opening statements so that it maximises our questioning opportunity. If we are going to receive it because it is in writing you could just highlight perhaps the key points.

Ms HOLLINGWORTH: Okay. So really the main point is early access and intervention for our services—and the other kinds already described—will make a whole lot of difference to affordability. It just means if you do not intervene early the cost goes up. It does not look like it straightaway but it comes through in the medium and long term. So that is affordable care and affordable access. Quality of life and cost savings disappear and therefore more urgent and acute costly care is required. It overloads the professional and carer community which also impacts their wellbeing and their effectiveness and causes burnout and attrition. In our case, due to the lack of adequate State Government funding, a poor electorate is obliged to fund its own urgent, short-term at-home care, which I cover further down in the paper. That gap is filled by organisations like us that are fundraising from an already impoverished community. I will leave it at that and submit the rest of the paper.

The CHAIR: Thank you. That is lovely, we have that document. I am sure some questions will arise from that. Ms Katsamangos, would you like to make an opening statement?

Ms KATSAMANGOS: Thank you. Ms Foster is with me and she will be sharing a personal story, but I will do the summary for Mid Coast 4 Kids. Just as a precursor to what I will state, we know that children who have a strong school transition do better across a whole range of domains than their peers who do not. So we are very much focused on early developmental screening and ensuring that all children have access to high-quality, timely services when they need them prior to starting school. On the mid North Coast one in three children are in the vulnerable young children group. The State average is one in five. On average these children are estimated to cost the New South Wales Government $171,000 each for the key human services they use up to the age of 40.

That is 2.9 times higher than for all New South Wales children aged zero to five. Mid Coast 4 Kids has spent the past 12 months investigating the early developmental screening system on the mid North Coast. Further to the recommendations outlined in the submission and in response to issues highlighted, I make a couple of recommendations and I will table this document so that you have a copy of those.

The CHAIR: That would be appreciated.

Ms KATSAMANGOS: We endorse the New South Wales Government's Brighter Beginnings initiative and through that the Government's commitment to give every child in New South Wales a strong start. We consider near universal before-school screening provided by child and family health nurses through community health to be the gold standard when it comes to comprehensively assessing and responding to children's early developmental health needs. We call for greater capacity and flexibility in child and family health services and how they are delivered—that is, integration of services into early childhood centres and integrated service hubs. We call for the reinstatement of the Medicare benefit for the preschool healthy kids check, including the nurse item number previously 10986. With evidence that children are not accessing the three- and four-year health check in sufficient numbers, it is vital that GP services are incentivised to promote and provide this service.

Further, the primary health network should play a key role in providing training and development to GPs and general practice nurses in the delivery of health assessments to children. We endorse the First Steps Count Child and Community Centre to be established in Taree in 2022. Stage one construction has been jointly funded by the State Government and philanthropic contribution. To meet demand, we call for State Government investment in stage two to ensure the full suite of early childhood, maternal, child health and family support services can be provided through the centre. We endorse and call for an extension of the Connected Beginnings program in communities where disproportionate numbers of children are vulnerable. The Connected Beginnings program is an integrated early childhood, maternal and child health, and family support service operating in schools in selected communities, providing greater access to these respective services for Aboriginal and Torres Strait Islander children.

We call on the State Government to invest in research on child and family health service hubs. Specifically, we refer you to the University of New South Wales' First 2000 Days Kids Connect research program. Following the pilot of an integrated health and social care hub in Rockdale, the university now seeks to evaluate the impact and social return on investment of integrated child and family health service hubs in optimising the early identification of developmental vulnerability and supporting unmet psychosocial needs of preschool-aged children and their families living in disadvantaged urban and rural communities. We see this research as vital in assisting the State Government to make evidence-based decisions on how to most effectively coordinate and deliver child and family health services to vulnerable communities.

We call for increased capacity in Hunter New England Local Health District funded services to implement strategies outlined in the New South Wales First 2000 Days Framework. This is essential if Brighter Beginnings is serious in its objective to co-design opportunities for improved service delivery in ways that best meet the needs of children. We call for additional State Government investment in Regional Development Australia to facilitate the development of a workforce development strategy for allied health services on the Mid Coast. This strategy should take into account current and forecasted demand, not just for child and family health services but aged care, disability and mental health services.

We call for an immediate increase in the number of allied health service providers funded through community health, particularly for children and young people. We emphasise the need for additional paediatric physiotherapy, occupational therapy, speech therapy, dietetics, diabetes education, social work and paediatric psychology services. An example wait time for service provision—speech therapy services for children aged three years up to school entry is up to 13 months, while school-aged children with language delay are offered assessment only, with restricted support for younger children. We also call for increased permanency for advertised positions through Hunter New England Local Health District for nursing and allied health positions as a key strategy to attract and retain allied health and other medical professionals. We call for greater transparency in public funding arrangements for specialist ear, nose and throat [ENT] services. Finally, we recommend urgent State Government investment in publicly funded specialist ENT services for children that include capacity for timely assessment and surgical intervention delivered locally. This should include access to emergency on-call ENT services. Thank you.

The CHAIR: Ms Foster, do you have an opening statement?

Ms FOSTER: Yes.

The CHAIR: How long is that, because I am conscious that we have got—

Ms FOSTER: The time? I am sharing my daughter's story.

The CHAIR: Okay, please proceed.

Ms FOSTER: I can table it.

The CHAIR: No, that is fine. Please proceed.

Ms FOSTER: Thank you honourable members for this opportunity to share my daughter's story. My daughter, who is nine years old, has had many complications with her hearing since the age of two. It was discovered in 2015 at aged 2½ when she attended preschool, where they had hearing checks by a Biripi health worker. It showed Melinda had glue ear and had to seek medical treatment. Melinda struggled with continual sinus congestion. I was concerned and confused of what to do and how to help. When my older daughter was getting her before school screening assessment, I expressed my concerns to the audiologist and if they could have a look at my younger daughter's hearing, which led to an assessment on the spot.

The audiogram showed that Melinda had moderate hearing loss in both ears. I got a referral to see the ENT, which added her to the waiting list to see the ENT in John Hunter Hospital. I got a referral. While waiting to be contacted I was concerned about the hearing getting worse as it took a long time. I asked my local GP to provide a referral to see the Mayo Private Hospital for a private ENT doctor. As I was a young mum I did not have the funds and did not have any savings. I knew it would be costly. In the lead-up waiting for that appointment I was contacted by John Hunter to get my daughter's adenoids removed and grommets inserted. Only gaining my licence, I was nervous to travel to Newcastle and I had to leave at 6.00 a.m. and organise care for my oldest daughter.

The doctors were very kind and helped make Melinda feel comfortable. After her grommets fell out in 2017 her hearing problems started again. She got glue ear again and had ongoing appointments with Hearing Australia and we were added to the ENT waitlist again. In 2018 when Melinda was in year 1 and aged six, I was contacted by Maitland Hospital, where she was due to be booked in to get another set of grommets. Melinda attended the learning centre at school as she was falling behind as she was not hearing and showing delays in sound blending and reading. In 2020 Melinda had another hearing assessment that showed that she had glue ear again and moderate hearing loss. The hearing would fluctuate, so some days were good and some days were worse. In 2021 we were added to the waiting list again when Melinda had to have her adenoids removed again and her grommets inserted.

The CHAIR: So that was 2021?

Ms FOSTER: Yes, this year. She has had three sets. The most recent event was on 1 May. Melinda got ear putty stuck in one of her ears and it attached to her ear drum and her grommet—as she puts the ear putty to keep her ears dry for having a bath. I rang John Hunter for advice on what to do and I was advised to go to Taree hospital. I waited for hours with my daughter. She was very nervous of what to do and how they were going to get it out. Once we had seen the doctor, he tried to remove the ear putty. It was just breaking apart. He was not sure what to do and we were referred to John Hunter with a letter explaining that we were just recently at Taree hospital. We left early in the morning and arrived at 8.00 a.m. at John Hunter in Newcastle, where we had seen reception and we were placed in the queue to see a triage nurse.

Taree hospital did not advise John Hunter of our arrival and the ENT services were disappointed that we were being sent down there with the hope to see an ENT. Melinda was feeling uncomfortable, scared, tired and hungry, which made the situation hard. The nursing team in Newcastle were wonderful and organised the ENT to come down to have a look. They came up with a plan to get the ear putty out. The ENT specialist was able to remove it in the emergency area under light sedation and had all the right equipment to remove the ear putty and her grommet was still intact. It would be great if our area were able to give this type of support—to be able to contact an ENT specialist in time of need and emergency. The benefit of having an on-call ENT specialist available in our area will reduce waiting times, travelling costs and provide support and reassurance to many families. Thank you.

The CHAIR: Thank you, Ms Foster, for coming along in the first instance. Thank you for sharing that very personal family example with us. That is very good.

Ms FOSTER: Thank you.

The Hon. WALT SECORD: Thank you for coming today, everyone. Mr Wood, nice to see you again. I think the last time we met was six or seven years ago.

Mr WOOD: It was, Walt, it was.

The Hon. WALT SECORD: I remember that I was shadow health Minister at the time and I came up here to address a rally to improve health care in the region.

Mr WOOD: Correct.

The Hon. WALT SECORD: In the last seven years, has health care improved or got worse in the region?

Mr WOOD: It has got worse. The only positive thing I can say is we now have a MRI scanner. Thank you to the pressure from our committee on Dr David Gillespie. So we got a licence for that, and that was it. We have got a new radiology department and we have also got a new renal dialysis. We had an existing renal dialysis but the money that we got—the grant, $20 million—we had an existing car park. This is typical of how Health is spending the money. We had literally a perfectly functional car park. So in their wisdom when the money was granted, they knocked the car park down and built another car park, with great fanfare. We have got a wonderful car park, it is brand spanking new, and we have got 12 extra parking spots.

The question you asked me: Has it improved or not? Our nurses and doctors do an unbelievable job under the most extreme difficulties. We commend them. The community see them working. They are short-staffed. The staffing levels are horrendous. For example, in our emergency department today, the nurses are outside protesting outside the hospital in their lunchtime so they would not compromise the patients. In emergency they are short of 7.1 full-time staff. There is no full time FACEM, which is a Fellow of the Australian College of Emergency Medicine. You need to have a FACEM. We have only got 0.5 for two weeks. We have got a shortage of staff. We have got an 18-bed emergency department that I was involved in as a nurse and in risk management in senior management. From the first day it was opened, it was clearly stated that it would only be funded for nine beds. Why do we build an 18-bed emergency department and only fund it for nine?

The Hon. WALT SECORD: So are there only nine at the moment? Only half the beds are—

Mr WOOD: Only half the beds are staffed and funded, and that has been since it was opened. So we have got shortage of staff. Staff are getting extremely demoralised. Staff are leaving, which is terrible. We cannot get staff. We have got the situation now where we have cleaners in the emergency department, which I never thought I would say, who are sitting with patients who may be confused or demented.

The Hon. WALT SECORD: Sorry, so cleaners are assisting with people suffering from dementia?

Mr WOOD: Cleaners, yes. They have also been asked on the wards to actually sit and monitor the dementia patients because we no longer have a 16-bed dementia ward, which was closed without any consultation whatsoever with the community. That has impacted in three ways: One, they are sending the dementia patients to the hospital; two, they send them home to their family members, who may be in their 80s and quite debilitated themselves and they are expected to look after their husband, wife or whoever it may be; or they send them to Tamworth or they send them to Newcastle.

The Hon. WALT SECORD: Mr Wood, I understand the population is growing here.

Mr WOOD: Yes, 94,000.

The Hon. WALT SECORD: So you are almost 100,000 people now.

Mr WOOD: Yes, 94,000 people. This hospital, when I did my nurses training here, under a lady who is here today, Mrs Patricia Maunsell, who was manager of nursing services, our hospital was the leader in education, in initiatives. Other hospitals, other health services used our systems. Once we joined Hunter New England, we started losing our services, and it was done subtly. We had an eight bed High Dependency Unit, which was functioning wonderfully well, and all of a sudden we don't have it any more.

The Hon. WALT SECORD: So you are not in the same health district as Coffs Harbour and Port Macquarie?

Mr WOOD: No, we are in Hunter New England—Newcastle.

The Hon. WALT SECORD: Why is that?

Mr WOOD: Well, Walt—

The Hon. WALT SECORD: I am sorry, I did not mean to make people laugh. Can you explain to me why the audience laughed?

Mr WOOD: Why we are in Hunter New England?

The Hon. WALT SECORD: No, why they laughed when I asked that question.

Mr WOOD: I do not really know, to be quite honest.

The Hon. WALT SECORD: I think you might know.

Mr WOOD: I will say this, Walt, it is not a laughing matter.

The Hon. WALT SECORD: No.

Mr WOOD: When you see your hospital and your staff demoralised and leaving, it is atrocious. It is done subtly. Hunter New England, the CEO and all the people will say, "Oh, yes, you've got plenty of staff." Well, you say that to the staff in the emergency department who are short of 7.1 full-time positions. You say that to the nurse on the medical ward who is a first-year graduate nurse and is put in charge of the ward.

The Hon. WALT SECORD: First-year graduate nurse in charge of the emergency?

Mr WOOD: First-year graduate nurse in charge of a ward.

The Hon. WALT SECORD: Mistakes happen when that occurs.

Mr WOOD: But it is unfair to the nurse as well. It is unfair to the patients. Imagine, we have got dementia patients, who I have the greatest of respect for, they deserve the same level of care as everybody else but it is a specialist care. The cleaners on the ward were asked to monitor and sit with or bring back the dementia patients. You may have a full-bedded ward with IV, indwelling catheter [IDC], you might have everything, but the poor dementia patient is going up trying to pull the IV down. It is horrendous. The patients who are in there trying to get well cannot get sleep, cannot rest. It is just atrocious.

The Hon. WALT SECORD: Mr Wood, you also mentioned in your opening statement that Manning Base and the region here has the worst cardiovascular rates in regional Australia.

Mr WOOD: Correct.

The Hon. WALT SECORD: Why is that?

Mr WOOD: Because we have not got a cardiac lab. We have only got one cardiologist.

The Hon. WALT SECORD: For 100,000 people?

Mr WOOD: He has been pushing for a cardiac lab for years and years and years. There is one set up at the Mayo Private Hospital but it is a non-functioning one. The cardiologist has actually approached the head of Hunter New England and said, "Well, why don't we set it up so that we can work with the private hospital and partly fund it with the public?" But we are in dire straits here regarding staffing and it is horrendous. If I can just give you this one example. I am sorry, I know you are busy.

The CHAIR: No. We just have to share it around. That is alright. Please, Mr Wood, go.

Mr WOOD: We had a 34-year-old young lady come to our hospital. She is a qualified paramedic and a qualified registered nurse. Our emergency department is 7.1 short. She asked for a full-time position. "No, we can't give you a full-time position. We can only give you casual." This lady wants to buy a house, wants to settle down here. They would not offer her a full-time position. "We'll give you casual", so we have lost her. She has now actually—which is really sad—gone completely out of health and is working in a medical centre in Port Macquarie doing botox. She would have been ideal for our emergency department. We are losing our staff. If I could put it in a simple analogy, once upon a time our hospital, we had a beachball full of experienced staff. Now we have got an orange. I know for a fact from a conversation I had with a gentleman yesterday, two more staff will be leaving from the emergency department.

The Hon. WALT SECORD: What were the nurses protesting at noon today?

Mr WOOD: Staff, staffing.

The Hon. WALT SECORD: Was it the staffing levels in the emergency department?

Mr WOOD: Yes.

The Hon. EMMA HURST: Ms Katsamangos, you say in your submission that parents are being told that there is a four- to six-year wait for intervention on hearing issues. That is quite shocking. Surely at that point the child's issues could be much worse. How are parents responding to that? What is the reaction in the community?

Ms KATSAMANGOS: If you take a look at some of the parents' stories that are included within the submission, it gives a rather detailed demonstration of how challenging that actually is. For people who can afford to go private, ENT services are readily quite accessible, but anyone who is reliant on the public system is being informed of anywhere of three years plus for interventions and surgical interventions all need to take place either in John Hunter, at Maitland or Gosford. So families are incurring costs for travel as well. For some families, depending on the type of surgical intervention, they are asked to stay for two weeks within the vicinity of an

emergency department with an ENT on call. So they cannot come back to Taree because that service is not available. They then need to cover the cost of accommodation for up to two weeks to provide that support to their children. On average, parents seem to be incurring debts of anywhere between $4,500 to one of our families anticipating approximately $20,000 because their second child has been identified to have issues as well and it is also linked to orthodontic work that will be required.

The Hon. EMMA HURST: You go on to say that there was a generous funding package, but these waiting periods still exist. What is happening here? Why has this funding not actually helped fix some of those waiting periods?

Ms KATSAMANGOS: Which funding package are you referring to?

The Hon. EMMA HURST: I am just looking at one part of your submission that I pulled out. It says:

> … despite having access to generous funding packages, extensive waiting periods mean that children miss vital hearing, medical and other allied health services in the preschool years.

Ms KATSAMANGOS: When a child is identified to have an issue or a concern perhaps with hearing, often they are referred to the Early Childhood Early Intervention [ECEI] program, which is for children identified to have a barrier prior to being engaged in the NDIS more generally, and children up to the age of seven do not require a formal diagnosis to access it. When a child is identified with a hearing issue, they cannot afford to go down the ENT path. Often the intervention in the wait time is a referral to ECEI where they get a funding package where they can get some early intervention in the meantime. The challenge with that is if you do get a package and you are referred to speech therapy in lieu of the surgery that the child really needs, it is limited in its impact because if a child cannot hear, they cannot derive the best benefit from speech therapy. So it is not a good use of funding.

The Hon. EMMA HURST: Yes, it is not directed in the right way. Ms Foster, thank you so much for sharing your personal story. I know that it can be quite daunting and difficult to come and share something so personal, so thank you so much. You mentioned that you were on quite a few waiting lists. How long did you have to sit and wait on the waiting list and what was that period like for you and your family?

Ms FOSTER: Once I had been added to the ENT waiting list, it was a waiting list for three months, and they will give me a call on a cancellation list or when a spot becomes available. One time I only had to wait two weeks, but then the first time I had to wait almost the whole three months where her hearing was very bad and she was falling behind in class.

The Hon. EMMA HURST: What was that like for her waiting in limbo for three months?

Ms FOSTER: She was very confused and a lot of people would say that she is deaf and it was very hard for her. At school she was not able to hear what the teachers were saying and she did not know what was wrong, and I did not really know what was happening until the doctor explained what glue ear is. It is like custard in a drum and if you bang it, it is very dull and very hard to hear, and that is how she is hearing—all muffled sounds. She is still in the learning centre at school where she gets support for reading and sound blending and one-on-one support—and she is in year 4.

The Hon. EMMA HURST: It is hard. Ms Hollingworth, you mentioned that your private charity is having to raise money to buy specialised equipment. What sort of equipment are you guys having to buy to help support the community and are there other people doing this as well to try to fill those gaps?

Ms HOLLINGWORTH: There is another organisation in the area called Can Assist and their focus is on cancer, so I cannot speak for what they are doing. What we have been buying is palliative care equipment like special chairs that allow people—one of the things that happens when you are prone for a long time or you are lying and you cannot move very much is that you have a risk of pressure sores which can become very complicated and so people need other ways of sitting, lying, positioning themselves. So we bought 12 special chairs for the hospital. Everything that we fundraised for we have put into the local HNE Health Taree equipment service. It is like a lending library of equipment. Some of that goes into the hospital and some other goes into people's homes as needed, and that is determined by the nursing personnel or the palliative care specialist personnel who are looking after the patients and saying they need this. If they have this, they could go home rather stay in hospital.

Some of them are Roho cushions, those honeycomb cushions that help lift the person off hard surfaces. We have done chairs. We have done lifters. It is a range of things—something about $75,000 worth of equipment over time. Why we do that is that you cannot get the funding out of the government system fast enough for the people to have the equipment. That also occurs with when we pay for people to have personal care services at home—the person will die before they get the help. For a community to have to fund its own palliative care or other types of care, transport or whatever it is, it is very difficult and not everybody can have that level of care.

The Hon. EMMA HURST: You said that you are also fundraising from an already impoverished community, so there is obviously an upper limit to what you can even achieve if there are gaps happening.

Ms HOLLINGWORTH: Yes. Of course, in the last year or so—in fact, in the last two years we have had bushfires, COVID, floods. So the capacity of the community to actually contribute anything is very—we stopped fundraising out of consideration for the people in the community. We are just running our funding program out of reserves.

Ms CATE FAEHRMANN: I will go to you first, Ms Katsamangos. Thank you for attending today, as well as Ms Foster. I must admit, reading the submission from your organisation, it was pretty shocking to think that here in New South Wales in the public health system we have children seriously waiting between four and six years to be able to get a tonsillectomy. Is that surgery?

Ms KATSAMANGOS: No. It is usually ENT related. We are looking at things like grommets and adenoids and that type of surgical intervention.

Ms CATE FAEHRMANN: You talked about some case studies in terms of kids who are clearly having extreme difficulties with hearing having to wait three years or more. You also point out in your submission the New South Wales Government's goal, if you like, in terms of Brighter Beginnings. You say that the Government is saying that they want to make sure children are developmentally on track, they are committed to giving every child in New South Wales the best start in life and they want to make sure that children can participate in terms of having the lifetime health, education and social and economic benefits that schools can bring. Do you think the Government in this area is doing that for the children of Manning Great Lakes?

Ms KATSAMANGOS: No.

Mr WOOD: No.

Ms CATE FAEHRMANN: Compared to the rest of New South Wales, do you feel like you are being left behind? Do you feel like you are being treated as second-class citizens?

Ms KATSAMANGOS: I do not think I would go to say second-class citizens. It really is a question about accessibility. It is about children being able to access the services they need in a location in which they are comfortable to do so in a manner that is timely and that any intervention that is required can be delivered locally and is affordable. That is not happening at the moment. As I have said in my submission, there are examples of great service delivery, but overall the system is fragmented. We support the Government's Brighter Beginnings initiative and we support the First 2000 Days health framework but, generally, our conclusion is that while the principles are good, the resources are not behind it, which makes it incredibly challenging.

For us, when we want to work with our local hospital, with our local healthcare providers, to form the types of partnerships that they want us to form in order to deliver better services, there is not enough flexibility within the staffing to enable that to occur. We need people within the hospital to be able to come into the community services sector, to help us identify and name the problem, to help us form solutions, but the flexibility is not there. So we sit on the sidelines trying to pull the bits of information that we need and it takes far too long. We need greater capacity in the health system itself to be able to develop the kind of partnerships that the Government says that it wants.

Ms CATE FAEHRMANN: You are talking about partnerships, but with something like parents being currently advised of wait times anywhere between four and six years, that really comes down to funding within the public health system, does it not?

Ms KATSAMANGOS: With that particular issue, yes.

Ms CATE FAEHRMANN: Children of parents who have private health, who can afford to go down that path, that is fine for them, but you are specifically highlighting the people who cannot afford the private health system as much, and the public health system is three to four to five years.

Ms KATSAMANGOS: Yes, and Ms Foster's experience is reflective of the fact that Aboriginal and Torres Strait Islander children are actually better off in this area in terms of accessing ENT services. They have a visiting ENT around every six weeks to the Biripi Aboriginal Corporation Medical Centre, but if they need surgical intervention they still need to travel, so that issue remains.

Ms CATE FAEHRMANN: Thank you. Ms Hollingworth, thank you for the great work that your organisation has done and all of the members of your organisation for doing so much fundraising and filling obviously a much-needed gap. What would be happening to the patients in this area if your organisation was not able to raise the funds and provide the services and resources that you have been able to provide?

Ms HOLLINGWORTH: In some cases, just to go back to the question about equipment, I was just remembering that we bought mini oxygen concentrators, for example, and supplied them. That means that somebody can actually go out of the hospital for a while or go home and have breathing support; they do not have to be attached to stationary equipment all the time. So what would be happening is that people would just be living it harder, so the people at home who care for them have more burdensome work to do. You have got somebody who cannot breathe at home or cannot manage to shower or do home care yourself, so if nobody else comes in and does that, then you have got a hygiene problem and exacerbating health problems. So the whole quality-of-life thing deteriorates for people.

Ms CATE FAEHRMANN: Is there a sense that the Government might also rely sometimes on the community fundraising and filling the gaps? Because, as you said, if you were not doing it—not that you should stop fundraising for the community, but it is a double-edged sword, is it not?

Ms HOLLINGWORTH: Yes. We are facing a difficulty ourselves—we may have to—because we are an aging population of people who are in this organisation and for various reasons people cannot go on doing the work and we are having difficulty finding people with the capability and capacity to pick up the organisation and keep it going. So that is one part of it: I do not know if we can keep doing it. Of course, if the problem is solved—the people we are supporting very often are not always able to advocate well for themselves. How this works, this partnership with the community works, is that the nurses in the community and in the hospital tell us when there are people who are in acute difficulties and say to us, "We think these people need X, Y and Z services. Would you pay the bills?" And we agree to pay the bills and they arrange it and the bills come through to us and we pay. We are not a frontline organisation; we are working in partnership with the care community.

The Hon. WES FANG: Thank you very much for appearing today. I will start with Ms Jenkins and Ms Hollingworth. Thank you both for appearing today. I know palliative care space is particularly challenging but it is also rewarding when you know that you have made a difference in people's lives or at their end of life. I think that is really important. Are you able to tell me about any recent changes in the palliative care space around this area? Have there been any updates that you might be able to provide?

Ms HOLLINGWORTH: You will probably see from our submission, which we made a couple of years ago to Hunter New England Health, that one of our main lines of advocacy was to get more palliative care specialists personnel into the area—allied health as well as clinical staff. The main wish was to have a palliative care specialist. We have actually managed to achieve half a palliative care specialist, but in a population of 95,000, and soon rapidly going to 100,000, the standard is 1.5 for a population that size. Arron Veltre is the palliative care specialist who is here now.

He makes an enormous difference in the work that he does; he has got phenomenal energy and he is doing a whole lot in the hospital environment, but also makes himself available to come and work with us to say, "How can we bring life back into this? How can we find people to pick it up and take it on?" That makes a huge difference to the morale of the whole community of people like us, a community organisation, the carers themselves, the practitioners—they have got somebody they can go to—the GPs can speak to somebody who is a specialist in this area and cover off things that they are uncertain about, and the peers and colleagues in the hospital now have somebody that they can put those really tricky life/death questions to, which was not available before.

The Hon. WES FANG: Have you had an opportunity to have those conversations with him and provide some support and feedback and collaborate on how you are best able to assist each other in the work that you do?

Ms HOLLINGWORTH: Yes, that is underway. His position has only been permanent since the beginning of this year, so we are having conversations about what can we do as a community organisation now that he is here: the changes, the direction. Obviously, we will go on advocating for another one whole palliative care specialist person. But also the allied health area, as the others have been saying, is really under-resourced and it is quite often the occupational therapist and the physiotherapist and the social workers in this area—people so desperately need support and how do I deal with the practicality of what we are living with?

The Hon. WES FANG: I just wanted to say well done on your advocacy.

Ms HOLLINGWORTH: Thank you.

The Hon. WES FANG: I know that it is going to make a huge difference in this area. So well done for that. Mr Wood, I just wanted to turn to you quickly. Looking at the questioning that the Hon. Walt Secord put to you around the structure of the health network here and the fact that you are with Hunter New England, can you just talk me through what you see as some of the difficulties in being involved with the Hunter New England network?

Mr WOOD: Most definitely. Since we joined Hunter New England, first of all the hospital lost its identity, then we started losing funding. We were treated—how can I put it—as the small hospital. You have got Port Macquarie and then you have got John Hunter. We as a base hospital used to deal with trauma and what we could not handle we would fly out by helicopter or by ambulance. Each year, since we have been with Hunter New England, the services have diminished. There has been increasing pressure—and this is a real factor—from senior management, and I am sure that the Government put pressure on the senior management that has passed all the way down through to general managers, managers of nursing services, managers of non-clinical services, to cut costs, and that is constant.

I worked with a general manager at Manning Base Hospital for 10 years—he was excellent—and this is an example. He came to us one day and he said, "I've been asked to cut the costs by 15 per cent." The following year he said, "I've got to cut costs but I can't do it." We had that general manager for 10 years and in the end he left; he said, "I just can't do it." That impacts on everything: It impacts on the infrastructure of the hospital, it impacts on the education programs of the hospital, it impacts on how we attract specialists and nurses to come to our hospital—not only to come to our hospital, but to keep them, and we have an enormous problem. For example, we got five practitioners who had Fellowship of the Australasian College for Emergency Medicine [FACEM] in our emergency department; they only lasted a short time. Once better positions came up somewhere else they left; they felt they were not supported.

The Hon. WES FANG: I know we are running out of time but I wanted to ask you a couple of more questions. You do not feel that it was appropriate that Taree was put in with Hunter New England?

Mr WOOD: We are treated differently—completely different. We had all our systems and it was, "This is how we do it in Newcastle."

The Hon. WES FANG: When you said the general manager had done it for about a decade I think you said—

Mr WOOD: Ten years.

The Hon. WES FANG: When was Taree incorporated with Hunter New England?

Mr WOOD: About 15 years ago we went to—

The Hon. WES FANG: Fifteen years ago?

Mr WOOD: Yes, about 15 years ago.

The Hon. WES FANG: It was quite a while ago.

Mr WOOD: Yes, it was, and each year it has diminished.

The Hon. WES FANG: Right, okay. You would be advocating for a change to the system. You would be looking to be allocated to a different network. Is that what you are looking to do?

Mr WOOD: Is that what we feel as a community we would like?

The Hon. WES FANG: Yes, I am just trying to gauge what it is that you feel the solution is, because obviously we write recommendations. What is it that you think is the appropriate fix for this?

Mr WOOD: If we did go, say for instance, to the mid North Coast, which is Coffs Harbour—and I used to serve at all those hospitals—we would have to go with fair equity, to be treated responsibly and treated as a hospital that we are but to bring us up to an acute care level. Professor Balogh—who is highly respected not only here but Australia-wide—clearly stated that our hospital should be brought up to an acute care standard and funded and staffed at that level. We are not now. The community expect—they do not expect five-star treatment but they are entitled to have fair treatment. The young lady at the end when she talked about her daughter with ear problems—education-wise, not having an ENT specialist that public patients can go to will affect those children—little boys, little girls—with the learning process and can affect them longer term as they get older.

The Hon. WES FANG: Fifteen years ago when Taree was incorporated, was there a case made at the time to the Government of the day to say that this should not happen?

Mr WOOD: Basically what happened was, they were changing the boundaries and the question was asked, "Should we move Manning Hospital to Hunter New England?" One of our orthopaedic surgeons said it would be wonderful if we went with Hunter New England because then we could have access to the specialists in John Hunter. That carried a lot of weight and we went across.

The CHAIR: Thank you very much. I have given a bit of latitude with time because the quality of evidence from the witnesses has been very good. Unfortunately we have to draw a line under it. Ms Hollingworth, there was an additional document you were going to provide to us.

Ms HOLLINGWORTH: Yes.

The CHAIR: The secretariat will obtain it. Ms Foster, would we be able to get a copy of your opening statement because we will give it to Hansard and that will help them with the transcription?

Ms FOSTER: Yes.

The CHAIR: Before we got underway, I received a single-page document which says "Manning Valley Push for Palliative". I have a copy of that. Mr Wood, I have a rather detailed document I think standing in your name which we will have access to.

Mr WOOD: That is right.

The CHAIR: We have got a further document from Mid Coast 4 Kids.

Ms KATSAMANGOS: Yes.

The CHAIR: From your original submissions to your very quality contributions today through your oral evidence and the additional material you have provided, you have given us a wealth of information, which I am sure will enrich our inquiry very much. Thank you all very much.

Mr WOOD: Is it possible for me to just say one thing, please?

The Hon. WALT SECORD: Yes.

Mr WOOD: I know you are busy. I am sorry about this. We have gone through floods, drought, fires, COVID and now we are in a situation where our health service is in crisis. There are no two ways about it. No matter which way you look at it, we are in a crisis situation. Irrespective of what the politicians say or the health service says, we are in a crisis situation. Thank you very much.

(The witnesses withdrew.)

SESHASAYEE NARASIMHAN, Visiting Medical Officer, Acute Care Physician and Cardiologist, Department of Medicine, Manning Base Hospital, affirmed and examined

SIMON HOLLIDAY, Private citizen, sworn and examined

NIGEL ROBERTS, Private citizen, sworn and examined

Dr ROBERTS: I am appearing as a private individual but I am the Director of the Department of Obstetrics and Gynaecology at Manning Base Hospital.

Dr HOLLIDAY: I have been a doctor in this area for 25 years.

The CHAIR: Good afternoon, gentlemen. I acknowledge all of your respective submissions, which have been received by the inquiry and processed. They have been entered as evidence and uploaded to the inquiry's webpage. Dr Roberts, your submission is No. 6 to the inquiry. Dr Holliday, yours is submission No. 379. Dr Narasimhan, yours is No. 168. With respect to those submissions, you can take them as all read by the Committee members. I am about to invite you to make an opening statement. There is no need to go through the content of your submissions in any detail. Rather, I ask you to make some broad comments to set up the questioning about the content of your submissions and matters arising from that. If you are agreeable to that, we will start with Dr Roberts.

Dr ROBERTS: As reflected in Ms Foster's testimony earlier, I believe the people of regional and rural New South Wales are disadvantaged by a lack of public outpatient services. Manning Hospital does not have the infrastructure nor the personnel required to run outpatient clinics efficiently. Because regional hospitals are largely staffed by visiting medical officers [VMOs] who generally run clinics in their private rooms but not the hospital, regional residents of New South Wales are forced to pay for the same care that their city cousins enjoy for free or they have to travel hundreds of kilometres for that care or worst of all they go without the care altogether. The problem is not with the VMOs; it is due to a failure to attract staff specialists to regional hospitals. It is with regional hospitals that do not employ VMOs to run publicly funded clinics on a sessional basis. There are numerous negative consequences of this imbalance of VMOs and staff specialists.

As I said, there is a lack of publicly funded clinics which rural residents can attend. Further, doctors in training do not receive the training that they require in outpatient care because it does not occur within the hospitals and they do not receive adequate day-to-day supervision and support. Furthermore, there is a lack of governance mechanisms to ensure that the right procedure is being performed on the right patient or that complications are adequately investigated and steps taken to prevent their recurrence. Finally, the VMO model can encourage overservicing. It does not always, but it can. I have seen this occur.

In 2018 I reviewed over 200 women who came forward to express concerns over their care at Manning Hospital under the care of one particular doctor. It was evident that a doctor there had been performing unsafe operations and unnecessary operations, which in my opinion at times reached fraudulent levels. However, he operated unfettered within the health system for some 16 years, despite multiple horrific complications that went unreported or were not investigated at all. As stated by Gail Furness in her independent report regarding surgical complications by this doctor, they—the patients—often returned to his private rooms and some were encouraged not to attend Manning Hospital after the complications arose. She goes on to say:

> There was no evidence available to me that, before the arrival of Dr Roberts, there was any reviews of the IIMS undertaken to enable any pattern to be detected or reviews followed up.

She continues:

> It is no coincidence that IIMS reports and other complaints escalated from mid-2015 ... there were discussions among colleagues and no reporting because "there was no-one to report to".

As I said, the problem is not with VMOs. It is with an unbalanced system which fails to attract staff specialists to regional areas. It is with regional hospitals that do not recruit staff specialists in the roles of director so that someone with expertise in the relevant specialist area has dedicated paid time to ensure that excellent standards of care are met and maintained. A director represents a role; it is not just a title. If we are to aim for and achieve excellence in our health care rather than just throw the term around as management-speak then we need to invest in the medical leadership of our regional hospitals. We need to incentivise working as a staff specialist in regional hospitals and we need to stop wasting money on unnecessary procedures. If we do any less than what is required to fix the system it is a rebuke to those 200 brave women who came forward to tell us of their injuries and it is an ongoing disservice to the people of regional New South Wales, who pay their taxes just like their city cousins.

The CHAIR: Thank you, Dr Roberts, for that very comprehensive opening statement. Can I invite you, Dr Holliday, if you would like, to make an opening statement?

Dr HOLLIDAY: Thank you. I am a GP. I am an addiction physician. I am a past GP anaesthetist and GP obstetrician and I am currently in both private practice and in hospital practice as the staff specialist here in drug and alcohol. Houston, we have got a problem, and the problem I would like to talk about is workforce. When I was looking to come to this area I looked around a number of rural practices as a GP proceduralist and every single one around New South Wales wanted to charge goodwill—sometimes up to $65,000 to join a practice. But now the tables have turned. We have to pay recruitment agents, sometimes $28,000, to get a doctor, plus promise them the earth. Even then we cannot get doctors to come. I was speaking to the owner of a recruitment agency in the last month and she told me her company has about 1,000 GP vacancies on their books. I think it is a national company. They place about 20 to 30 a month. She has got to the point where they actually refuse to accept practices that are trying to get vacancies advertised through their agency because they are wasting their time trying to get them filled.

You in this Committee have a very tough job. I do not envy you, because there are a lot of inquiries, there a lot of requests for attention, a lot of ways of looking at things and a lot of complexities. But today you have heard about the pain and anguish in our community, as in many other regional communities, and you have the weight of our expectations on your shoulders to look at the whole health system not just in a blinkered fashion or with electoral advantage. I would hope that four proposals that I make to you today could help you improve our health outcomes. First of all, research. I think we need to facilitate clinicians researching and I think we need to also evaluate policy. A failure to do that will mean that we do not identify best practice and policy. We need to improve recruitment, especially rurally. Less than 5 per cent of Australian-trained doctors choose to practise rurally. This is a disaster. To fill the void we seek international medical graduates. They endure a horrific time, months and years, of Kafkaesque barriers and multiple fees. It is an awful marathon.

There are at least half a dozen Federal and State agencies all not talking to each other and making life hell for the international medical graduates and for those people in rural areas trying to get them to come on board. Your committee must look to ensure these bodies coordinate. Without this, the health system enters a state of functional stupidity where competent bureaucrats work in a blinkered, piecemeal fashion, creating an incompetent whole. My third suggestion is you need to facilitate retention. A lot of the doctors around here are burnt out. One senior GP in town recently had to stop working very suddenly. I was just speaking this afternoon to an owner of a large practice who said, "I'm just so burnt out I'm going to have three months without seeing patients." Rural GPs earn no more than their urban colleagues. Payroll tax is destroying our viability. It is important for this Committee to recommend to Revenue NSW that it drop payroll tax on rural medical practices, especially practices that are employing GP registrars to encourage them to come to the bush. Revenue NSW recently dropped it for Qantas and you need to do it for medical practices on the same grounds of public interest.

Rural public hospitals need to stop ignoring GPs. We need to start collaborating better. We need to stop deskilling GPs and undermining them with competing outpatient services. Rural GPs must not be regarded as gatekeepers. I do not think there is any evidence that, outside tertiary referral centres, only specialists should provide hospital and outpatient services. Well-trained GP proceduralists or rural generalists can deliver much or even most of the services in their area in a competent fashion and such a lower cost and accessible model of care may help reverse some of the deterioration of our health services.

The CHAIR: Thank you very much, Dr Holliday, and can I just acknowledge the length and the quality of your submission, which was very detailed. It was appreciated very much by the Committee. Dr Narasimhan, would you like to make an opening statement?

Dr NARASIMHAN: I would like to acknowledge the traditional custodians of the land on which we meet today. I would like to thank this Committee for this opportunity to tell our story of the Manning. I come here with the support of my physician colleagues at Manning Hospital. There is agreement amongst all health practitioners that urgent steps are required to address the understaffing and inadequate facilities within the Manning Hospital. The department of medicine has identified these issues and we have provided solutions to address them in our submission 168. I believe these problems stem from a disconnect between decision-makers and local stakeholders providing services. I would like to highlight the pertinent problems for further discussion later. They are: chronic inadequate funding and downgrading of facilities and services; a centralised decision-making process that disadvantages those providing the care; and the failure to provide contemporary facilities and infrastructure, thereby not allowing health practitioners to provide standards of care as expected by NSW Health.

We have challenges in attracting and retaining suitably qualified staff. Nobody wants to come here. Chronic underfunding means we have an exhausted and severely downgraded hospital—we have lost CCU beds. It is not an appealing hospital for new recruits. We are haemorrhaging qualified and experienced allied health practitioners. I am the first and currently the only cardiologist living and working in the Manning. *The Heart of Inequality* study, which was done by the Government, has shown that the Federal seat of Lyne has the worst

cardiovascular outcomes in regional Australia. This automatically explains why I have an extraordinarily large workload with major responsibilities. I constantly work 80 hours per week at the bare minimum to provide 24/7 care for my patients.

The natural disasters—as well explained—have further highlighted the issues of not having local facilities to support our community. Roads were cut off and planes could not land here. This could always happen again. The Manning has the oldest age demographic in Australia. People are living longer, which means they have multiple more complex, chronic medical problems, which makes management of these patients complex leading to longer length of hospitalisation. We have high levels of socio-economic disadvantaged patients and a large Indigenous community, which have their own requirements which are appropriate and should be respected. All these factors in combination make the needs for this region complex and dictate a higher level of service provision.

Provision of contemporary medical care requires better funding and up-to-date infrastructure because without these appropriate resources it is impossible to provide this care to our community and patients and address what NSW Health expect practitioners to provide. COVID has educated all of us on various issues. One issue is the population expansion in regional Australia. Many Australians are moving out of metros to come to regional areas. In general, 40 per cent of Australians live in regional Australia. That is why I left my university job in New York City and I have moved here. I am very happy to do so. We have to provide the same level of care to these people as those in Sydney and Melbourne and other metros. There are more than 250 developments at Taree and surrounding areas and more than 150 at Harrington. These developments are experiencing a high level of pre-sales. This implies approximately 400 new families are exploding into this region and this hospital will not be able to cope.

The latest figures indicate that the Manning has a 10 per cent higher level of residents over the age of 55. By implication, it means 10,000 additional people in the higher care needs bracket are living in this region. This hospital was not capable of supporting that. The bare minimum the hospital needs is an acute assessment unit; cardiology services, including an updated CCU; a cath lab to provide and treat locals locally; a delirium unit because it is repugnant allowing our elderly to travel far away outside this region; a respiratory assessment unit, including a sleep unit; and an updated ICU. The current ICU works far more than what it is funded for and, as my colleagues and others have mentioned, there is true burnout.

The department of medicine invested a lot of time and passion in preparing this clinical services plan, which you all have, to advocate for the service improvement of the Manning Hospital. We have tabulated it into short, intermediate and long term in a concise form. There are cost neutral solutions provided, which may actually save resources in the long term. Unfortunately, there is no feedback, there is no transparency and there is no update. A response of, "It's confidential," when we ask, "What is the accepted, updated, submitted clinical services plan?" does not foster a good working relationship between the medical workforce and the administration. I look forward to having further discussion in the question and answer session.

The CHAIR: Thank you, doctor. I acknowledge your submission—the content and detail. Thank you very much.

The Hon. WES FANG: Thank you very much for appearing today. Dr Holliday, I want to start with you first by looking at some of the workforce issues. You provided to us in your opening statement and your submission some ideas around what it is you think can be done to start addressing it. Obviously there are issues like taxation and remuneration. Can you expand on a few of those and just provide some insights into how the dynamic has changed in the past 20 or so years? I noted you talked about what it was like when you came and having to pay goodwill to join a practice to now finding it hard to attract people and how that has changed, what has changed and what can be done to return it back to an equilibrium of where we want to be.

Dr HOLLIDAY: Sure. I think if I had to choose two points one would be that the various authorities responsible for health care regulation need to talk to make sure it works because at the moment there is no talk. It is dislocated and, because there is no coordination, it is a disaster. A very simple thing of just trying to look at the pathway that people can enter the workforce or remain in the workforce or leave the workforce and getting the different stakeholders to make sure this works better would be something doable. There are the issues of State and Federal contests, but that is a good start.

The second thing is I think it is really important that we need to make sure Australian-trained doctors come to rural areas. I did speak to one of our local politicians who told me that the Australian Medical Association [AMA] would not allow medical conscription. I think that is passing the buck. We already have a form of conscription in that international medical graduates are required to come to rural areas. What's good for the goose is good for the gander. I think that Australian taxpayers—rural and urban—pay tax to develop wonderful universities and wonderful curriculums and wonderful culturally appropriate training for our doctors with the

skills and the interpersonal and social and cultural skills that they need to deliver great health care. I think that rural people should access such a product of our system.

In the meantime, we are reliant on international medical graduates. I think something like 35 per cent of the medical workforce is going to international medical graduates. We have got to look after them because they have a hell of a time. It is a disaster. If you read my submission you will see reports about marriages breaking down and it has been very difficult. It is the way that international medical graduates are treated like cannon fodder, really, for the fact that we do not provide for our rural communities from our own medical graduates so we take medical graduates who are very expensive to train—often from developing countries. I think it is like reverse foreign aid. We should not be relying on international medical graduates, even though most of my colleagues are and I have a wonderful relationship with them and great respect for them. But I do think that we need to say Australia needs to start providing its Australian-trained workforce for rural areas. I could go on.

The Hon. WES FANG: If we are able to supply our own organic workforce with Australian-trained doctors only, how do you think we are best able to attract those doctors to places like the Manning Valley over a metropolitan area? We know the quality of life you get living in an area like this, but how do we impart that to those new training doctors to make them want to come here and actually set up their life and their practice?

Dr HOLLIDAY: That is a great question. You have to look at the doctor and you have to look at the spouse of the partner and the family as well because they come together. In terms of medical training I think we do have to make more graduates think about general practice and rural generalism is dying out in my opinion. I think it is a perfect solution for rural areas. I have worked in Condobolin, Singleton, Perisher Valley, Lake Cargelligo, Hay, Dorrigo, all around the place and in all those places, except for Perisher Valley, I worked around hospitals as well. If GPs have appropriate procedural skills they can look after an emergency ward, trauma they can do, maybe surgery, maybe anaesthetics, take an X-ray. We looked after most of the inpatients we would have.

Rural generalism, we run on the smell of an oily rag. We used to do anaesthetics for tonsillectomies for a quarter or a fifth of what a specialist would command in the public system. I do not know why there has not been an experiment to see that this is inferior; this is just a cultural change. I think it is to do with power and the fact that cultures and people look at specialisation. It is very hard to support moderates in a shooting war and it is hard to support generalists.

The Hon. TREVOR KHAN: Dr Holliday, I am sympathetic to the proposition but I am interested as to whether my perception that particularly younger GPs are less enthusiastic about providing the procedural care that you are enthusiastic about, whether it is paediatrics or anaesthetics or the like. Is my perception wrong? Are the GPs that are leaking into the system now taking a much more confined role than GPs of, say, my age would have done 20, 30 or 40 years ago?

Dr HOLLIDAY: Yes, of course there are cultural changes and people also looking at lifestyle. They say, "What is the best lifestyle for me and my partner and my kids? What are the best schools and the best jobs?" Often the lifestyle and rural life are not that attractive to some people. There is cultural change. I think also all the levers are going in a different direction. When you are doing the hospital training GPs are out there in no-man's-land and everyone is looking at specialty progress and the ones who fail seem to go to general practice. There is that cultural change. I do think we need to rewrite that and if we do not rewrite it rural communities will suffer because they will not be getting accessible competent medical practitioners. We cannot have every specialist represented in every district general hospital.

The Hon. TREVOR KHAN: I have one final question to Dr Roberts. I might be wrong but I suspect there is a degree of tension in how Dr Roberts sees hospital staffing as to perhaps how Dr Holliday does. That is maybe my perception. In regard to the Gayed matter—I know you have not referred to the name but it is in your submission—there was what I think is called a section 122 inquiry. Is that what it is called? It was what Hunter New England imposed.

Dr ROBERTS: There were four look-back inquiries. I believe one of them was a 122, yes.

The Hon. TREVOR KHAN: My understanding is there were a series of recommendations that came out of the 122 inquiry which are in a sense obligatory to be carried through on. Can you identify what those findings were and whether they have satisfied some of the concerns that you had and have that arose out of the Gayed matter?

Dr ROBERTS: No, they do not satisfy me at all.

The Hon. TREVOR KHAN: Well, that answers that part.

Dr ROBERTS: I saw the 200 women and I wrote a report on each of them. I wrote a letter to the GP. I was then asked to come up with overall themes and suggestions, which I did. They were essentially ignored and

a different report was written, the one you are referring to. There is a little acknowledgement on the end of that one saying that—I can find that for you if you like?

The Hon. TREVOR KHAN: Sure.

The CHAIR: I am having a little difficulty hearing you.

The Hon. TREVOR KHAN: It is not your fault; it is the nature of these microphones.

The CHAIR: Please proceed.

Dr ROBERTS: It states:

> The steering group acknowledges the significant work completed by the Director of Obstetrics and Gynaecology, Manning Hospital, as part of the various look-backs and thank him for a commitment to the patient safety and women of Manning. In conjunction with this document a clinical report consolidating individual patients' care was undertaken by the director. The clinical report has been provided with this document. There are additional recommendations in the clinical report from the Director of Obstetrics and Gynaecology, Manning Hospital, which were outside the scope or jurisdiction of this look-back investigation. The Gayed steering group acknowledges the recommendations and the director's disappointment that they are not included in this report.

Essentially, I wrote a list of recommendations and those recommendations were summarised and then sent through a vote to the other committee members who were directors of communications, human relations, legal representatives and governance officials who ignored the initial request for a look-back two years earlier. So, no, I am not satisfied.

The Hon. TREVOR KHAN: I suppose I am asking this: There were some findings made in the 122 inquiry.

Dr ROBERTS: Is this Gail Furness's inquiry?

The Hon. TREVOR KHAN: Yes.

Dr ROBERTS: Well that is separate to mine.

The Hon. TREVOR KHAN: I accept that.

Dr ROBERTS: I think she came up with three recommendations that were rather woolly, in my opinion.

The Hon. TREVOR KHAN: Sorry, rather?

Dr ROBERTS: Were a little bit vague, not very specific. Three recommendations that really did not help fix the problem, I believe, in a practical sense. What we need are practical changes and solutions.

The Hon. NATASHA MACLAREN-JONES: Dr Roberts, could you elaborate a bit more? In your submissions you talk about—and I am summarising— the challenges of a VMO model. I would be interested to hear your views as to what you see are the challenges and potential solutions, and then to hear from other doctors here as well in relation to that.

Dr ROBERTS: So the challenges of a pure VMO model?

The Hon. NATASHA MACLAREN-JONES: Yes.

Dr ROBERTS: Okay. So for instance until late last year Port Macquarie and Coffs Harbour had a pure VMO model. There were no gynaecology outpatients for public patients. Essentially they were sending—I was receiving a lot of referrals for colposcopy, for example, which is a follow-up for an abnormal Pap smear, so to check if someone has cancer of the cervix. People in the Port Macquarie and Coffs district either had to travel hundreds of kilometres to get that care or go without, or pay somewhere in the range of $400 or $500. We are talking about pensioners who might have to have this test done every year under the new guidelines. It is not the fault of the VMOs, because the VMOs could be paid a sessional rate at a hospital. And some would probably be pleased to know one of the registrars I taught in Queensland I met at a conference lately, he is a GP, but he actually does the colposcopies in regional areas in Queensland, which is a great model. It is free and it is publicly funded. My problem is that there are not publicly funded clinics for the people of New South Wales in regional and rural areas.

The Hon. NATASHA MACLAREN-JONES: Do either of the other doctors want to comment further on the VMO model?

Dr HOLLIDAY: Suffice to say whichever way you go there are problems. I have worked in Britain where everybody is salaried and a lot of the consultants barely bother to come into the operating theatres during their sessions because they are paid the same whether they came or did not. And I have seen fee-for-service medical practitioners do exactly the opposite—just basically go for it in an excessive fashion. There are pros and

cons in every system. I have been a VMO and I have been a staff specialist. I do not think it has made too much difference to the way I practised and I have had registrars in both capacities. I do not think it is black and white.

The Hon. NATASHA MACLAREN-JONES: We were given additional documents in relation to BHI—the Bureau of Health Information. I noticed that the data is almost 10 years old. Do you have anything more recent?

Dr NARASIMHAN: First, I think all of you should call me Dr Sesh, like everybody in the region does. It is easy. I feel your pain. All the evidence which we have, which I have submitted and tabled, is what we have up to date. *The Heart of Inequality* report has overshadowed this, where it has clearly stated that the worst cardiovascular outcomes in regional Australia are in the Federal seat of Lyne. We live and work in the Federal seat of Lyne. The evidence we have submitted is 10 years old, correct. It is 2012 and 2015. But there is none up to date. Because the population is getting old—heart disease is an old person's game.

Once you are over the age of 60 and above—there are certain ethnicities in the world which have far earlier onset of heart disease. So the subcontinents, like myself—I only have baldness so I am okay—are particularly at high risk. We beat the Aboriginals in gold, silver and bronze in terms of early onset heart disease. We have a reasonable size of both communities living in the Manning. The BHI document—I do not think it is going to get any better, because the population is aging. The population is expanding. By the principles of common sense—if the problem is not appropriately addressed, it will not get better. I do not have anything else to provide. I have given you all that I have.

Dr HOLLIDAY: Could I possibly chip in there too? In my submission I put some references for Lyne. This electorate is the oldest electorate in Australia. Also, Painaustralia and Deloitte's report two years ago said the highest rate of chronic pain in Australia is in this electorate as well. So we also feature highly in issues like cardiovascular disease and diabetes and poorly in issues like socio-demographic factors.

The Hon. WALT SECORD: Dr Roberts, in your opening statement and through questions and exchanges that you had with Mr Khan, you made reference to a previous gynaecologist who worked up here. Now, you are referring to Dr Emil Gayed. Is that right?

Dr ROBERTS: Correct.

The Hon. WALT SECORD: Are you still looking after the patients whose lives he ruined—the 200 women?

Dr ROBERTS: Yes.

The Hon. WALT SECORD: I see your colleague next to you is also nodding his head. Why do you think that he was allowed to operate for 16 or 17 years by the local health district up here? Is it because of staffing shortages? They just looked the other way? What was the reason that you think he was allowed to act like a barbarian?

Dr ROBERTS: Honestly, I believe it was because there was no-one in a role with the proper level of expertise who could judge what he was doing. You need someone with the time and expertise to look into the complications and see if there is a common thread. That is what Gail Furness pointed out in those comments I made. It is not that a staff specialist is special in relation to a VMO but they have that paid time. They are not running a business separately. They are not missing out if they are doing this investigation. They are not missing out on seeing patients and making sure that they can run their business and pay their staff. You needed someone. And at that time the medical superintendent, who was in charge at the time, said that was why he did not pick it up. The medical superintendent who followed him said the same thing and the general manager said the same thing.

We all said that was what was missing. Because within nine months of me arriving there without having any forewarning of him—he is not there anymore. And it is not because—there is absolutely nothing special about me. It is just that there was someone in that role. There was someone there who had the time and means to check what was going on and follow up complications and see if things were being done correctly. Look, I can tell you stories about a woman who was 20 getting seven curette procedures in 13 years, none of which were indicated. In six of them—it is a diagnostic procedure. You are meant to get some tissue so it can be looked at. In six of the seven he did not get tissue. I do not know what he was doing. On the one occasion he got tissue it was because a registrar performed the procedure. He was putting the device in and waving it around so he could claim the money for it.

The Hon. WALT SECORD: Terrible.

Dr ROBERTS: I have tried to raise this as an issue because this aspect of the care is not being followed up.

The Hon. WALT SECORD: Do you think that the local health district ignored his activity—even if in fact signs came forward or questions were raised—because of a lack of staffing?

Dr ROBERTS: I do not think so, honestly.

The Hon. WALT SECORD: What about the women who suffered under his so-called care? What has happened?

Dr ROBERTS: I can say that in my opinion some of those complications were then understated.

The Hon. WALT SECORD: Sorry, understated?

Dr ROBERTS: They were under-investigated. The seriousness of them was understated. So there was a lady who had an infection following a hysterectomy and she ended up with gangrenous bowel. We are now 10 years down the track and she still has a stoma. She still has an enormous wound turning up. I can tolerate a complication if an operation has to be done. Complications occur. We all get complications. I am not complication free. So this was initially put in as what we call a severity assessment code [SAC] 2, saying this is a serious thing. It was downgraded to a SAC 3, saying it is a moderate temporary inconvenience. She still has a stoma. Do not tell me this is a SAC 3.

There was a case when a lady—he is burning the lining of the uterus as a treatment. You do not do this for postmenopausal bleeding. You do not do it if a person has a precancerous condition. He did it on a lady for postmenopausal bleeding and she had a precancerous condition there. She turned up a couple of years later a few months after he had his licence removed—or not renewed—and she died a few weeks later. It is because she had a procedure on a precancerous lesion on her uterus. I am horrified by this so I put it in as a SAC 1. You know, she is dead and she need not be dead. If she had had the correct operation she would be alive. And it was downgraded to a SAC 3.

The Hon. WALT SECORD: By who? Who downgraded it?

Dr ROBERTS: Someone in governance. I do not want to bring in third parties. And then I got in strife because I conferred with colleagues to see—am I insane? Is this not one of the most serious things you have ever heard? People from governance are yelling at me down the phone, "How dare you question this. Why are you asking other people?"

The Hon. WALT SECORD: Are you being supported?

Dr ROBERTS: I have not received as much support as we needed. And the women have not received as much support. The last time I spoke—Hunter New England executive have made it clear that this matter is over and they do not want to talk about it anymore. They made that clear to me two years ago—that the Gayed matter is over. "It's over. I don't want to talk about it anymore."

The CHAIR: Clearly, there is a legacy issue which is going to have a long tail for these women who obviously had this experience that will run into many years in front of us.

Dr ROBERTS: Yes. In gynaecology clinic yesterday two of the six patients in the morning were ex-patients of Dr Gayed. One of them was a direct—I saw her for follow-up of the procedure he did and I had an ongoing treatment. I think in the end, yes, she is going to need major surgery perhaps now, which perhaps she could have done without.

The CHAIR: Individuals like that, in a sense have they been red-circled as individuals who need to be particularly looked after, given they arose from these circumstances and their care is going to be obviously taken into account?

Dr ROBERTS: Last Friday I got called to theatre to see a patient because she was an ex-Gayed patient. Is that what you are getting at? They are highlighted like, "Oh, this could become a legal issue." For me it is not a legal issue, it is a medical issue. I want these women to be well and I want us to put in the steps to stop it happening again, even though it is painful, even though it is hard—and it is hard. I have spoken to secretaries of health, I have spoken to health Ministers. I have emails from secretaries of health saying, "We are not going to respond to your emails anymore. It is out of a frustration that things are not being done. It is hard and not everyone is in agreement, but you need someone. Unfortunately some doctors are not honest and some doctors are not safe. Even though the vast majority are, you need these safety mechanisms.

The Hon. WALT SECORD: Dr Narasimhan, you talked about working 80 hours a week as the region's only cardiologist. How does working 80 hours a week affect your ability to provide care to patients?

Dr NARASIMHAN: I am lucky that I only sleep four hours a day and I have boundless energy to burn. That is an advantage I have. It does not affect my ability to provide care but it incredibly frustrates me that I cannot provide the contemporary, current expected care to my community and my patients. I have been advertising for five years for a second cardiologist on my own time and effort. The phone call is unique. First I have to educate most Australians on where Taree is, which is interesting. As a naturalised Australian, I am educating the locals where the region is. The second question is, Do you have a public hospital? I said yes. The third question is, Do you have updated cardiology services, which is an updated coronary care unit [CCU], a cath lab and the ability to provide and treat heart attacks locally? I said no. "Any options?" "No." "Any future plans?" "No." "Thank you very much for your time." That leaves me in a position of no win and I have got to do this.

I agree with Dr Roberts that we need to have governance, we need to have the ability to provide and care for people. I have had similar experiences. I have met the health Minister, the current one, in his office in Sydney and I have asked questions. We are in a faraway area. I do not think we need cardiac surgery or neurosurgery in Taree, I will be the first one to fight it, but we need to have updated services so we can attract other specialists: nurses, pharmacists and other allied health care. We do not have an active pharmacy. The majority of our patients do not have pharmacy reconciliation because there are not enough pharmacists. There has to be a solution. Sweeping it under the carpet, like the royal family or *Downton Abbey*, is unhelpful. You have got to address this straight out.

The Hon. WALT SECORD: Doctor, if you are the only cardiologist in Taree, what do you do if you want to go on holiday?

Dr NARASIMHAN: Before COVID came in I visited my family in Dubai and I met my cousins after 30 years. I got phone calls because we had wi-fi and I got ECGs sent to me, which I answered and I said, "Sorry, I am in another continent." I have my colleagues, who are fantastic, who support to the best of their ability. We have an excellent network in John Hunter cardiology, who are very helpful and supportive. Before I came here, everybody had to leave to have everything done—meet people, have a conversation. We do not have all that, but it is still unacceptable. There is no point people acknowledging age and the oldest demographic but nothing is being done. "Yes, I understand", "I acknowledge", I feel your pain" does not save lives.

The Hon. EMMA HURST: Dr Narasimhan, you talked in your opening statement about this real disconnect. In your submission you talked about $20 million for 12 car parks and new beds that do not fit in hospital rooms. This all sounds quite absurd. How are these decisions being made? What is the fallout?

Dr NARASIMHAN: If I knew the answer, I would be the first to stand at the top of this building and share it with the whole world. There is no consultation. If we say, "We need a table and a chair to help this process get better," we go to our line manager or whoever. He or she goes up and then we get them saying, "Yes, everything has been acknowledged, accepted. We have read everything. We have submitted it to the ministry of health, politicians, blah, blah, blah," and we get a pencil. So $20 million for a car park. I do not even think that car park is functional, to be absolutely honest. We have an updated nice renal and oncology service. The problem is the local nephrologist was not contacted and his opinion was not sought to build the facility. If a person has something needing to be acutely done, like an X-ray, we cannot achieve it because it does not fit. Now they have built everything and then they have gone and refurbished it. The majority of the tradies in town are either patients or friends of mine. I can tell you how much money has been wasted on erecting scaffolds, pulling them down and re-erecting scaffolds. I have more information which I can share, but it might not be the place for it.

The decisions are being made by I am not sure whom, but I am 100 per cent sure they are being made by people who do not live and work here. Living in the middle of Newcastle or in Coogee Beach and deciding what the hell Taree needs is inappropriate. It is totally inappropriate because we are the ones who are here dealing with these sick patients. There has to be a better way, there has to be. Victoria taught us this: "Build it and we will come". It is called phasing in Victoria, and that hospital is doing well. Dubbo and Orange are an example. Port Macquarie was a fishing village when my wife, who is from this part of the world, was a young girl. They are a thriving metropolis and I am not sure why. Taree was the big hospital in the seventies where Katrina had her ear surgery. Now we are so downgraded, I do not even know if I can call it a joke. I am going to retire here, I am not leaving, but I have to—and my colleagues are going to help me—make this better because we have a community to support. We cannot just carry on the way it is. We are tough in the country but there is a limit to that.

The Hon. EMMA HURST: Dr Roberts, we have heard in other parts of this inquiry that the system around recruitment and retention is quite different in Queensland than it is in New South Wales. My understanding from your submission is that you have worked in both States. Have you noticed a difference? And, if so, what should we be borrowing from what Queensland does to make things better in New South Wales?

Dr ROBERTS: In terms of staff specialists and probably VMOs, I believe the pay scale differs based on the remoteness of where you are working. For instance, and no disrespect to Broken Hill, I would not want to

live in Broken Hill. I like living by the sea. If I was to live in Broken Hill, I would want to be paid more. I often see advertisements for working in Broken Hill, and they must really struggle because it is a long way away. The travel would be more grievous and it would be a difficult place to work. It is not rocket science, it is not brain science, it is not even orthopaedic surgery! That is a doctor's joke. That was really funny, actually.

The CHAIR: I think we needed a bit of levity. After the heavy-duty evidence today, a bit of levity is helping us all.

Dr ROBERTS: The other thing is that they are paid for when they are on call and for call ins. If you are living in regional or rural Australia and you are in on call one in four nights—I am on call two in seven nights, so I am on call Wednesdays and Thursdays. If you are on call one in four, you do not get paid for that and you do not get paid for on call. So you could be in the hospital from 6.30 in the morning till 6.30 the next morning and you get paid exactly the same. When I moved to Manning Hospital they said, "Yeah, that's true, but we'll give you time in lieu." There is no opportunity for time in lieu. It does not happen.

The Hon. EMMA HURST: Too busy.

Dr ROBERTS: In Queensland you are paid for call ins. So if you get called in and you are there all night, you get paid for those hours, which to me seems reasonable. If you are in a city hospital, you might be on call one in 20 and you are paid exactly the same amount. You have been on a six-year training program, five years of which you are in the city. Your spouse is in the city, you are working in the city, you have bought a house, the kids are in school in the city. We are trying to get people to move to regional and rural Australia and give up that thing, give up all that, and for what? Like you said, they do not know the lifestyle. They do not know how great it is to go a couple of kilometres off shore and catch snapper. They do not know what it is like. All they see is they have to sell their house, their spouse has to change jobs, the kids have to change schools and maybe the area does not have the sort of schools that they want to send their kids to, or they think they want to send their kids to. That is the difference in Queensland and that is why they do not struggle quite so much to get people to regional and rural areas.

The Hon. EMMA HURST: I have just one more quick question—

The Hon. TREVOR KHAN: I think Dr Narasimhan had something to say on the same subject.

The CHAIR: Doctor, do you have something you want to contribute to that answer?

Dr NARASIMHAN: Thank you. I have an appointment in Queensland Health as well. I go once a month and provide acute ST-elevation myocardial infarction [STEMI], or full-blown heart attack services, where I wake up at two in the morning, take them to the cath lab and stent them. I do that once a month in my exciting life. As Dr Roberts has eloquently summarised, that is an advantage Queensland has over NSW Health. If you take Broken Hill as an example and Manning as an example, I am fairly confident we are far better. We are not far from Sydney; we are not far from Port Macquarie or from Newcastle. We have vineyards and rivers and lakes; I live by the river. I am 53 and I will probably, hopefully, live to 80. The first half of my life I have spent training. The second half of my life I have family, children, practice, superannuation, retirement, making sure the children are sorted out. For a doctor, work is worship.

You tell a doctor to come here, "This is paradise. We have dragons, purple clouds, beautiful beaches, supermodels feeding you grapes and you can't work"—nobody will come here because half our life we spent training. To come to a place where the hospital is up to code is, I believe, a great step forward to attract staff. The majority of my surgical colleagues are over 65. We have two surgeons under the age of 50. When my surgical colleagues—and Dr Roberts' colleagues—who are over 65 retire or catch the A train, as they say in the world of cardiology, we do not have a plan to replace the surgeons. Cardiology and surgery or not very different. We are a dynamic speciality. You cannot get a surgeon to come and work in this hospital where there is no operating theatre. Nobody will come. It is the same thing. So Queensland has strategies to address—they have this public-private partnership. They have got a whole range of activities which they call upon which New South Wales, the first and the biggest State, has not. I hope that is helpful.

The Hon. EMMA HURST: Very helpful. Thank you.

Ms CATE FAEHRMANN: I will just say at this stage I could ask all three of you multiple questions but we do not have much time, so I only have time for a few questions, unfortunately. Dr Roberts, during your opening statement you referred to the fact that there are some recommendations in relation to the Gayed case that have not been acted upon. I would like to explore some of those if I may. You have said in your submission that "there may be dozens of Gayeds employed and acting without appropriate clinical oversight". You mentioned that essentially in terms of VMOs there is no-one to report to. So what checks are there in place for VMOs?

Dr ROBERTS: If there is no director in the—

Ms CATE FAEHRMANN: Yes.

Dr ROBERTS: I mean, within the hospital it is very difficult. As Gail Furness pointed out, you do not have the letters, you do not have the investigations, you do not have the reports. A person with complications can go back to their rooms and you just never know about it. There may not be anyone else in theatre with the knowledge to say, "Hold on, that's not what he's really doing," and if you have got those suspicions, there is no-one to go and have a look. The vast majority of VMOs are just honest, hardworking people.

Ms CATE FAEHRMANN: Of course.

Dr ROBERTS: I want to make it really clear because this has been misinterpreted. My issue is not with VMOs. I actually agree completely with Simon Holliday. I have worked with some staff specialists who were so lazy it caused me a great deal of distress. That is why you need a director there to make sure that staff specialists are working and that VMOs are not potentially doing the wrong thing.

Ms CATE FAEHRMANN: What are some of the key recommendations or themes, I think you referred to as well, that have not been addressed that you would like to raise this afternoon?

Dr ROBERTS: I think it is the lack of actually having clinical directors in various departments in regional and rural hospitals. The reason you do not have them is because you do not have staff specialists in that role. I am not saying replace all VMOs with staff specialists. I would not want that because you do have a private system out there that is taking the load off the public system. You need both, and I think you need both, but I think that some of those governance issues—well, I have seen it, those governance issues were not there. They were not addressed. I have had VMOs in this hospital say, "I wouldn't look at another doctor's notes. That's insulting."

That is the job as director. It is not fun. Last Friday we had a high-risk meeting, something that would never have happened unless there was a director there and a properly functioning unit, and someone was wanting to do something outside of the guidelines. They are wanting to do it out of the goodness of their own heart—they want to be kind for someone—but if our hospital does not have the correct equipment and safety procedures for that patient, that patient needs to go to a tertiary hospital, not with us. If there was no director there—there is no properly appointed director in some of the departments within the hospital and I am sure within a lot of NSW Health.

Dr NARASIMHAN: I agree with Dr Roberts. When I started in the Manning Hospital—I was the first Director of Medicine—I started as a staff specialist, but I was provided no staff specialist requirements, like a secretary and an office. So I spke to my senior colleagues, who advised me that that will never happen—they have been here for 20 years—and it is better you become a VMO. So most of the department of medicine are all VMOs. We now have co-chairs. After five years I stepped down, because it is only fair, and now we have got—finally the hospital has appointed two VMOs who co-chair. We have a very robust system at the department of medicine. We are the biggest department. We are the largest consumer of the resources because we have got the most patients.

Ninety per cent—80 per cent of the hospital patients are us; our physicians manage them. The surgical patients always have medical problems. As a VMO-driven department, we have got very strict guidelines. We have—because this is something which we all spoke as a group. I brought it in from my experience at John Hunter and overseas, and now we have just built on that experience. So I agree with Dr Roberts, but not every department and not every hospital which has got a VMO-driven department like us. As you all understand and hopefully acknowledge, this is not a VMO vs staff specialist problem; it is an individual problem. Unfortunately, we had a bad practitioner, who has left this whole region in disarray. But our department has got VMOs and we have got an official co-director system and we deal with everything appropriately and there are no issues.

Ms CATE FAEHRMANN: Dr Holliday I think also wanted to comment on that.

Dr HOLLIDAY: I think in the bigger picture we do not really have a system to make sure most doctors are performing at an adequate level, apart from waiting for complaints. All doctors have to do continuing professional development; that means usually attending education. But in terms of finding out when you have got the bad apples or whatever, we tend to wait on the complaint system. I think this is trying to close the door after the horse has bolted. When I was doing anaesthetics in the UK, we had morbidity and mortality meetings—M and M meetings—and it was not just the stats; morbidity is when you have a problem from something you have been involved in and mortality is when someone dies. I think it would be really good maybe for us to make discussions with our peers more comfortable, where we do say, "Look, I did this and we didn't have a really good outcome", or "we had a terrible outcome." I think if we get doctors working together and supporting each other and commenting on each other's work and feeling comfortable trying to improve the services that we all provide together to the public, that would be a good thing.

Dr ROBERTS: I think it is too easy to just blame one individual as a bad apple that operated within a system and the system did not detect it for decades. I think Gail Furness' report, in answer to your question, was more about how that was allowed to happen across areas and then within the hospital.

Ms CATE FAEHRMANN: I have one last question. What has happened to that report? Who did you submit that to in terms of your themes and recommendations, and is it up for public viewing or could the Committee see it?

Dr ROBERTS: I believe it is confidential. I have been able to send it to the Committee as a confidential report. I believe that has been sent to you electronically.

The CHAIR: Doctor, I will arrange for the Committee secretariat to liaise directly with you in regard to that document so it is treated in the way that you just requested. Gentlemen and doctors, thank you very much. It has been a real privilege to have such distinguished witnesses all on one panel this afternoon. You have obviously collectively spent many years of dedicated work on the mid North Coast and I am sure the community is all the better for it in terms of their health and wellbeing. On behalf of the Committee I would like to thank you for that contribution and the ongoing contribution you make. I hope that we ultimately can produce a report with recommendations that will pick up some of the key ideas that I am thinking have been brought forward this afternoon. Thank you all very much, it is appreciated.

(The witnesses withdrew.)

ALAN TICKLE, Private citizen, sworn and examined

MARION HOSKING, **OAM**, Private citizen, affirmed and examined

The CHAIR: Thank you both very much for coming along this afternoon. I acknowledge and thank you both for your submissions to this inquiry. They have been received and processed and stand as submissions to the inquiry and are evidence to the inquiry. Mr Tickle, yours is submission No. 222 and, Ms Hosking, yours is submission No. 32. I also note for the record, Mr Tickle, that you have provided some further material this afternoon: a copy of a letter on the letterhead of Leslie Williams, MP, and a document which is with that, titled *Hunter New England Lower Mid North Coast Child Clinical Services Plan 2013-2017*. Can I invite you to make an opening statement? If you can keep it reasonably tight, that maximises the opportunity for questions.

Mr TICKLE: Thank you, Mr Chair, and distinguished members of the parliamentary inquiry. I will also acknowledge the Elders past, present and emerging. I think reference to that is highly applicable given that something like 6 per cent of the population in this area is Aboriginal and Torres Strait Islanders. I would also like to acknowledge in the audience Liz Hayes. I think the whole of this area is indebted for some of the aspects that she has raised in the *60 Minutes* program, which brought a lot of this to light.

In the opening statement, I will cut to the chase. I will touch on aspects of governance, probity and accountability, which is in the submission, and cut straight to the chase and pick up what other speakers have alluded to. If we look at the history of the Manning hospital, 16 years ago the North Coast health district from Tweed Heads down to Taree was run out of Lismore. With the stroke of a pen, sometime later there was a split where you had the North Coast district from Tweed Heads down to Coffs Harbour, Coffs Harbour then through to Port Macquarie.

It is worth noting the difference in the number of hospitals and population that those health districts serve in contrast to Hunter New England Local Health District. The Mid North Coast Local Health District has seven hospitals and 211,000 people. The Northern NSW Local Health District has 12 hospitals and 288,000 people. Both have direct budget allocations and continue to grow in resourcing while Manning hospital has suffered. It is also worth noting that the catchment that is served by the Manning Hospital is actually larger by population than the catchment of Port Macquarie hospital. You can understand the disquiet. The catalyst was in 2016 when I was at the time deputy mayor. I chaired a public meeting concerning the resourcing of the local hospital. That mobilised the community to say enough is enough.

I was also the trustee chair of First Steps Count organisation, which is involved with early intervention for early childhood and which has also been highlighted by earlier speakers. I want to contrast the Hunter New England Local Health District, which is made up of 38 hospitals and a population of close to one million people. Further concern is the make-up of the board of the Hunter New England Local Health District. There is one representative from Forster and the rest of the board is dominated by the New England district and the close environs to Newcastle. I put it to the distinguished parliamentarians that there has been discussion about the role of the local health district and where Manning ought to reside. My concern is that in the previous health district we were the bottom end of Lismore, now we are the top end of Hunter New England.

I think it is incumbent upon the Parliament—and I am looking here at three levels of government: local, State and Federal—to work out what their role is. It is absolutely abominable and disgraceful that during the period of COVID-19, State of Origin occurred where the Premier of Queensland put up a line and said, "No, you shall not go into the Brisbane Hospital, which is largely funded by the Federal Government." It is critical that we look at the role of John Hunter Hospital and how it services the likes of Port Macquarie in another health district. If the will is there to recognise that the Manning hospital more appropriately belongs in the Mid North Coast district, there be adequate compensation with additional funding to allow for that from the Parliament and that the role of John Hunter Hospital in servicing that area is not lost.

Some of the concerns I have had relate to probity when I look at the board. I have found a massive difference in accountability from health district to health district. One only has to look at the various websites of the various health districts to question: Where is probity? Where is accountability? Where is the governance flowing down from the Ministry of Health where there are KPIs? And where is the accountability to the Minister? There is a laissez-faire attitude where we will set our own policies without any accountability, which I pointed out in the submission by contrast to what occurs in local government, for example.

The board minutes I see from Hunter New England Health—they are supposed to be meeting monthly, yet in 2020 the minutes appeared of six board meetings. In 2021 so far, the minutes have appeared on the website for February 2021 only. What is apparent when I look at those minutes is report number such and such—no report. Report on such and such—no report. Report on something else—noted. There is a complete lack of resolution

from the board, complete lack of accountability, benchmark and indeed outcome-based expectations of the board upon the CEO and those who serve at Hunter New England Health. I got really excited when I saw mention of Manning hospital, and that was all about a name change.

Then we saw some board minutes referring to the challenges of the clinical services plan, which this community started agitating to have addressed in 2016. You will see in front of you, the date says 2013 to 2017 and now we have 2021 where finally there has been sign-off on a clinical services plan. Yet we find the irony when we read through the notes from the 2013 clinical services plan, which states that in tying building projects to clinical priorities, there has to be a link to clinical services. Yet the health board did not think it was appropriate to actually pursue and update the expired clinical services plan. Page 22 highlights the challenges that occurred for Manning hospital and how to meet those challenges is, "Okay, people, go to Port Macquarie or you go to Hunter New England Health."

Much of the problems we have now were highlighted in 2013, yet nothing was done about it until this community said enough is enough and drove it to the extent where it became an election issue at the last State election and we had a bidding war. "Here is $60 million. We will call you and raise you by another 40; now it is $100 million." Yet, when that was put to the CEO of Hunter New England Health—if you are going to get $100 million, you might as well build a new hospital. But what are your priorities? How are you going to manage the money when we get it? When we get it we will work out the priorities and how we are going to spend it.

Members of the inquiry, I point out that that money is not yours; it belongs to the taxpayers. It is not for you to put it out for political opportunism. If an organisation, whether it be local government or whether it be a community group, went to a State government and said, "We want a grant," there needs to be a business case that needs to be outcome-based to justify that grant. Yet, political opportunism allows money handed out without a business case to justify it—not good enough.

The whole issue around probity—if we compare what occurs with local government, and it goes to all local government areas, you will start with a community plan. That will cascade down to an integrated planning mechanism that is non-negotiable. The oversight is from the Office of Local Government and much of the planning instruments, in fact, have to be signed off by the planning Minister or the Minister for Local Government. But the same appears not to occur when it comes to the vitality of public health in New South Wales. Where is the accountability from the Department of Health in how health districts operate, how boards operate, the accountability of boards and how people in regional areas will get their fair equity? It is not good enough, public health is suffering and the regions have said we have had enough.

The CHAIR: Thank you, Mr Tickle, for that frank and forthright opening statement. Ms Hosking, would you like to make an opening statement?

Ms HOSKING: Yes. This will be sort of male-female.

The CHAIR: That is okay. If we could keep it to maybe two or three minutes and then we can open up for questions.

Ms HOSKING: I have changed my thing because of what I have heard. Strangely enough, I never thought I would be saying I have been through this—well, 30 years ago. We came to Taree 40 years ago—Marion, don't cry!—and became involved, as I was in Sydney, hence the OAM—for what it is worth these days, Peta Credlin. I had been working for women's issues and came up here. The long and short of it was we got a women's refuge going. It was highly successful, federally funded, State-managed, community-based. Everyone was employed. The First Nations people, for the first time they had proper jobs. I cannot remember how many years. Two or three or four years ago, all this stuff that you are talking about starts happening.

I will again cut the story short and say that we now no longer have the refuge and neither have a lot of people up and down the coast. They gave it to the Samaritans, a non-secular religious organisation. Ours was a secular organisation. They just handed it to them, without reference to the president or the committee. It was just as you describe—before you know it, they jump on you and it is gone. So we are in the process of losing our hospital. I tell you what, it is that close. If you do not do something about it you will not have a hospital. "Oh, it is just down the road to Newcastle"—that is what they will say and that "They don't need a refuge. We have got police. We have got 1700 RESPECT", or whatever they call it. It is nothing. I have been through it and I know it will happen. So I accepted this offer to submit my views in general and my impressions and experiences of Manning Valley health and hospital services—this is where I have got to be careful not to cry—because my son died.

The CHAIR: Take your time. Have a sip of water.

Ms HOSKING: But you cannot be here forever.

The CHAIR: No, that is okay. Take your time.

Ms HOSKING: On the one hand, the State spent thousands of dollars on taking him for trials. It was very much appreciated at the time, because each trial you think, "This is it." But while they spent thousands on his trials, they then already have the heap of dead ready to toss him onto that. So when he comes back and this trial does not work and that trial does not work—"No, Rick, it doesn't work"—then it is, "What will we do with him? Oh, there is a heap of dead over there at Karingal, dead or dying. Toss him over there." Which they did, without reference to me. Could you read this bit? Because I think you should.

The CHAIR: Thank you. Is that in your statement that you are wanting to present?

Ms HOSKING: No, I will try and make myself. I got there one day—I went every day—and up at the end—you cannot be here forever. Just wait there.

The CHAIR: If it is in your statement, Ms Hosking, it might be easier if—

Ms HOSKING: It is only when I talk about that.

The CHAIR: That is okay. It is very difficult. I understand. But if the statement comes forward to us we will have that—

Ms HOSKING: You can have it.

The CHAIR: —and that will provide the detail perhaps of what you are wanting to—

The Hon. TREVOR KHAN: Mr Tickle might be able to read it, if that is what is being asked.

The CHAIR: Did you want to perhaps pick out the paragraph that Ms Hosking—

Mr TICKLE: Yes.

Ms HOSKING: He is a friend.

The CHAIR: Of course.

Mr TICKLE: On behalf of Ms Hosking:

> My personal experience during my son's dying days was disappointing. While he was at home, a nurse appeared at intervals, leaned into the doorway of his room and asked in a merry voice, "How are your bowels, Rick?" By not entering the room, she was indicating she was in a hurry. Rick was also visited by two kind males who, on one occasion, advised Rick to go to hospital because of cellulitis setting in. They were kind but did not visit regularly. It was never suggested that Rick be supplied with a particular bed. My son was never visited by palliative care—if so, it was without my knowledge.

Ms HOSKING: You will never ask me again, will you? The thing was, I got there to Karingal. It is very fresh, very clean, very bright and you think, "Oh, this is not bad. This is pretty good." But they have no nurses. They might have one or two, but not enough staff. Anyway, he was right up the end of the corridor, naked and looking like this. Faeces were right up the corridor. So I dashed up to get him and bang the thing.

The CHAIR: The buzzer, yes.

Ms HOSKING: Up came the poor nurse, two steps at a time up the granite steps. If she had fallen she would have killed herself. So she comes up two steps at a time and rushes in. He had walked past his ensuite, looking for a lavatory and ended up there. He was trapped. They brought him back and cleaned him up. Just imagine what they had to do. They cleaned him up. Then the other awful thing—perhaps you cannot avoid it, I do not know—the last few nights I stayed with him and two husky men in white coats, like something out of a horror movie, stomped in, turned him over to stick morphine in and out they go. He is trying to fight a bit but cannot. After the second night of that—with no reference to me again, as if I am not there—I then went out to the head nurse or whatever she was and said, "Dr Keegan authorised a morphine"—what do you call it?

The CHAIR: A syringe driver, for the pain control.

Ms HOSKING: Yes, a morphine driver. "Will you please put that on?" I was told, "In the morning." I said, "No"—well, to cut a long story short there, I am shouting. Finally they said, "Well, he can have it when a chemist brings it on his first round." So, first. It went right down the track. He was going to come at the last round or the second last round. Fight, fight, fight. So, finally, they put that on. I think that was my last fight.

The CHAIR: I suspect it is probably not your last fight, Ms Hosking. You strike me as someone who is a very determined and a very compassionate woman. We thank you very much for being prepared to share a very personal—

Ms HOSKING: But can I say something else now?

The CHAIR: Please, yes.

Ms HOSKING: This will improve me. Not improve me, but get the other side of me going. We are talking about a government up here—not here—that hates government. So it has a dilemma, doesn't it? It wants to privatise everything, but it does not dare come along and privatise the favourite hospital in Taree. So it gives them bits. "Change your name", "Here, go and buy that MRI" or whatever it is, "Here, have a bit of this and have a bit of that." But what they really want is to get rid of the government hospitals. They want to get rid of Medicare and they want to get rid of government health because that is not their thing. It is like asking me to take on their attitudes.

The CHAIR: Thank you very much. We might move to the questioning now. We have got a bit of a time constraint, which is no-one's fault in particular—it is probably mine, as the Chair.

The Hon. TREVOR KHAN: Yes, it is yours.

The CHAIR: Yes, it is always mine.

Ms HOSKING: Have I said the wrong thing?

The CHAIR: No you have not. No, I am blaming myself in all respects, Ms Hosking. So if we do five minutes each, how does that sound? We will see how we go.

The Hon. WALT SECORD: I will be very short, Chair.

The CHAIR: That is fine. We just want to make sure we can get through this.

The Hon. WALT SECORD: Ms Hosking, thank you for your evidence. It is very intimidating and very difficult to sit here and answer questions and address us, so thank you for sharing that with us. Mr Tickle, you made mention about the clinical services plan. I remember when I was shadow health Minister, about five or six years ago, there was talk of updating the clinical services plan to put it in line with the needs of the community. So is there a new clinical services plan or not?

Mr TICKLE: I believe that has been signed off and my understanding is that the CEO of Hunter New England Health, Mr Michael DiRienzo, has kindly offered to present that to the key stakeholders who have given input into that document, which we certainly look forward to.

The Hon. WALT SECORD: Have you or the community seen the document?

Mr TICKLE: No, we have not.

The Hon. WALT SECORD: Have you had input into the document?

Mr TICKLE: Yes. The community had input into the document and I was privy to part of that input, yes.

The Hon. WALT SECORD: What were the key recommendations that the community had? What do they think is the key to improving—let's name the issue properly. Manning base is in trouble.

Mr TICKLE: The community highlighted needs, certainly. That has been called out by various speakers. I will pick up on something that Dr Simon Holliday spoke about earlier and also Dr Roberts. There is a concept which—I did meet with Dr David Gillespie in his capacity of the assistant Federal Minister for Health. It is a concept around "grow your own". What we are looking at is where you have university attendees, whether it be nursing or whether it be medicine, to have some HECS discount, some indenturing or some bonding to bring them back to this area. That was something that—I guess there was a change in the Federal budget where there was some consideration of that.

We certainly need to incentivise because the problem we have at the moment is the revolving door of appointments coming to the area and then disappearing. Picking up what Dr Roberts spoke about with VMOs, the VMO model that has worked in Port Macquarie, Coffs Harbour and has served us well in the Manning area, needs to be encouraged. It needs to be incentivised. There needs to be some incentive for trainees to work under the VMOs because if there is the revolving door of those in the public system, it needs to be picked up by the VMOs. While there was one slip through with Dr Gayed, which was really a product of someone coming from overseas and not properly vetted in the first place, the VMO model has been serving this community well. It is disturbing that that needs to be encouraged more because I do not think it has been. Case in point is obstetrics and gynaecology.

The Hon. WALT SECORD: You made reference to a debate about a name change to the hospital. What is that?

Mr TICKLE: There was the public perception that calling us a Manning rural referral hospital is a downgrade—it is an insult. The preferred name was Manning Base Hospital. Of course, we considered ourselves a base to service this area and that was the preferred name so it has been renamed back to Manning Base Hospital.

The Hon. WALT SECORD: What is it currently called, officially?

Mr TICKLE: My understanding is Manning Base Hospital.

The Hon. WALT SECORD: When it is a base hospital it comes with certain levels of clinical care. Is that correct?

Mr TICKLE: One would expect that and it has been highlighted by other speakers that you would expect to have capacity for acute care.

The Hon. WALT SECORD: Do you feel that, in fact, Manning Base Hospital is a base hospital or is it a referral hospital?

Mr TICKLE: I believe that it is a base hospital, but there are certain aspects at the moment—because of resourcing—we need to refer outside.

The Hon. WES FANG: Ms Hosking wants to make a comment.

Ms HOSKING: I saw all these changes. It was Manning base and that was it, nobody questioned that. Then it was Manning rural and nobody questioned that. But I saw a little letter in the Taree Times. This woman said, "Why is it that my son is in Port Macquarie hospital with a broken arm when I live next door to my hospital?" That is Manning referral. He had been referred. For what reason, who knows. But that referral means a lot. Do not ignore that word. They have used that word for specific purposes. Do you agree with that, Mr Tickle?

Mr TICKLE: Yes.

The CHAIR: Thank you.

The Hon. TREVOR KHAN: I have heard a lot of the comments made today and I do not argue with a lot that is said, but I think Tamworth hospital is actually Tamworth referral hospital. It used to be Tamworth base.

Ms HOSKING: I am 94. Can you please speak up?

The Hon. TREVOR KHAN: Sorry. I will keep my voice up. Tamworth used to be Tamworth base hospital. For some few years now it has been Tamworth referral hospital and yet, in terms of Manning Hospital, some of the evidence today has been referring to the better services in hospitals such as Tamworth rather than at Manning. I wonder if, with respect, too much concern is being expressed with regards to a name as opposed to its categorisation under the system that is adopted by NSW Health. Do you have a view in that regard?

Ms HOSKING: I am very suspicious, as you can see. I do not think that is for nothing.

The Hon. TREVOR KHAN: You are entitled to be suspicious.

Ms HOSKING: They do not put a name there for nothing. They think about that name. They referred my son to Karingal.

Mr TICKLE: I think it is probably a fair comment, but I guess it is a slap in the face to the community to say, "Look, you're now a referral hospital." I think from the PR exercise, that was a silly thing to do.

The Hon. TREVOR KHAN: Sure. I must admit, I prefer Tamworth Base Hospital as the name. I still probably call it Tamworth base. I am just wondering if we could get hung up too much on a name.

The Hon. WES FANG: I can actually provide some insight into this because Wagga base hospital was renamed to Wagga referral hospital. The name "referral hospital" is to represent that—

Ms HOSKING: To refer.

The Hon. WES FANG: —it is a larger area that gets referred to. For example, places around Wagga would refer to Wagga base hospital. Wagga base hospital had been known as Wagga base for a number of years so there was a community movement and it was renamed back to Wagga base hospital from Wagga rural referral hospital. The name "referral" does not mean that they refer out; it usually means that they get referrals in. I will just address that one first. That is not a concern.

Ms HOSKING: I can understand that. But before that is was Manning rural. It has had three name changes.

The CHAIR: That was not a question, Mr Fang. That was providing a statement.

The Hon. WES FANG: I was addressing—

The CHAIR: Let us try to do this. We are in crossbench time and then the Government will have some time.

The Hon. TREVOR KHAN: Sorry, I assumed—

The Hon. WES FANG: I thought it was Government.

The Hon. EMMA HURST: I think Trevor had a follow-up question and that is why it moved over.

The Hon. TREVOR KHAN: I do not, but I do not want to chew up crossbench time so give it to us and then the crossbench can have their time.

The CHAIR: Let us get stuck into it.

The Hon. EMMA HURST: Thank you, Chair.

Ms HOSKING: Can I offer something else?

The CHAIR: Perhaps at the end. Let us get the questioning done first and we can return to it. Hold that thought.

The Hon. EMMA HURST: I actually have a couple of questions for you, Ms Hosking. As I understand it, you yourself were treated at Manning hospital about 20 years ago.

Ms HOSKING: Yes.

The Hon. EMMA HURST: I wanted to know how it has changed in that 20 years compared to what kind of service would be provided now.

Ms HOSKING: I had my first hospital experience at Manning base—or whatever, I do not remember the name—and I could not find fault with it, I don't think. The only thing I did want to say—do I dare say this about my doctors? That is right. I had pain. So I went to Dr A, the GP, and he said it looked like whatever it was I had. So I went and had an ultrasound and the ultrasound man said, "Oh, no, there's nothing. Only crumbs." So I went back to the GP and he said, "Crumbs are important. You had better go to Dr S and he will operate." So I go to Dr S and he says, "Yes, yes. That had better come out. The gallbladder." So out came the gallbladder.

It was not until much later that I was at Kurrajong for the weekend and I had this terrible night of pain. So along came the ambulance and took me to Windsor hospital, lovely Windsor hospital, with an amazing surgeon there. I died twice that night, so he said, because I had a gangrenous appendix. I do not know if anybody here knows what that it like. It is ghastly. I had 12 days of vomiting, I think, after the operation. I do not want to point the finger at doctors. I would not want to be a doctor in a million years. I think it is the most frightful job. They are not magicians. They cannot see inside you. So I do not blame doctors. But the system that holds the doctors up—the hospital—should be the overseer. They should be able to say, "We better look at that again. Do you think you really should be taking that gallbladder out? Perhaps it is something else." Or the terrible stuff they did to that woman.

The Hon. EMMA HURST: You are talking about that system and there was something in your submission that I was really concerned about and it is something that we have heard a bit of a pattern of here in this inquiry. You said that your son saw a gardener who was brought in to sit with a dementia patient and look after that dementia patient.

Ms HOSKING: Yes. That was one of the times he was in hospital at Manning Hospital. I think he went and came home a couple of times. It was lung cancer and he had had operations with cutting out the cancer. That is a hospital I call the wonderful John Hunter. Whether I really know what I am talking about I do not know but that is the way I feel about John Hunter. I went in there to see him and he said, "Do you know what, there was a demented man in the bed next to me this morning and they had no staff. They got the gardener to come up and sit with him." There was no reason to tell me that other than amazement. And I was amazed. Really, with Rick—this is a very unpopular thing I am going to say—I have volunteered all my life but I do not believe in it because it is all right to go and be the pink lady and put cream on the cake, yes. But we end up using volunteers and being ruled by volunteers.

You do not have a volunteer army, you do not have a volunteer police force, so why should people go and risk their lives in the bush as volunteers or go into the hospital as volunteers? No. I think it was volunteers who started the help during your dying days—palliative care. I nearly said something like that in front of somebody. They are very precious and they own their particular model of volunteers. But you cannot run a good

business or a good hospital or a good school on volunteers. That is what a lot of these governments are trying to do because it is cheap.

Ms CATE FAEHRMANN: Mr Tickle, you were referring to the LHDs and accountability, which I think is extremely interesting. Who does the LHD, and the people on the LHDs who are they accountable to and who do they report to? Can you take us through that in a little more detail?

Mr TICKLE: It is a very good question that one. I was hoping that there would be some accountability to the public. You only have to look at trying to extract the current clinical services plan when it was announced—that part of it that has been signed off on. We were trying to get a copy of that but there is an issue there. Back to what I said before, I think it is a matter for the Parliament to ask that question through the Department of Health. Where is the accountability back to the Department of Health? One would have expected that the Premier's plan or the government of the day policy concerning regional health ought to be communicated, cascade down, then benchmarked and report back to make sure it is on track. I cannot see evidence where that is occurring. I have not got an answer for that but I believe the Parliament ought to ask for that and insist on it.

Ms CATE FAEHRMANN: Also in your submission you point out that experienced emergency doctors reported this new regime of triage.

Mr TICKLE: Yes.

Ms CATE FAEHRMANN: Could you expand further on that?

Mr TICKLE: Just by way of background, I have had for some years medical staff and VMOs meet with me in absolute confidence because the regime they were under and the threat for VMOs of complaining, staff complaining, the lack of credibility or understanding a whistleblower, they were in fear of complaining or bringing out issues that concerned them with the running of the hospital.

Ms CATE FAEHRMANN: Could I just ask for clarification. They came to you in your position as what?

Mr TICKLE: They came to me in my position as the community leader who had been agitating on behalf of the community. To answer the question, yes, it was pointed out by a senior clinician who had retired from emergency medicine. He said his observation is that what is coming out of the universities now, which is adding to the cost and causing a bog down in process in emergency, is that in years gone by the experienced clinician would take a history, they would interview the patient, they would look at their observations and see if there is a repeat of what is occurring in front of them of what happened in the past. Quite often they would make a diagnosis, do the treatment and perhaps they would need follow-up with their GP.

They would be satisfied and out of emergency. Many times it is a low socio-economic area where they cannot afford to go to a GP so they will present with something that is fairly simple. What has been occurring is that the modern doctor will order a battery of tests, unnecessarily, wait for them to come back, look at those results, do a diagnosis which is back to the obvious. They chew up time, chew up expense, add to the waiting time and finally that patient gets the obvious treatment that should have been in front by appropriate inquiry. That is his observation and I respect that because he is an extremely experienced doctor in emergency medicine.

The Hon. TREVOR KHAN: My concern is that we have one more round of witnesses. I think these witnesses have been very clear in their evidence.

The Hon. WES FANG: I just wanted to thank Ms Hosking, in particular, for coming and sharing your story. I pass my condolences to you for the loss of your son. Thank you for coming and being so open and frank with us. It has provided us with some invaluable insights.

Mr TICKLE: Could I just add that Marion Hosking is certainly a legend in our area. She got the OAM justly and she has been a wonderful warrior for women—women who have suffered at the hands of men—which we are all appalled with. She is certainly a warrior and a legend and very respected in our community.

The Hon. WES FANG: We can tell that and that is why I wanted to mention that.

The CHAIR: Thank you very much; we are most grateful.

Ms HOSKING: Thank you. Are we dismissed now, are we?

The CHAIR: Yes.

(The witnesses withdrew.)

PETER CHOI, Director of Medical Services, John Hunter Hospital, Hunter New England Local Health District, sworn and examined

MICHAEL DIRIENZO, Chief Executive, Hunter New England Local Health District, sworn and examined

The CHAIR: I commence by apologising for the lateness of the call. I hope you do not see it as disrespectful. We will provide you with plenty of opportunity to outline your contribution this afternoon. We understand it to be important and I do not want it to be seen as depreciated or diminished in any way by the fact that we are running a bit late. I do apologise and accept responsibility for going over time. We have had a number of important witnesses today and we just want to get through the evidence as appropriately as we can. Just to help with audibility for the audience, would you pull the microphones closer. As you would be aware the New South Wales Government, through the New South Wales Department of Health, had an omnibus submission to this inquiry which stands as submission No. 630. I am sure you are aware of it. It has been accepted and it stands as a submission to the inquiry. Committee members have seen that, studied it and are aware of its content. I invite an opening statement from you. Keep it within a reasonable period of time, if you do not mind—a few minutes.

Mr DiRIENZO: Thank you, Mr Chair. Firstly, I would like to acknowledge that today we are meeting on the land of the Biripi people and pay my respects to Elders past, present and future. On behalf of the district, I acknowledge the importance of this inquiry for our rural and regional communities—which, in Hunter New England Local Health District [LHD], we have many. They are asking us to hear their stories and learn about their individual experiences, and we are committed to listening and learning. Our staff work hard to ensure that people living in rural, regional and remote areas of the district have access to quality clinical care and experience the best health outcomes possible. Our staff have strong connections to the communities in which they live and are dedicated to providing the best care they can to their patients. Despite this commitment and a number of strategies employed over many years, we continue to face challenges securing the necessary clinical workforce for our large and expansive district on a daily basis. I know that we are not alone and that attracting and retaining the required workforce, especially GPs, to rural and remote locations is a problem being faced across the country.

Today we have heard many people talk about their challenges accessing care and medical workforce issues in our regions. I appreciate the bravery and the candour of those appearing as witnesses. While in most cases I believe that people receive quality care and good outcomes, I know there are occasions when this is not the case. If we as a health service have let you down, then I truly am sorry. Please know that your personal experiences matter to us and as a district we have a strong culture of inquiry and accountability and ensuring that we learn from every missed opportunity or adverse outcome. Health care is a whole-of-system responsibility and as a district we are committed to working with the Federal Government and primary healthcare providers to build a more sustainable medical workforce in our rural and regional communities. I genuinely hope this inquiry assists us in achieving this goal and I welcome any recommendations forthcoming. Finally, I have prepared some information about the environment at Taree and Gunnedah—I believe you were there earlier today—that I would like to table for the Committee. I have got copies available for everybody.

The CHAIR: Thank you for that opening statement. I acknowledge the specific comments you made. I appreciate that very much.

The Hon. WALT SECORD: Mr DiRienzo, why were the nurses protesting today outside Manning Base Hospital?

Mr DiRIENZO: My understanding is the nurses today outside Manning hospital were protesting against—it was a statewide dispute that they are having currently with the New South Wales Government around nursing ratios and pay rates. It was not a specific—

The Hon. WALT SECORD: It was not specific to your—so the evidence we heard earlier today was incorrect?

Mr DiRIENZO: No, I can only tell you that my understanding is that they were there today but the issues that they were making comment about or trying to bring to the Committee's attention are a statewide issue, not a local issue.

The Hon. WALT SECORD: So there are no problems at this hospital?

Mr DiRIENZO: I did not say that there are no problems. I am saying that the purpose of their action outside the hospital was a statewide action around nursing ratios and, of course, the recent pay rate.

The Hon. WALT SECORD: You made reference to Gunnedah and Manning hospital. How many operating theatres are actually in Manning hospital?

Mr DiRIENZO: Manning hospital? I believe five.[1]

The Hon. WALT SECORD: Are all five in use at all times?

Mr DiRIENZO: At the moment they are, yes.

The Hon. WALT SECORD: Has that been the case for a number of years?

Mr DiRIENZO: It depends on what you mean by a number of years. The operating theatres are there to provide the activity that is required. At the moment the hospital is doing a marvellous job in meeting their activity targets. If you are aware, during COVID unfortunately we were unable to perform a number of elective surgeries and we have been diligently across the district—and this hospital in particular has done its very best to catch up basically on the fact that we were unable to do elective surgery. As at the end of June we believe that the hospital will have achieved its target of having nobody waiting outside of its clinical time frames for surgery, which I think is a very good effort by all the staff.

The Hon. WALT SECORD: How many hospitals are in the Hunter New England LHD?

Mr DiRIENZO: Off the top of my head—I think the word "hospital" is a bit challenging. We have a huge number—

The Hon. WALT SECORD: Hospitals, multipurpose services [MPSs]—how many facilities are you in charge of?

Mr DiRIENZO: Quite a few.

The Hon. WALT SECORD: You do not know the exact number?

Mr DiRIENZO: I do not know the exact number.

The Hon. WALT SECORD: How long have you been CEO of the Hunter New England LHD?

Mr DiRIENZO: I have been CEO for 10 years. What I do know is that we do have—

The Hon. WALT SECORD: Okay, so 10 years.

The Hon. TREVOR KHAN: Let him answer.

The CHAIR: Yes.

The Hon. WALT SECORD: You have been CEO for—

The CHAIR: Order! This has gone very well today, I think. If we just go back and forth with the questions—so pose a question, answer and back and forth.

The Hon. WALT SECORD: Mr Chair, I accept that. So you have been CEO for 10 years?

Mr DiRIENZO: Yes, I have.

The Hon. WALT SECORD: How many hospitals and MPSs are in your local health district?

Mr DiRIENZO: Can I take the exact number on notice? We have up to 100 facilities across our district.

The Hon. WALT SECORD: Up to 100 facilities? Why would you say up to 100 facilities? You are including MPSs—

Mr DiRIENZO: Yes, if I can help you here, we have three tertiary referral hospitals. We have a number of—we heard earlier—rural referral hospitals, of which one has now been changed to being referred to as a base hospital, but it has basically the same role delineation as a rural referral hospital. We have a range of district hospitals. We have a range of community hospitals. We have a range of MPSs. We have a range of community health services, a number of outreach services. We have a number of remote health services. So I do apologise. The number is a large number. I do not know the exact number but I am happy to—

The Hon. WALT SECORD: Can I ask you a question? Why do you not know the exact number? Is it because it changes? Does a hospital suddenly close and reopen?

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[1] In correspondence to the committee, dated 27 July 2021, Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, provided a clarification to his evidence - "The number of operating theatres at Manning is actually 4, not 5 ...".

The Hon. WES FANG: Point of order—

The Hon. WALT SECORD: This is a fair question.

The Hon. WES FANG: I am going to take a point of order there.

The CHAIR: Stop the clock. What is the point of order? It seems to me the line of questioning was reasonable, but go on.

The Hon. WES FANG: Chair, the witness has already taken it on notice. He has provided an explanation as to why he is going to take it on notice. For the Hon. Walt Secord to continue down this path of questioning is only wasting his time but also it is badgering the witness. There is a procedural fairness resolution that we have all got to adopt. So I would ask the Hon. Walt Secord to move on.

The Hon. WALT SECORD: I take the Hon. Wes Fang's point. Mr DiRienzo, you can take the exact number of hospitals and medical facilities that you are in charge of on notice.

The CHAIR: I will intervene here because I am quite unsure about this. The question started off with hospitals. Then you went through and named a number of establishments, if I could describe it that way, or facilities, and then towards the end you added in community et cetera.

Mr DiRIENZO: Yes, because we provide a wide range of services.

The CHAIR: You need to be clear about what the question on notice is for the purposes of actually answering. So it goes beyond bricks and mortar to other things. Is that what you are actually asking for in terms of—

The Hon. WALT SECORD: I would like both. I would like to know the number of hospitals, MPSs and facilities that you are in charge of. I would like to move on. Dr Roberts gave evidence earlier involving Dr Emil Gayed. You have been around for 10 years.

Mr DiRIENZO: Yes.

The Hon. WALT SECORD: He gave the impression that the local health district had said, "Okay, let's put that in the past." That was the impression that he gave. What about the ongoing treatment of those women who are still living in the community? What is the status of their cases before the local health district?

Mr DiRIENZO: Again, it has been a very sad situation for those women and, again, apologies for what they have gone through. We are continuing to provide support to those women. I think you heard Dr Roberts say that he is still treating some of those women in his outpatient clinics. I can give a firm commitment that the district and Manning hospital is continuing to care for those women and we will continue to care for those women.

The Hon. WALT SECORD: I understand that there was some movement to do a class action suit against the local health district from those women. Is that correct?

Mr DiRIENZO: I am not aware of the class action against the local health district, no.

The Hon. WALT SECORD: Are you aware of any legal proceedings or malpractice suits against the local health district?

Mr DiRIENZO: Not against the local health district, no.

The Hon. WALT SECORD: You said that there are around 100 services in your local health district. Does telehealth play a role in those facilities?

Mr DiRIENZO: Yes, telehealth plays a significant role in our facilities, a very important role. It is a role that complements and assists patients in not having to travel unnecessary distances where it is appropriate and also assists in us having clinicians who do not spend time travelling so they can spend more time providing direct clinical care.

The Hon. WALT SECORD: Are there certain things that you would say are no-go areas and you do not do them on telehealth? If you are at an MPS and you are a nurse on a weekend and there is no doctor, is telehealth the way to go?

Mr DiRIENZO: No. Our telehealth system is about providing that complementary care and care where it is appropriate. If you take the example you are giving of an MPS, we roster a doctor to be available to that MPS or to any of our hospitals in our rural areas. If we are unable to have a doctor on site, then what we do is we have a telehealth system where we have a doctor who is available to provide that assistance.

The Hon. WALT SECORD: Of the around 100 services, hospitals and everything you have under your purview, last weekend—and if you do not know this now, you can take it on notice—how many of those facilities relied on telehealth and had no doctor on the premises?

Mr DiRIENZO: I would have to take that on notice. I am better off taking that on notice.

The CHAIR: That is okay. Take it on notice, that is fine.

The Hon. WALT SECORD: Does your local health service rely on telehealth frequently on weekends involving MPSs?

Mr DiRIENZO: Not frequently, no.

The Hon. WALT SECORD: When a doctor is on the other end, the clinician that the nurse seeks advice from, is that person always from within the local health district or can they be from Newcastle or Tamworth? Can they also be from Sydney?

Mr DiRIENZO: We do not utilise Sydney. What we do utilise is our resources in our local health district. In some of our rural areas we actually rely on what is known as the Small Towns After Hours [STAH] program.

The Hon. WALT SECORD: Sorry, I am not familiar with that. Can you give a very brief explanation?

Mr DiRIENZO: Yes. It is an after-hours service that is in partnership with our primary health network. Our primary health network is also charged with providing after-hours GP coverage .Therefore where we have a hospital where the GP is not available, then we have very experienced general practitioners who work in the primary health network to provide that particular service.

The Hon. WALT SECORD: Is the STAH program you are referring to a service that is for profit? Is it a private enterprise that provides doctors for telehealth?

Mr DiRIENZO: It is funded by the Commonwealth through the primary health network. It is basically government funded in which it provides that service for backup, after-hours GP services where there is not an after-hours GP in some of our rural towns.

The Hon. WALT SECORD: Previously when we conducted hearings in Cobar, Deniliquin, Wellington and Dubbo, after I asked a series of questions about telehealth, a number of doctors and nurses came to me and said, "Yes, telehealth does have benefits and merits in situations, but sometimes we are worried when telehealth involves doctors who reside overseas." I say, "Do you mean foreign-trained doctors?" They said, "No, you're misunderstanding us. Sometimes telehealth is provided from Europe."

Mr DiRIENZO: We do not have any telehealth provided outside of our district. Can I give you an example?

The Hon. WALT SECORD: Yes.

Mr DiRIENZO: There is a wide range of different telehealth principles here. There is telehealth that we provide that actually supports our smaller emergency departments when they do get a particular patient—whether they have got a GP or a doctor in the hospital—they actually require specialist advice. We call them critical care cameras and critical care telehealth. We provide that from our two major tertiary centres. One would be providing from our John Hunter ED and ICU and the other one is from Tamworth through its emergency department. We have specialised emergency medicine doctors who provide advice to the doctor in the small hospital to help them treat that patient. That is one particular type of telehealth.

The Hon. WALT SECORD: Mr DiRienzo or Dr Choi, have there been occasions when deaths have been certified by nurses with doctors through telehealth, meaning they have put a person who has clearly passed away in front of the camera to indicate to the doctor so the doctor can then certify that the person has passed away?

Mr DiRIENZO: I will take that on notice. Not that I am aware—

The Hon. WALT SECORD: Can you also tell me how many times that occurred in 2020?

Mr DiRIENZO: Sure, I can do that.

The Hon. EMMA HURST: We heard today that often when there is funding provided, there is little or no consultation with local healthcare professionals on where that money should specifically be sent. We heard evidence that new beds were purchased that do not actually fit in the radiology rooms and that millions was spent on a car park that added just 12 new car spaces. What is going on here? Where is that communication collapsing?

Mr DiRIENZO: I am not really sure why the communication is collapsing. I think what you are talking about is the last two major capital works, or major expansions, to Manning Hospital. They were the last two projects. The first one I think people were talking about was our chemotherapy and renal dialysis units that we built. Following that, the most recent one is the much larger and expanded diagnostic and pathology centre that was built. Again, we did community consultation. They both had service planning as part of the establishment of those two projects. We had a number of staff involved; everybody was involved. If I can talk about the renal dialysis—

The Hon. EMMA HURST: It sounds like you are saying that there was consultation. But if there was consultation and people were working in those spaces, then how did these things happen? How are we now hearing reports that beds do not even fit in the rooms? Have you done any investigation? Are you planning to do any kind of work to find out what went wrong?

Mr DiRIENZO: I have not heard of any reports where the beds do not fit and so on, so I am happy to have a talk to the general manager and get more information. Definitely, it is basically quite clear that we need to have these spaces work effectively. What I can tell you is the feedback that I am getting from patients and that I am getting from our clinicians and staff using those areas, it is a major improvement on what they had and they are very, very happy in what they are doing, and we are getting compliments back from our patients. If I can just mention, Dr Choi is actually the leader of our renal stream and may be able to give you a little bit of information about one of those projects, which is the renal service.

The Hon. EMMA HURST: I will not go there because I have a very short amount of time.

Mr DiRIENZO: Sure.

The Hon. EMMA HURST: I have another question about something else that was brought up today about private charities fundraising to buy needed medical equipment. We heard from Manning Valley Push 4 Palliative, which said they fundraised and donated specialist palliative care equipment for Manning Hospital. Were you aware that this was happening?

Mr DiRIENZO: Yes. I have got to say that we are blessed with the number of organisations and people who fundraise for hospitals. They do it quite willingly and they do it passionately and they are committed to help the hospital get more and more equipment. But what I can say is we do provide equipment and while that particular organisation does a great job, it just means that it gives us more ability to purchase even more equipment across our hospitals. I do need to say that if for some reason they were unable to help us, then patients requiring the palliative equipment will get that palliative equipment.

The Hon. EMMA HURST: So you are saying you have not been providing that palliative equipment because these fundraisers have done it on behalf of the LHD but if they stopped fundraising the LHD would step in and pay for that equipment themselves?

Mr DiRIENZO: Exactly, and we do that many times. We actually welcome and appreciate what they do.

The Hon. EMMA HURST: We also received a number of submissions which raised concerns about the four-hour key performance indicator in emergency departments and how this was potentially leading to patients being discharged before it was appropriate just to meet that KPI. Are you aware of this and is any work being done to ensure that the patients are genuinely getting the help that they need and are being legitimately discharged within four hours?

Mr DiRIENZO: The four hours is what is regarded as best practice, you could say. We also have a range of other indicators to be able to satisfy us that at the end of the day we are still providing the best quality care. Those other indicators are not indicating in any way that if patients are able to be discharged from hospital or to be admitted to hospital that the four hours is creating some form of quality issue or safety issue. Just recently also at Manning Base Hospital we looked at some of that activity and we undertook an internal review of quality and safety within the emergency department. We discovered that it is performing extremely well and there are some areas for improvement that we are working with our clinical staff to actually address.

Ms CATE FAEHRMANN: Mr DiRienzo, going back to the evidence we heard this afternoon by Manning Valley Push 4 Palliative in terms of your responses just then to my colleague, that does not seem to match, with respect, the evidence that they did present today—like the fact that they have assessed that there are not essential services being provided in terms of palliative care and hence their needing to raise the money for it. I understand that, for example, they have had to co-fund for six months the palliative care clinical nurse consultant position.

Mr DiRIENZO: Sorry, I was referring to equipment when I was making those comments because I believed the question was around palliative care equipment provided.

Ms CATE FAEHRMANN: Let us stick to equipment then.

Mr DiRIENZO: Yes.

Ms CATE FAEHRMANN: They also said in their submission that "in order to have an adequate and accessible supply of essential items, the community has to source and buy its own".

Mr DiRIENZO: Yes.

Ms CATE FAEHRMANN: With respect, your evidence is suggesting that what the Manning Valley Push 4 Palliative is doing is something that they wish to do, just to volunteer for something to do. But their evidence was cleared today that the LHD is not funding palliative care to the needs demonstrated in this community. Do you accept that?

Mr DiRIENZO: No. All I am saying is that that group is working with us to ensure that we have appropriate and timely equipment to people with palliative care.

Ms CATE FAEHRMANN: The reason that they submitted to us today that they are fundraising—I am sure a lot of them would prefer to be having cocktails in the sun—is because there is not the funding provided in the services for palliative care. It is a very detailed submission. So you do admit that they have potentially requested to the LHD to fund certain things that you have not been able to fund? Is that correct?

Mr DiRIENZO: I am happy to take that on notice to make sure that it is correct. What I do know is that we provide equipment to palliative care patients requiring palliative care in the community.

Ms CATE FAEHRMANN: I am sure you provide equipment but you are receiving feedback within this community that there are not enough palliative care services for the number of people who need palliative care. This is services and equipment.

Mr DiRIENZO: But I think you are talking now about services. I was—

Ms CATE FAEHRMANN: Services and equipment.

Mr DiRIENZO: Okay. I was making the comment about equipment that we actually do provide equipment to palliative care patients.

Ms CATE FAEHRMANN: Do you provide enough equipment?

Mr DiRIENZO: I think some of our issues may be that it is the timing of when equipment is provided and then we need to work with other organisations to ensure that we get that right.

Ms CATE FAEHRMANN: Mr DiRienzo, I am sure you are in this position where you have to do what you need to do with the money that the Government provides you within the LHD. We have heard some alarming evidence this afternoon about the lack of ENT positions within the public health system. Have you advocated for more ENT positions within this LHD?

Mr DiRIENZO: Yes, we have. We have had a couple of attempts at getting ENT into the local community. It has been challenging and difficult. Predominantly it is the lack of available ENT specialists that wish to come to Manning and provide a service that is safe and reliable. Right at this moment we are working with the Mayo Private Hospital, who have been able to just recently get an ENT surgeon to come to Manning, and we are going to be seeing whether we can come up with some arrangement to provide some ENT or the formation of ENT through partnering with the Mayo.

Ms CATE FAEHRMANN: For public health patients, to reduce waiting lists from what we are hearing is four, five or six years—the LHD recognises that is a problem?

Mr DiRIENZO: Yes, it is a problem.

Ms CATE FAEHRMANN: Do you also advocate to the Government or the Minister, when you are talking with him at some point about the lack of health services in the region, for more public outpatient clinics, for example? We heard about this in Gunnedah and we have heard about it today the extreme concern at the lack of public outpatient clinics.

Mr DiRIENZO: Yes, we do. I think you heard Dr Roberts that we are the only local health district here that provides public outpatient clinics for gynaecology. We started that service here. In all of our clinical service planning and when we look at expansion of our hospital services, we prioritise outpatient clinics and do our very

best to increase our ability and our range of outpatient clinics. Again, we will be looking at that as we further develop Manning Hospital with its recent $100 million capital increase.

The Hon. TREVOR KHAN: Can I just ask you this? Some of the evidence we heard this morning in Gunnedah related to the use of locums in Gunnedah Hospital. I think you would agree with me that that is hardly a sustainable model. Would you like to comment on why that is being used and what you are doing to correct it?

Mr DiRIENZO: I agree, it is not sustainable. It is very high cost. If we can come up with better models and better ways to medically cover those hospitals, it would return a lot of our clinical budget back into more frontline services. We are relying on locums because of the inability to attract medical staff to many of those smaller hospitals, in particular the challenges with GPs in rural areas and the inability of the old GP VMO model going into the future. So we are looking at a range of ways to improve that. One of those complementary services I mentioned earlier is telehealth. An appropriate telehealth backed up by nurse practitioners and increasing the skill and scope of our nursing staff, increasing the range of allied health staff that can also help in those hospitals will go a long way to sustaining some of those services.

The Hon. TREVOR KHAN: The evidence was not effectively elucidated, I think, by me today but do I take it that one of the problems that you have had at Gunnedah Hospital is that you have actually had a reduction in the number of VMOs because GPs have withdrawn, essentially, interest in being VMOs in Gunnedah Hospital?

Mr DiRIENZO: Exactly, yes. There was a large number of GPs in the town and that number of GPs also worked in the hospitals on the on-call roster within our emergency department. Unfortunately, as those numbers have diminished, less are able to work in the hospital. We cannot rely on making it too onerous for the remaining GPs because we need them as well.

The Hon. TREVOR KHAN: Otherwise they will just walk out.

Mr DiRIENZO: Otherwise they will just walk. So what we do as best as possible is then bring in locum doctors to actually relieve the burden on the existing GPs as the first call and also make sure that we have got a doctor in the hospital as well.

The Hon. TREVOR KHAN: We heard some evidence by I think it was Kate Ryan, a nurse practitioner.

Mr DiRIENZO: Right.

The Hon. TREVOR KHAN: I am not trying to put you on the spot, but she in a sense put, I think you could say, a business case for the use of nurse practitioners, particularly in the area of diabetes, and that that be an outreach service into Gunnedah. I am from Tamworth. Are you attracted in terms of the proposition of nurse practitioners? I suppose the second question is: Where do you get the nurse practitioners from if that is going to be the model going forward?

Mr DiRIENZO: Good question. It is a challenge in itself. The answer is yes, of course. Hunter New England has the largest number of nurse practitioners across any other local health district.

The Hon. TREVOR KHAN: Again, can I just stop you there. What I would be interested in, either in your evidence here now or later, I think I am not being unfair when I say Ms Ryan was sceptical about the proportion of those nurse practitioners in terms of their location. Are they all in Newcastle? If they are not in Newcastle, where are those nurse practitioners?

Mr DiRIENZO: I can tell you that of the 50 or so, I think—I am happy to provide the exact number, but over 50—there are of the order of over 20 in rural areas.

The Hon. TREVOR KHAN: Does that mean they are all in Maitland or does it mean that they are actually more dispersed—

Mr DiRIENZO: I think what I can tell you if we talk about Taree, because I have looked at that coming here today, we have eight here in Manning, which I think is pretty good in relation to the number of nurse practitioners that we do have across the State. One of the things that we are doing is running a major program in gaining more nurse practitioners. The challenge, of course, is a bit like getting specialised medical staff, because we are talking now about specialised nursing. When we cannot get a nurse practitioner, we actually do our very best to upskill a registered nurse to provide not all those elements that a nurse practitioner can undertake but try to upskill and get some of those additional qualities that we do need in nursing in some of our hospitals.

The Hon. TREVOR KHAN: My final question goes to what I think is the elephant in the room, and particularly this room, but it really applies across the whole Hunter New England system, and that is the question of essentially the provision of network services. Why are you doing some things here or not here? Why are you

doing them in Newcastle, and I think I know that part? Why are you doing some things in Tamworth and not doing others? I want to understand the rationale for your modelling.

Mr DiRIENZO: I could spend the whole evening talking about it because—

The Hon. TREVOR KHAN: I could give you that opportunity.

Mr DiRIENZO: It is critical to the way that we provide services across our district and I believe it is critical to how we should be providing services going into the future to ensure that smaller hospitals and communities get access to those specialised services, which I think you have been hearing are very difficult and challenging to be able to, one, attract and then sustain and then, more importantly, grow. Could I just pass that question on to Dr Peter Choi? The only reason—no, sorry, there are a lot of reasons, but what I mean is Peter is actually leader in one of those networks, so it would be good for it to come from one of our clinical leaders on how they work and why they are important.

Dr CHOI: Thank you. I am grateful for the question. My background, I am a kidney specialist and a general physician and most of my working life has been around organising networks for what is a highly complex and expensive skill, to be able to provide it on an equitable basis in all the areas that I am involved in, and that has been here and also in the UK. This, I think in terms of the issues that we have been discussing, speaks to two things of great importance: one is the issue of retention of medical staff in rural and country areas; and the second is the safety of the clinical services that are provided.

The basic balance, if you like the payoff, is between having all clinical services locally provided against the understanding that there are many services that require scale, expertise and patient numbers. And that becomes more and more of an issue the more technical and specialised the area of medicine that you provide. This is not an issue that is unique to Australian medicine; it preoccupies the NHS, it preoccupies all public health services. What the evidence shows is that in some situations local services are helpful. But very often local services cannot sustain their infrastructure or the patient numbers for staff experienced to provide a fully functional service. And that is a really important thing because we have already heard today about the implications of employing someone to do a specialist skill that the facility could not provide. You have heard that very clearly and we have seen the consequences of that. So these are not small issues. For me, it is the nub of the whole focus of this inquiry.

So to answer your question, each network for each specialty has to be organised, depending on the locality, the services available, the staffing that is available and the specific service that is provided. But I can give you an example of the service I know most intimately, which is the nephrology service of Hunter New England. There are aspects of nephrology that are highly complex—transplantation—highly specialised services that can only be provided in Newcastle. We provide those services with a view to how we can sustain patients from more distant areas, from country areas, and then as we get to services that are less technical, that are able to be managed at a local level, then we work those through.

That is why we have a renal unit in Taree, that is why we have a renal unit in Tamworth and we have a network of community dialysis units. They are not managed in isolation by the local hospital management; they are managed as part of a network within Hunter New England, so all of the specialists can support each other in terms of their professional development in terms of again the issue that we talked about today, the audit and the monitoring of their activity and the outcomes of their work. I can tell you, for instance, that if we network our specialist unit in Taree, as we have done, we know that the outcomes there are safe because we are networked. I could go on. I am just wondering if I should stop. I don't know if I have answered your question.

The Hon. TREVOR KHAN: I think you are going to have another chance to reboot in another round.

The CHAIR: Can I just jump in with a couple of questions before we commence the new round? Did you want to allocate another 10 minutes each?

The Hon. TREVOR KHAN: I think the Opposition and the crossbench are entitled to their full amount of time. So we will see how we go.

The CHAIR: Let us do 7.5 minutes, but I will just jump in. With respect to one of the earlier questions today, it was a matter of when would be the public availability of the new Hunter New England LHD clinical services document? When will it be released and publicly available? Can you enlighten us in regards to the timing of that?

Mr DiRIENZO: Yes. Our clinical services plan is the document that the LHD produces and then basically it is approved by NSW Health and, once approved, the LHD, with hospital management, then is able to start to put in place the necessary elements of that clinical services plan.

The CHAIR: My question is: When will it become publicly available?

Mr DiRIENZO: Typically they are not publicly available documents. Our clinical services plan is usually for the local health district to introduce. What we do with clinical services plans is that we then come and consult and discuss with the community the main elements of the clinical services plan. If I can give you an example?

The CHAIR: Before you go on, I have a document in front of me which is *Hunter New England Health Lower Mid North Coast Clinical Services Plan 2013-2017* published in July 2013. That is obviously a publicly available document.

The Hon. WALT SECORD: No, I got that under a GIPAA.

The CHAIR: I withdraw that then.

Mr DiRIENZO: That is right. They are not publicly available documents.

The CHAIR: And my second question is—

Mr DiRIENZO: Sorry, if I can just mention—it is important—we have in place now a schedule where I will be during the month of July coming to the region and presenting to a range of our clinical and our community stakeholders the outcome of the clinical services plan and discussing the major elements and services that we intend to move forward with the new development. I recently did that at Gunnedah and it was taken very positively by the community.

The CHAIR: Thank you very much. My second and final question is this: With respect to palliative care, I think it is taken as a given about the population here and its growth and expected growth and the average age or median age and that ageing is taking place. You would be aware that there has been, I will use the word agitation, lobbying, call it what you wish, for not a 0.5 of a full-time equivalent palliative care specialist but in fact a palliative care specialist here. The people who are primarily involved in advocating for and articulating this are not happy, I think it is fair to say, with a 0.5 of a full-time equivalent. When can they expect to have a full-time palliative care specialist working in this area?

Mr DiRIENZO: We have listened to the community and our clinicians, and what we have put in place for the first time is actually an acute palliative care service, which was not present in the hospital. I think in the past we have been talking about community palliative care and the role that we play out there in the community, but we do now have a staff specialist—0.5 because the rest of the appointment is a university and research appointment. That particular specialist for us is playing an enormous role and I think we are very grateful to have the calibre of the person. We have got that—

The CHAIR: I do not think that is in dispute. We know the demography here. We know what is happening. When can people expect to have one full-time palliative care specialist based here in Taree?

Mr DiRIENZO: We are going to grow that particular service. We have now got a clinical nurse consultant [CNC]. We are now growing that particular service and we are going to let the director basically of palliative care, which is our new position, work with us in attracting more palliative care physicians.

The CHAIR: I take it that there is no timetable, then.

Mr DiRIENZO: There is no exact date at the moment.

The Hon. WALT SECORD: Mr DiRienzo, this morning the Bureau of Health Information data was released. It is independent data and it showed that 25 per cent of elective surgeries at Tamworth Hospital were not performed on time. Why are three operating theatres at that major hospital empty? We had evidence today that they are used for storage and places to make quiet telephone calls rather than performing surgery.

Mr DiRIENZO: The reason for that is that when Tamworth was redeveloped it was redeveloped with a plan that it would have the capacity to be able to grow into the future and to future activity. I only just recently spoke to the medical staff council last Thursday night about the prospect of utilising the sixth theatre. We went through a process where they do get access to that theatre at the moment and we are working together to see whether we need to access that theatre on a full-time basis as opposed to—we have been doing a remarkable number of additional surgery at places like Tamworth, as I mentioned earlier.

The Hon. WALT SECORD: It says 25 per cent are not performed on time, though.

Mr DiRIENZO: One of the reasons for that is because of the delays because of COVID and we were unable to provide—

The Hon. WALT SECORD: You cannot tell me that those three theatres were empty because of COVID.

Mr DiRIENZO: No.

The Hon. WALT SECORD: They were empty and not used prior to COVID.

Mr DiRIENZO: No, those three theatres have not been required because of the activity level of the hospital.

The Hon. WALT SECORD: I think the community might have a different view on whether they are required. Do you think it is acceptable that cleaners look after dementia patients at Manning hospital?

Mr DiRIENZO: I do not believe cleaners look after dementia patients at Manning hospital.

The Hon. WALT SECORD: That was the evidence we received earlier today.

Mr DiRIENZO: I will need to follow that up, but I do not believe the cleaners do that and if they were, I would know because I would assume that the cleaners themselves would want to bring that to our attention.

The Hon. WALT SECORD: You are going to investigate that. Nine out of 18 beds in the emergency department are funded—half. What is happening with the others?

Mr DiRIENZO: That is actually not correct.

The Hon. WALT SECORD: That is not correct either?

Mr DiRIENZO: No, it is not correct. The funding of the emergency unit is based on the activity that goes through the emergency department. It is funded on the patients that go through the department. There are no treatment spaces in the emergency department that are closed and not being utilised.

The Hon. WALT SECORD: Do you use short-stay units in Tamworth Base Hospital to get around the four-hour emergency department benchmark?

Mr DiRIENZO: Emergency short-stay units are a model of care in all of the emergency departments that have the ability to put that particular model of care in.

The Hon. WALT SECORD: So the answer is yes, you do use them.

Mr DiRIENZO: No, the answer is no.

The Hon. WALT SECORD: You do not use short-stay—

Mr DiRIENZO: No, we use short-stay units as a model of care in emergency departments.

The Hon. WALT SECORD: Yes or no?

Mr DiRIENZO: I am not sure what the question was again now.

The Hon. WALT SECORD: The question was very clear. Do you use short-stay units in Tamworth Hospital to get around the four-hour benchmark?

Mr DiRIENZO: Not to get around the four-hour benchmark. Not at all.

The Hon. WALT SECORD: Do you use them? Yes or no?

Mr DiRIENZO: No, we use emergency short-stay units as a model of care in our emergency departments to provide the highest possible level of care.

The Hon. WALT SECORD: Dr Choi, you are a medical professional. Do you use short-stay units?

Dr CHOI: No.

The Hon. WALT SECORD: You do not use them?

Dr CHOI: We use them but we use them for appropriate clinical care and not to fiddle the figures, which I think is the question.

The Hon. WALT SECORD: What do you use them for, then?

Dr CHOI: They are for short-stay clinical scenarios that do not require a full admission but that are longer than is required to stay in the ED—

The Hon. WALT SECORD: Are they in emergency departments, these short-stay units?

The CHAIR: I think you have had a fair go at this one.

The Hon. WALT SECORD: I am going to keep going, Mr Chair.

The CHAIR: I know you are a wilful man and you will continue for as long as I give you. I am saying no. It is over to Cate Faehrmann.

The Hon. WALT SECORD: You are a stronger man than me, Greg. I will back down.

Ms CATE FAEHRMANN: How is funding allocated between Newcastle and the rest of the LHD area? We have heard concerns that it seems to be quite Newcastle-heavy from witnesses in this area as well as Gunnedah as well as Tamworth.

Mr DiRIENZO: The funding is allocated to each hospital based on activity-based funding. Can I just make a comment? I heard earlier about the fact that the hospital here has reduced funding. You will see in the document that I have given you, in 2016-17 the budget for Manning hospital was just over $97 million and the funding for 2021, the year just about to complete, is over $118 million. That is an over 20 per cent increase in funding to the hospital. I do not believe that we have been reducing services over the past five years.

Ms CATE FAEHRMANN: Is that part of the upgrade that we have heard about? The $22 million in terms of—

Mr DiRIENZO: That was capital. This is recurrent funding.

Ms CATE FAEHRMANN: With activity-based funding, for example, with Gunnedah Hospital, today we heard from a number of witnesses and in the submissions that there are lots of people just being diverted to Tamworth. Does that affect the funding that Gunnedah is going to get then if less activity goes through Gunnedah Hospital?

Mr DiRIENZO: No, it does not. Gunnedah Hospital is funded on activity-based funding. It is also then provided with additional funding given that it is a rural district hospital and has additional costs, which metropolitan hospitals do not incur, such as the patient transportation cost to actually take patients, say, to Tamworth if they require a high level of care and the ever-increasing costs of locums. They are just a couple of examples of why their particular cost structure is higher than it would be in a hospital in metropolitan Sydney.

Ms CATE FAEHRMANN: We have heard this from some other hospitals that we have visited as part of this inquiry—particularly smaller rural hospitals—of this kind of vicious cycle, if you like, of less people going into the emergency department because they cannot be treated there or they have heard of poor service. They prefer to drive the 100 kilometres to the next hospital. That does affect activity-based funding, though, doesn't it?

Mr DiRIENZO: Those numbers are extremely low.

Ms CATE FAEHRMANN: Please. I am asking a very specific question here. It is a fact, isn't it, that with activity-based funding if you do not have the activity, the hospital gets less funding? It is a bit of a vicious cycle.

Mr DiRIENZO: The funding comes in different activity streams. There is emergency department, then there is inpatient, then there is rehab and so on. Also the funding is not just—

Ms CATE FAEHRMANN: Can we just stick to the emergency department? Again, it is just a fact. We are committee members trying to find information. Take it as a question from me wanting to understand how this activity-based funding works for emergency departments. With activity-based funding, it does fund the amount of patients coming through emergency departments. The less patients, the less funding for that emergency department. Every year it gets worse if less people are going through and tending to go 100 kilometres down the road.

Mr DiRIENZO: But as I said before, it also gets funding for the fact that it has higher fixed costs and it also has higher costs. I can assure you that the funding to hospitals like Gunnedah do not go down each year; they actually go up.

The Hon. NATASHA MACLAREN-JONES: I just wanted to follow on in relation to nurse practitioners. We are seeing a trend every year. I think it was about 100 additional nurse practitioners are being registered. New South Wales has a good fair share and overall I think this area has a good proportion of that compared to the State. As my colleague raised about utilising nurse practitioners more, what would you say in relation to it? Because one of the things that was raised this morning was about providing more support for nurses to take on becoming a nurse practitioner, similar to what we do with doctors in providing study leave or scholarships and things like that, particularly if you mark them purely for rural and remote areas. Is there scope for that?

Mr DiRIENZO: Yes, there is, and we currently have a fund available within the district. Within our nursing and midwifery unit, there are funds available for nurses who want to undertake further education or training. We actually can sponsor them and assist them in getting that higher education.

The Hon. NATASHA MACLAREN-JONES: Is that being utilised at capacity at the moment? What is the uptake?

Mr DiRIENZO: The uptake is that for anybody that wishes to undertake it they put an application in and they will get sponsorship.

The Hon. NATASHA MACLAREN-JONES: But are you finding there is a high demand for it or not?

Mr DiRIENZO: We find that it fluctuates. It really depends on the registered nurse usually wanting to undertake that particular type of program. It is quite a challenging program to undertake—nurse practitioner. We promote it heavily and then we also provide that assistance in that further education.

The Hon. NATASHA MACLAREN-JONES: The other question I have is in relation to bed numbers. It was raised this afternoon that the number of beds here is less than what it should be. First of all, I just want to know what the numbers of beds are and, secondly, whether or not they are at capacity or fully occupied?

Mr DiRIENZO: I have got that information for you in that particular information on bed numbers. We have 202 beds and of those 202 beds there are 20 specific mental health beds. I can tell you that right at the moment those beds are basically fully occupied. We have had an increase in activity across all of our hospitals across New South Wales and Manning, like all the rest, has seen an increasing number of patients requiring admission to our hospital. So, at the moment, in talking to the general manager, we are basically at nearly full capacity. We have been opening up what we call our "surge" beds, which is basically our seasonal beds. So what we have across the year is we know, and it is quite predictable, that during the onset of winter and winter there is going to be more reliance on the hospital with our aging population.

Of course, as we get into the summer months, there is less reliance on inpatients. So at the moment we are travelling with quite a large number of patients requiring admission. What we also do have is the ability—we have an arrangement with Forster Private Hospital which gives us the ability to utilise around 20 inpatient beds within that particular hospital to assist Manning Hospital where there are patients who reside in the Forster area and would be better catered for towards the end of their inpatient stay to be transferred to Forster and have care there. Some patients are prepared to utilise that.

The Hon. WES FANG: Dr Choi, I just wanted to touch on some of the points that the Hon. Walt Secord was questioning on earlier around telehealth. We have seen a lot of political attack on telehealth. There has been a run of questions in previous hearings around the provision of telehealth—for example, the doctors being overseas. Can you talk about sleep inertia and how that would affect a doctor here, getting a call late at night, versus a doctor that is fresh and awake overseas? I know a doctor that does telehealth provision in the Riverina for the United Kingdom. Do you know of other stories like that, where we have this reciprocal arrangement because they are awake during the day and so they are more able to provide timely responses to provide that telehealth support to medical staff?

The Hon. TREVOR KHAN: Accepting the evidence so far, they are not being provided.

The CHAIR: It is not utilised here.

The Hon. TREVOR KHAN: They are not being provided in the Hunter New England Health area from outside the LHD.

The Hon. WES FANG: No, but the Hon. Walt Secord actually raised it in this one today. I am just asking—

The Hon. TREVOR KHAN: I know what he did.

The Hon. WES FANG: I am asking for an opinion on it.

The Hon. TREVOR KHAN: But I am just worried if Dr Choi gives a different story—

Dr CHOI: I am not going to give you a different story. I was going to say that I am aware of those sort of arrangements. They make a certain amount of intuitive sense to me, but I have no experience of them. We do not utilise those sort of things, those sort of arrangements, in Hunter New England.

The Hon. WES FANG: I accept that. But have you heard of, say, colleagues in Australia that provide that reciprocal help where late at night in UK time is obviously daytime here and doctors are more awake and the sleep inertia issue is not a factor?

Dr CHOI: Yes. The other scenario in which that arrangement works is radiology reporting.

The Hon. TREVOR KHAN: Just a couple of things to you, Dr Choi, with regards to the network services. There is clearly in the evidence that we have received today, as you are aware, a push for expanded cardiac services in this area. Do you want to just address that issue as to why we are at where we are at and why you say, I assume, that this is the best model of care?

Dr CHOI: Yes. Look, I think it comes down to a very careful consideration of what is the best network to run for a particular area. In the context of a cardiac catheter lab, we know that is a highly specialised skill that is not reliant on a single specialist. Let us be clear about that. It is reliant on having specialised technicians and having the correct nurses. We know that if you do not put that together in the right configuration then your outcomes are not going to be good. So really the model of care that you have to use in terms of discussion is you have to get everything else in place and work iteratively. I mean, these are not one-off discussions that we are having. None of these things are set in stone right now. The view within my colleagues in the cardiac networks—and I do not want to speak for them, so I am going to be careful—is that the current arrangement, which is for acute myocardial infarction in Taree to be sent directly to John Hunter Hospital without touching anybody apart from the emergency departments, provides the most timely and the safest care.

The Hon. TREVOR KHAN: I have run out of time. There is so much more I could ask.

The CHAIR: Beaten by the bell, as they say. Gentlemen, we did push on. We did not quite get to the one hour that we had promised you but we are not too far short. I am sure that honourable members will have some supplementary questions to follow up for anything that they—

The Hon. TREVOR KHAN: And there might be another opportunity later on.

The CHAIR: Indeed. On behalf of the Committee, once again, I do apologise for the delay in getting underway this afternoon. We do appreciate that you are very busy in your respective roles, so I sincerely apologise. But thank you for coming along and thank you for the forthrightness in the way in which you have come along and presented the answers to the questions this afternoon. It is appreciated very much. We thank you for the important work and the good work you do for and on behalf of the New South Wales residents who live within the Hunter New England Local Health District. Thank you very much.

That brings this session to a close. I thank particularly those who are still with us, hanging in there. We do appreciate it. It just reflects the deep interest in matters of health in this neck of the woods, so thank you very much. For those on the internet who have joined us, it has been almost four hours pushing through without a break. I think everyone is quite tired now, so we are about to sign off. Thank you all very much and we look forward to joining back with people tomorrow in Lismore.

(The witnesses withdrew.)

The Committee adjourned at 18:53.