REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Jubilee Room, Parliament House, Sydney on Tuesday, 1 February 2022

The Committee met at 9:15 am

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Shayne Mallard
The Hon. Walt Secord

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

The CHAIR: Welcome to the fourteenth hearing of Portfolio Committee No. 2 – Health, Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales. My name is Greg Donnelly and I am the Chair of this Committee and this inquiry. 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 Gadigal people, who are the traditional custodians of the land on which the Parliament of New South Wales sits. I pay respect to Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginals viewing the broadcast today.

Today's hearing is being conducted virtually. I ask for everyone's patience through what may be, but we hope not, any technical difficulties we have during the course of the day. If participants lose their internet connections for any reason and are disconnected from the virtual hearing, they are asked to rejoin the hearing by using the same link as provided by the committee secretariat. Today we will hear from a number of local health districts whose jurisdictions include regional, rural and remote New South Wales. On behalf of the Committee I thank everyone for making time to give evidence to this inquiry. We know that you have very busy programs of work.

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

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 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 House in 2018. There may be some questions that a witness could answer only if they had more time or with certain documents at hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer to the Committee secretariat within 21 days.

Finally, a few notes on virtual hearing etiquette to minimise disruption and assist our Hansard reporters. I ask Committee members to clearly identify who questions are directed to. I ask everyone to please state their name when they begin speaking. Could everyone mute their microphones when they are not speaking. Please remember to turn your microphones back on when you are getting ready to speak. If you start speaking while muted, please start your question or answer again so it can be recorded in the transcript. Members and witnesses should avoid speaking over each other so that we can all be heard clearly. Also, and finally, to assist Hansard, I remind members and witnesses to speak directly into the microphones and avoid making comments when their head may be turned away from it. With those opening words I welcome our first witnesses for today, Mr Dowrick and Dr Tranter.

STEWART DOWRICK, Chief Executive, Mid North Coast Local Health District, before the Committee via videoconference, sworn and examined

RICHARD TRANTER, District Medical Director for Integrated Mental Health and Alcohol and Other Drugs, Mid North Coast Local Health District, before the Committee via videoconference, affirmed and examined

The CHAIR: Gentlemen, you would be aware that the submission by the New South Wales Government to this inquiry on behalf of NSW Health is an omnibus submission. I am sure you are aware of that and I suspect probably would have read it. It is submission 630 to the inquiry. Your specific local health district does not have a submission per se, but it comes under the umbrella of the omnibus submission. We will begin with our questioning. We have a time allocation through to 10.15 a.m. As you would be aware there are representatives from a number of parties on this inquiry, Opposition, Government and crossbench. We will be sharing the questioning between the three groups and rotating those. Are you okay if we proceed that way? Great. There is provision for an opening statement. I invite the chief executive, Mr Dowrick, to make an opening statement.

Stewart DOWRICK: I thank the members of this parliamentary inquiry for allowing me to appear on behalf of the Mid North Coast Local Health District. I acknowledge the many lands upon which we are meeting today and that I am appearing from Birpai land. I acknowledge the Elders, past present and emerging and pay my respects to those with us today who are Aboriginal. The Mid North Coast Local Health District extends from the Port Macquarie-Hastings local government area in the south, to Coffs Harbour local government area in the north, and provides healthcare services across a geographic area of approximately 11,335 square kilometres. It is estimated that up to 220,000 residents live within the district. People of Aboriginal and Torres Strait Islander heritage make up 5.7 per cent of the population, compared to 2.9 per cent for all New South Wales.

Over the next decade the district's population is expected to increase by 13 per cent. The largest increases are being projected for the Coffs Harbour and Port Macquarie Hastings local government area. In the district we provide healthcare services from seven public hospitals and 12 community health centres. The district has an expense budget of $740 million and we employ 3,800 full-time equivalent staff; 5,500 actual head count. Over the last decade we have seen a significant expansion of higher education presence, offering university and other tertiary opportunities to locals, and attracting students from across Australian and overseas. This has been helping us to build a stronger regional workforce in health, as we know if they study with us they are more likely to return to work with us.

Since July 2019 our region has experienced a series of disasters. After many years of drought we had a peat fire that burnt for many months, blanketing our region with smoke and causing some of the worst air quality in the world. This led into catastrophic fires across the whole district and was followed by one of the worst floods the region has experienced. Over this period I have witnessed the incredible work of our healthcare teams and the communities of the mid North Coast. I admire their resilience, I congratulate their ability to work as a team, and I truly appreciate the support offered by our healthcare teams and the community to each other in rebuilding lives after such devastation. Noting the disasters I just mentioned, the region has also had to deal with the impact of COVID on health care in regional areas. Looking to the future, COVID has reinforced the importance of partnerships and these will need to be strengthened in the future. Many of us are in awe of our frontline healthcare workers who keep turning up day in, day out to keep our community safe. I thank them again.

One of the most important lessons post COVID is finding solutions, now and into the future. To support this I am pleased to have recently been working with our governing board to draft a new 10-year strategic plan for the district. This plan will focus on delivering the key requirements for the future of health care, supporting our workforce and being an important part of helping to build a thriving, healthy regional community. Attending with me today is Dr Richard Tranter, Medical Director Mental Health, Alcohol and Other Drugs. I sincerely thank the members for this opportunity and welcome the discussion.

The CHAIR: Thank you, Mr Dowrick, for your opening statement. We will have the first tranche for 10 minutes, 15 minutes. That means you will not come back for a second time or a third time.

The Hon. WALT SECORD: Okay, thank you.

The CHAIR: We will get underway for about 15 minutes each, or thereabouts, depending on the flow. We will move to the first set of questions from the Opposition, the Hon. Walt Secord.

The Hon. WALT SECORD: I am Walt Secord. I am the shadow Minister for Police and I am Labor's representative on health in the Legislative Council. Mr Dowrick, in your opening statement you mentioned that there were seven public hospitals and 12 community health centres in the Mid North Coast Local Health District. You would be aware of evidence that we received from around the State that there were hospitals and MPSs,

particularly in western and southern New South Wales, that did not have doctors during certain periods. What is the status of having a doctor 24/7 at those 19 hospitals and community health centres in your local health district?

Stewart DOWRICK: Thank you very much for the question. We have one MPS in the local health district at Dorrigo; a 27-bed facility, 21 residential aged care packages and six inpatient, the beds combined. We rely on a workforce, a locum GP support for that hospital and for that service. We have 24/7 coverage there through the locum support there. Medical practitioners will come in during the day and support the patients and if we require someone after hours the locum as required during that time. So we have approximately 1,500 or 1,700 people attend the emergency department there. We have a [inaudible] supported by registered nurses during that time that are Flec trained. [Inaudible] emergency care problem, and if they require GP support.

The other hospital we have in the district, the smaller facilities such as Wauchope, for example, which is just west of Port Macquarie, we have clinical staff during the day. We have an urgent care centre, it has been there for a number of years. We converted the emergency department there to I guess an 8.00 to 6.00 p.m. service which operates seven days a week and provides like a GP type of model service there. We have palliative care sub-acute and there are medical staff there during the day but after hours it will be on call. In case of an emergency they will activate a surge response to have the ambulance service transfer patients to Port Macquarie or other place. It does not happen a lot but it is there and they have palliative care and Rehab facilities.

The Hon. WALT SECORD: Mr Dowrick, could I get you to speak into the microphone a bit. I did not actually hear the answer because the sound was not right. Were you talking about Wauchope District Memorial Hospital? Is that what you were referring to?

Stewart DOWRICK: Wauchope District Memorial Hospital, yes.

The Hon. WALT SECORD: My question is very specific involving the 19 health facilities. How many of the 19 facilities have a doctor in the hospital 24/7?

Stewart DOWRICK: We operate 12 community health centres. We do not have medical staff there located at community healthcare centres. Of those seven facilities two will not have 24/7 cover [inaudible] in the hospital itself, but they have on call available from other GPs or specialists available to support them like at Dorrigo.

The Hon. WALT SECORD: I ask a specific question; all of the hospitals and MPSs in the local health district that you represent have doctors 24/7?

Stewart DOWRICK: They have doctors available 24/7.

The Hon. WALT SECORD: What do you mean "doctors available"? Do you have to go to a medical hospital or a doctor comes in?

Stewart DOWRICK: Again, with Dorrigo there is a doctor available at Dorrigo after they care to come into the facility if called upon by nursing staff there at the hospital if they need to. The same with Wauchope, getting someone on call to provide support to that facility if they need to in regards to palliative care or with accidents or such.

The Hon. WALT SECORD: You would be familiar with recent concerns about safety of staff at hospitals in your local health district, particularly Port Macquarie where Health and hospital staff had pieces of skin ripped from them and they were attacked. Is it correct that you operate one of the most dangerous local health districts in the State for staff and patients?

Stewart DOWRICK: We operate very good facilities that are safe, very safe. We operate within the State security guidelines. That was a very difficult event last January. Five Health and Security Assistants were on duty for a very tragic event regarding delivery of a patient in the early hours of the morning. I do not believe that we operate unsafe or insecure facilities. We have very good security initiatives across the district. This was a one-off event. I have met personally with all the staff, the nursing staff, the medical staff involved with that incident and we're very careful to bring other staff through how to, I guess, implement change to learn from that activity that occurred. So, it was a very difficult event. I thank all those involved in supporting us through that process and I do sincerely apologise to those who were injured at the time, but I believe that staff did their best in the very difficult situation in the early hours that morning.

The Hon. WALT SECORD: Mr Dowrick, you said that there were learnings from the incident in January. What steps did the local health district take to protect patients and staff? Did you hire additional security staff? You said there were learnings. Can you detail what improvements were made after the Port Macquarie incident in January?

Stewart DOWRICK: Another thing had taken place, the violence prevention management training program, we are talking about this sort of security assistance or training. Over a number of years health security assistants at Port Macquarie Base had increased from over a number of years from 19 to 26 to 27 security staff in the hospital, or HSAs as we call them. There was an additional 1.5 HSA put on after discussing that with the HSAs at the time, to support that evening period from 4 to 11 o'clock at night [inaudible.] A lot of this is to do with this culture as well, to integrate in the whole clinical team, looking at how they action their take down procedures, how they work as a team, clinically with nurses, medical and themselves. There are a lot things we put on and also a district security manager to oversee across the whole LHD, those activities as well. So there are a lot of things we took in, but also supported training [inaudible.]

The Hon. WALT SECORD: Mr Dowrick, in your answer to my previous question you used the word "culture". What about the whistleblowers who came forward that made allegations that there was retribution about them speaking out about the violence in the local health district? What protections and what have you done to support the whistleblowers?

Stewart DOWRICK: We have a very good system to support whistleblowers. We have a very robust public interest disclosure and previously we have supported our staff to come forward if they believe there is something to disclose. We have very robust systems in place in accordance with the policies around it in the moment. We welcome our employees to come forward and speak with us and also raise issues that they see fit through the appropriate channels. We continue that culture and the training of OLHT ongoing and we regularly do that work.

The Hon. WALT SECORD: You gave sort of an in principle statement about whistleblowers in general, but what about these particular whistleblowers, and they publicly identified themselves? What measures and steps were taken to support them and what has been the outcome?

Stewart DOWRICK: One of those employees are no longer with us. They went through a workers' compensation process in regard to that. There were apologies given to those who felt and in reflection there were things we could have done differently in that regard, but we did give apologies to some of those individuals. Again, we wanted to support them as best we can through their workers' compensation program.

The Hon. WALT SECORD: You mentioned earlier about COVID in the regions. Do you have enough RAT tests to cover all of the institutions that are within your purview?

Stewart DOWRICK: Yes, we do. We are supporting also the aged-care sector and others about rapid antigen testing really through that care. So we do monitor that carefully and I believe we have enough to support all their needs entirely. And we also support the aged-care sector if they request some tests from us as well.

The Hon. WALT SECORD: This morning it was reported on ABC radio that elective surgery was going to resume in some rural and regional areas. What is the current state of the elective surgery waiting list in your local health district?

Stewart DOWRICK: At the end of December, and it would be your question end of December, we had approximately 7,300 people on our waiting list. That came down from 10,600, which was the figure at June 2020, because of the public health issues that we have experienced, including the bushfires and other catastrophic events we had to delay the surgery program again so we were able to make massive inroads and I thank all the healthcare teams, the local and district and others who supported us in getting that down. Regards to category B and C patients, at the end of December they have generally [inaudible] around about 230, 240 people were, B and C were over benchmark. That had come down from about 1,400, 1,500 from June 2020. So we have made good inroad, really pleased with progress. Still more to do and at the moment we are operating in the restrictions, or the change that had been put in place across New South Wales and LHDs.

The Hon. WALT SECORD: You would be familiar with the Bureau of Health Information data and there is a percentile, the 10 per cent of longest waits. How many people are waiting more than a year for elective surgery in your local health district?

Stewart DOWRICK: I have to take that on notice, I am sorry. I have not got that figure in front of me.

The Hon. WALT SECORD: If you do not have that—

Stewart DOWRICK: I do not.

The Hon. WALT SECORD: That is fine. I would like to know how many people are waiting—

Stewart DOWRICK: [Inaudible], say about 220 to 230 people who are category C over, B and C sort of, about 200 category Cs, so I have given it the 200. I can get those figures passed on, take it on notice.

The Hon. WALT SECORD: What are the longest waiting lists in your local health district? Can you give me in order? I will give you the categories: cataract, knee and hip, back, gallbladder, things like. What are the longest waiting lists in your local health district?

Stewart DOWRICK: In our local health district, again we know that orthopaedics is one of our areas for long waits, so cataracts as well, probably seven, eight months. Again, the last 15 to 20 months we have made a big inroad into the orthopaedic long waits with significant improvement in reducing those [inaudible] the situation we had before. We are seeing those times come down, but we are actually [inaudible] in time, sorry, in time.

The Hon. WALT SECORD: With regard to midwifery, are there currently vacancies for midwives at Coffs Harbour, Kempsey and Port Macquarie base hospitals?

Stewart DOWRICK: I am not aware that there are vacancies, but it would not surprise me. I can take it on notice. We have, because of COVID and issues that deal with recruitment of midwives across the LHD who deliver 2,200 babies across the region. I have wide respect for their services across the region but I have to take that question on notice and then provide information. I am not aware it is causing a concern. I do not know.

The Hon. WALT SECORD: Can I take you back to attacks on Health and hospital staff in Port Macquarie. Were there similar incidents at other hospitals in your local health district?

Stewart DOWRICK: We have a range of critical physical events, nothing like that [inaudible.] That was a one off, which the incident management policy in LHD we treat as a Harm Score 2. We undertook a very thorough investigation, shared the results of that with the employees and the Health Services Union and SafeWork as well, so that is an exception.

The Hon. WALT SECORD: I go back to the waiting lists. During the COVID period what were the areas of elective surgery that were most impacted upon? What lists grew by the most proportionately during COVID in your local health district?

Stewart DOWRICK: Again, I have to take that on notice, only because it affected more categories and I can only assume equally during that period we did category A. Again, if we added category B during that period, the Prime Minister made that announcement last March to make that change, I think 26 March or thereabouts in 2020, it would have been equally shared but I'll have to get that information to the Committee but it was shared across all categories regards to the composition.

The Hon. WALT SECORD: My time has expired.

The CHAIR: Moving now to the crossbench. First of all the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: I want to go back and talk a little about COVID. Obviously there have been a lot of media reports about the burnout and staffing shortages in the hospitals, specifically on the mid North Coast dealing with the current COVID outbreak. Can you give us an update on the current situation and how the hospitals are currently coping?

Stewart DOWRICK: Yes. In the main we have around 50 patients with COVID related in our facilities. Obviously we have got around about 200 employees furloughed at the moment across the LHD. We know that we are doing the best to support employees. We know we have that change in elective surgery. Recently we just had to free up additional workforce there. We know that in the recent times, which has assisted, we entered that very difficult period from December through to January with that rapid, that increase in COVID testing going on, which meant a significant impact on our service across the North Coast and the State. Those numbers have dramatically come down. We have gone from 2,000 tests a day down to 200 to 300 a day in the week just gone. So those numbers were up to 11,000 tests a week and now down to 2,000 and 3,000, so that frees up employees to help other parts of the workforce.

We have had some units, some of our emergency department units and some of our wards have had large groups of staff off. We have restricted the amount of beds there. Again, our healthcare team do a wonderful job trying to support as best they can those holes that are there. We do not use a lot of agency nurses on the mid North Coast. Our level of agency nurses is generally less than 1 per cent, a group of 1 per cent. We are trying to get those staff. We are buddying with Sydney and south-west LHD to help us when we have some shortfall. That has not been used that often. We have had just a handful of people come and help us during that time as well. I have to say our people have done a great job, it is very difficult, our teams don't shirk away from that.

It has been a very difficult time for our healthcare team over this period. We do have dedicated COVID clinics a challenge for all us is into the future what will this mean to our business as usual, how do we support this new cohort of inpatients. And most of the people that we look after, are looked after in the community. As of

today there is around about 3,500 people in the community with COVID. We are caring directly for providing higher acuity care for about 350 of those people through our program. The other 3,000 thereabouts are via HealthDirect which are considered lower acuity, which is a statewide position of course. [Inaudible.] Our big program is to support people in the community and that has extended through to those resources there. It is a massive challenge. The vaccination program as well, we are continuing that in supporting the children who are coming through now. The young people, the numbers coming through at those levels on the North Coast, whereas last year between, say August through to November when the drive to get the vaccination rates for second dose.

The Hon. EMMA HURST: I will go back. You said about the agency nurses. I know that a nurse at the Coffs Harbour Base Hospital told the media that staff were doing as much as 40 hours overtime in just one week. She told the media that staff were burning out and that standards of care were dropping. How is the LHD specifically responding to these concerns with nurses doing such enormous amounts of overtime at the moment?

Stewart DOWRICK: Yes, thank you for the question. We have just gone through our largest recruitment program in relation to our nurse graduates. This year we normally take around 110 nurses, 140, 150 nurses across the facilities to improve that build, bring people on a little bit earlier than we normally would to support those nurse graduates. That has been a really important program for us to do to support our workforce. We know there has been additional overtime to support work in the present COVID environment but one current brief strategy is the need to increase the amount of public nurse graduates and bring them on a little bit sooner and we will and that has been a real positive. We know that mental health were taking 80 nurse graduates for example to support the mental health team.

The Hon. EMMA HURST: I move on to something else. A member of the Australian Salaried Medical Officers' Federation reported to this inquiry that access to specialty care was a specific issue. An example that was given is that there is no neurologist, no endocrinologist or infectious disease specialist at Coffs Harbour Hospital, meaning that patients have to be referred elsewhere. Are there plans to offer these services in Coffs Harbour in the future, or is something being done in that space?

Stewart DOWRICK: Thank you again for that question. We have previously attempted to recruit infectious diseases physician in Coffs and we have been just unable over a number of years to recruit to that position. We will look at and the plan is to liaise with other areas to support us there or whatever that might look like. With neurology services, we do not provide inpatient neurological services in Coffs Harbour. There are outreach services provided. People do visit from Wollongong, Newcastle and Sydney to provide an outpatient primary care service in that region, and there are plans—we would like to consider the plans in the future expansion of Coffs to look at neurological services there. I know the provision of a primary health network, GPs across the region might have to support that space and [inaudible.]

The Hon. EMMA HURST: I am going to go back. My colleague has already asked quite a few questions about the incident that happened with five workers at Port Macquarie Base Hospital. I want to expand on the information you have already given him. Are there going to be further reviews in the future or do you have plans for further reviews in the future about being able to keep staff and patients safe?

Stewart DOWRICK: We have got plans to over time review how to keep our staff safe, especially through COVID, how we have an employment, a wellness [inaudible] employee support program across the district to look at people's emotional, social security, their physical and personal wellbeing, we do, which that will be rolled out very soon. In regards to our wellness program, looking at their mental wellbeing, cultural, physical, personal, organisational wellbeing. That will be important things to look at going to the future looking at those things in the program that we have there. So, yes, the answer is yes.

The Hon. EMMA HURST: Sorry, I am just having trouble hearing you, the microphone seems to come in and out. You have got the existing program and you are adding to that? Is that what you are saying?

Stewart DOWRICK: Yes.

The Hon. EMMA HURST: Fantastic. Thank you. Another common theme throughout this inquiry has been around the difficulty in recruiting and retaining staff in regional and rural LHDs. What problems have you experienced in this space? I know you have talked about getting extra student nurses, but do you also experience recruitment issues and if so what plans do you have in place to address that?

Stewart DOWRICK: We always have challenges in recruiting employees. This local health district has provided an additional 1,000 full-time equivalent staff over the last 10 years, our medical workforce employees has grown from around 210 to 360 full-time medical employees employed plus our VMO workforce has increased. We know we have challenges in mental health, mental health psychiatry, which there is a plan approved to change that medical knowledge. We also know that in the workforce of today, which is so different to a decade ago, so many things changing but people are looking away, and I will use Medicare for example, visiting medical officer

arrangements to make their salary arrangements, seeing if they can shift from VMO arrangements to those employed by the LHD, especially obstetrics and paediatrics.

We are looking at a different medical model in Bellingen and our nursing staff there, a different medical support model might have in a sustainable facility going into the future, as opposed to relying on locums there, so that will be paid for. We will have medium, short and long-term strategies, creating a training partner would be great. And with nursing we are looking at how to, nurse graduates, but also can I say we have been working very hard with the universities in the region to offer locally AI health and nursing opportunities. We are the only local health district that has a G8 university, University of NSW will have the complete medical degree in our backyard so they can actually do a complete first year to sixth year all the way through. Charles Sturt University only offered one course ten years ago now they offer 24 face-to-face courses, in particular nursing, allied care, physiotherapy, occupational therapy. Southern Cross University is also doing the same.

We have one of the largest paramedical training schools on the mid North Coast, they have been growing locally our own and regions like this are expanding their opportunities there, Country University, giving their people more opportunities in that space. In regards to workforce—and I make a special note of our Indigenous workforce—it is really important growth, our Aboriginal health workforce. The last 10 years our Aboriginal workforce has grown about 1.5 per cent to 5.2 per cent of our workforce. Our aim is to get to a population share of 5.7 per cent to 6 per cent. We still have a little way to go, and make sure it is across all groups, clinical groups and everything. That is a long term program. We are pleased with our progress to date but we are still doing the hard work in universities to engage in all avenues through the various opportunities available through allied health in the universities.

The CHAIR: Thank you. I move to Ms Cate Faehrmann and note that Dr Tranter is looking out for some incisive questions to come his way. I just pass that on.

The Hon. WES FANG: I do not think he is. I think he is quite happy sitting there.

Ms CATE FAEHRMANN: Thank you, Chair, for that prompt. Indeed, my first question is to Dr Tranter because I am particularly interested in the impact of COVID, obviously the Omicron outbreak in the region, on the mental health and alcohol and other drug workforce. The question is, have nurses and healthcare workers in the area that you look after been called in to other duties? With COVID have you seen staff furloughed? What kind of an impact generally has it had, firstly?

Richard TRANTER: Similar to all of the LHD workforce you have had to be flexible helping to support a lot of the initiatives that Mr Dowrick has had to set up at short notice, be that testing, helping vaccination, et cetera. That has had a call on our workforce. We also actually specifically stepped up to help the special health accommodation very early on to an agreed role in those facilities because we had very good, very helpful information from other colleagues of LHDs around a lot of the issues that we were basically charged with would be health and drugs and alcohol issues. So, by being very closely involved in that from the outset we were able to manage a lot of those issues at source, help minimise the impact in terms of the use of admissions through to specialist facilities. That worked out very well, but it also had an impact on available staff.

Yes, we confirmed we had staff furloughed same as other areas of the LHD and that combined with some outbreaks within the inpatient services as needed. To respond to that we have had to very rapidly shift plans, almost on a week to week basis, sometimes on a day to day basis. So when we set up plans for red and green-coded areas within the inpatient pathways, we would then get a case cropping up in a green zone and had to swap around those provisions very quickly. We have had to temporarily suspend admissions to units and shift beds and resources to and across the service. Most recently we have been able to take up an offer from private providers that had staff available and beds to help us out. But again had to very quickly put in place operational plans and procedures at very short notice. So, it has been incredibly impressive how all our staff, like from senior managers down to my clinical staff, had to move very quickly in terms of adapting to these situations.

Ms CATE FAEHRMANN: Can I check just with the mental health wards, how many beds, what wards are you dealing with in the LHD, firstly?

Richard TRANTER: In terms of our normal complement of inpatient beds, yes. Our two main sites are Coffs Harbour and Port Macquarie where we have our declared beds. We have 30 declared beds in our acute unit in Coffs Harbour, then there are 20 beds in the rehabilitation unit there. Port Macquarie, we have 12 declared beds. We have a capacity for another, open up another further 12 beds there. That is not operational at the moment. But we have utilised as COVID red areas over the last few weeks.

Ms CATE FAEHRMANN: I just want to jump in there because I have limited time. With those declared areas, in terms of having a COVID plan in place, did they have the same measures put in place? For example, the

nurses and healthcare workers having full PPE, in terms of fitted P2 and M95 masks and all of that, and if so when did that happen?

Richard TRANTER: Yes. We got in very early in terms of the fit testing and that continued to provide the testing to staff members, there was new staff come on board as well. I give you an example, we were actually the first clinical team on site when we first opened the SHAR we were able to get our fit testing done on the day as we got into the SHAR. So, yes, we tried to keep pace with fit testing and ensuring that the staff who are able to provide care to identified COVID positive clients are fully protected.

Ms CATE FAEHRMANN: Protect, in terms of when? There have been terrible outbreaks in some mental health wards. The P2 and M95 masks were worn by nurses in the COVID clinics, if you like, and not somewhere like mental health wards. You are saying that the fit testing of masks was put in place before the Omicron outbreak—

Richard TRANTER: It is still an evolving process in terms of the fit testing, but certainly we were having frontline staff get tested certainly before this current Omicron outbreak and pretty early on in terms of the Delta variance outbreak. So, yes, that has been an ongoing process for us. But one of the lessons we have learnt though, is we are putting in measures in terms of treating the identified clients, but it is also recognising we have got to keep our guard out in terms of all our frontline clinical work and add in throughout the additional units because we have had outbreaks occurring there and people have not previously been identified.

Ms CATE FAEHRMANN: My question has been answered. Thank you. I turn to Mr Dowrick now. There are many more questions I could ask you, Dr Tranter, but I have limited time. We were talking earlier about the waiting list. Earlier you said I think 7,300 on the waiting list now. That was in December and came down from 10,000 in June. Are you aware in terms of the fall off of waiting list, the attrition rate if you like, is that all because that had been dealt with within the public health system? Do you have an indication of how many scrounged the fees to get to private hospitals, whether some people just fell off because they could not wait, whether some people died? Do you know the reasons why that waiting list is—how much has been dealt with by people actually getting the surgery they need in the hospitals that they have been on the wait list for?

Stewart DOWRICK: Thank you very much. It has been a very comprehensive program by the private hospitals, public hospitals in relation to the LHD. We have a very local surgical program where many of our facilities provided with the opportunity of much more surgery. For example Bellingen Hospital used to do 200 operations ten years ago, now it is doing 1,400 this year Macksville is doing 2,000. Locally, we have been using our local facilities and we have not been able to do that for the entire sector to assist us locally at Port Macquarie, Private or Baringa in Coffs Harbour, or facilities elsewhere, Newcastle, Taree on occasions as well. It has been quite an extensive program. I do not have on my fingertips a split between the two. I think it was about 50 per cent in total. I can take that on notice and provide that as a response to that debate, but 50:50 I think private and the public. We really thank the private sector for working with us.

Ms CATE FAEHRMANN: Just to follow up on that, thank you, that is very interesting. Is there an additional cost to the patient when you say that then goes to the private, that you find groups other than the private sector? Is that at no cost to the patient?

Stewart DOWRICK: That is my understanding. It is these State contracts [inaudible] as part of the pandemic response when that change was made. They are commercial in confidence, they are private contracts. I do not know the costs associated with that. It is no cost and we are doing our best to put those people who may have had to go somewhere else and it has made a massive difference, it really has.

The CHAIR: Ms Faehrmann, that has brought your time to a conclusion. You may not have heard the bell but it has gone. I move to government members. We will start with the Hon. Wes Fang.

The Hon. WES FANG: Thank you to both witnesses for appearing today. Mr Dowrick, I was listening to your opening statement. You were talking about the 10-year plan and the work that has been going into that. Obviously the future of the health provision in the mid North Coast is of interest. Are you able to elucidate a little more on the work that is going into that 10-year plan and perhaps some of the consultations and how the plan is actually coming together?

Stewart DOWRICK: Thank you very much. We have been so far through a 12-month program of intensive consultation with 300-400 other people have been involved in that consultation, a number of working groups online, doing most of it online just providing the platform to deliver really good information. There have also been face-to-face consultations that has formed, I guess the background to the plan. The plan will have a number of key aspects. I guess having a world class regional health system would be the priority of ours, looking at integrated care. We cannot do everything by ourselves, a working partnership should have primary healthcare providers. We have had a great example of that, the last two years has been really strong. Research, building on

our research platform. I think there is a great opportunity for the mid North Coast. We have a number of great universities who have been developing and will make a big difference to us. We would like to build more on research being a part of that.

Obviously, within the funding pattern use our resources wisely is an important part, but also I guess working more with our consumers and partners and try to be more patient centred than we have been. We have made some good inroads there but we have more to do and that whole area of integration how do we work across primary care, Aboriginal Medical Service, aged care, the local—the mid North Coast is one of the most self-sufficient for care services, LHDs in New South Wales, 93, 94 per cent of people treated within our footprint here. We have some wonderful services. There's things we don't have here. Again, it is working with partnership and also I guess investing more in primary prevention, so those community based services..

The Hon. WES FANG: You said that you have been working on the plan for about 12 months now. At what stage do you see the future part of the plan being developed?

Stewart DOWRICK: We are getting through to the end of the plan. We had a change in our board composition so we were sort of halfway through the plan when the new board came through. The chair and obviously the new board members would want to contribute or see what is in that plan and they were able to have a further meeting in January about that—a lot of consultation. It led on from the future health strategy that the ministry did at the back end of 2019 around the future health strategy around 2020—sorry, [inaudible] a bit mixed up but around it we have been doing a lot of good work there, noting that the ministry still has their future strategy [inaudible] and now we want to make sure we are aligned to that as well. Over the next few months [inaudible] will continue to plan. In that plan, too, it is time for change. The iterative will not be fixed or static. We need to look over that over coming years and keep coming back to it and changing as we need to.

The Hon. WES FANG: So there are some mechanisms within the plan itself that should there be a change to the situation, i.e., like another pandemic, there is the ability within the local health district to amend it to suit the requirements at the time.

Stewart DOWRICK: That would be a decision for the board but, again, all plans should have an iterative process to allow change as we go on. We sort of took general direction and then and obviously over 10 years of changes you would expect those plans—what underpins that is the strategy of the key operations and they will change over 10 years as well. So we know the high level themes off we go; they will change as we operationalise it.

The Hon. WES FANG: Thank you for that. Part of the other part of your opening statement that I found compelling was that you said that the local health district has been providing support to the aged-care sector. I was just looking to touch on that because obviously we all know that the aged-care sector has been experiencing some difficulties around the pandemic outbreak. That your local health district has been providing support is admirable and I am just curious as to what support that might be. If you could provide some insights as to what support has been provided but also what you anticipate might be some future assistance or collaboration that the local health district can do with the aged-care sector in order to support them through the rest of the pandemic.

Stewart DOWRICK: In April 2020 we commenced a range of regional forums with different stakeholders—Aboriginal services quite often through to aged-care providers. Aged care was important but the major assistance was education, making our resources available if they need be, providing PPE to people to assist immunisation [inaudible] of us—PPE and infection control procedure was really important. Recently we have been including RAT testing and providing support there as well. During the case when we had our first aged-care outbreak, our local aged-care manager went in to assist the facility in supporting them because that was the first time our region actually had an outbreak and they needed advice and expertise there, so our regional manager provided support for a couple of days.

What the future looks like—when you put the question to the aged-care centre and ask them what they would like to see, I think it is the ongoing education. Communication has been a really important source of truth. There is a lot of information out there and they have appreciated the ongoing communication that has been provided by the LHD about the status of things at the moment. I support providing them with that information to get a source of truth as well. So we will work with them, ask feedback and also during that period what would happen is some of the transfer back and forth.

The Hon. WES FANG: I am struggling to hear you, Mr Dowrick. Maybe if you could perhaps lean in a little bit closer because I think that there are voice pick-up issues that are occurring there. I just was listening to your answer and I think you said it was your aged-care health manager went in to provide assistance and support to the sector. Is there a lot of engagement between the aged-care sector and the local health districts through that aged-care manager? Is there a feedback loop that allows you to actually have that understanding of what is

happening in the aged-care sector within the local district and then provide direct support to accommodate any outbreaks or any COVID cases that do come up in your health district?

Stewart DOWRICK: Yes, there is. Look, that forum is co-jointly chaired by the local health district and a private health network. They do it collaboratively and it is a feedback loop so there is information exchange and support, but also through our public health team. They provide any support as required to the aged-care sector regularly, which is ongoing; it has not stopped for a long time.

The Hon. WES FANG: Fantastic, thank you. I am going to turn to Mr Tranter now. The State Government has been looking at a lot of new programs in the mental health space. Are you able to provide some insights into some of the new programs that are being rolled out by the Government and how the Mid North Coast is able to participate in those trials?

Richard TRANTER: Thank you, yes. I think probably one of the really big initiatives that has had a profound impact is Zero Suicides in Care initiative. I think on [inaudible] that has been a real driver for expanding our peer workforce. I think we have had 11 new recruits into that space in the last 14 months. We are really seeing some of the benefits from those new models of care, particularly we have Safe Haven operating in Port Macquarie, which is a peer led service that specifically looks to try to avoid people going through ED and provide a far more receptive and, I guess, accepting environment for clients presenting with a range of mental health and crisis needs. That has been incredibly effective and we are really keen to see that expand across the district.

We are working towards building our community suicide prevention outreach service. Alongside that that is really helping to support some of our own initiatives, particularly looking to reach out into Aboriginal communities. We have been very aware from the suicide statistics that while there is an overrepresentation of people from the Aboriginal communities in terms of suicides, we are not seeing those figures coming through in terms of our RCA investigations and that is telling us that actually some of the most vulnerable people in those communities are not actually accessing our services. We have to do something profoundly different in terms of engaging with those communities. Bec Sant'Anna, our lead for our Aboriginal mental health services is doing some excellent work in building an Aboriginal wellbeing service—really looking towards the models of care that will connect with those communities.

A lot of that has been spurred from the Zero Suicides in Care initiative and that has had a particularly big impact. We were closely engaged with the mental health patient safety program that CEC operated, and that has had a big impact for us going forward around how we have approached a lot of our quality initiatives and service developments, particularly around how we engage stakeholders, particularly in terms of consumer collaboration. Ally Wilson, one of our CNCs—senior nurses—has really taken the lead for us in terms of that consumer engagement, collaborative development of services and trauma-informed services as well. A lot of these are really deriving from the statewide initiatives, and then we are really drawing a lot of support from a statewide level. I think those would be the key examples I would point to.

The Hon. WES FANG: Thank you very much for that, Dr Tranter. I would have loved to have had more time to ask you about the Safe Havens because I think they are a fantastic initiative. Unfortunately, we have reached the end of this session, so I will have to cede back over to the Chair to close out.

The CHAIR: Gentlemen, thank you very much. Our time has run out, unfortunately. It has been a very useful and valuable session this morning. I expect there will be some questions on notice that Committee members will have or supplementary questions arising from what we covered this morning, so they will be provided to you through the secretariat, who will liaise with you over the return of those. On behalf of the Committee, thank you for the very important work you do for and on behalf of the citizens of New South Wales and in your LHD. We appreciate it very much, particularly during this difficult time.

(The witnesses withdrew.)

(Short adjournment)

KAY HYMAN, Chief Executive, Nepean Blue Mountains Local Health District, before the Committee via videoconference, affirmed and examined

ELOISE MILTHORPE, Acting Deputy Director Planning, Nepean Blue Mountains Local Health District, before the Committee via videoconference, sworn and examined

SCOTT McLACHLAN, Chief Executive, Central Coast Local Health District, before the Committee via videoconference, on former oath

STEEVIE CHAN, Acting District Director Medical Service, Central Coast Local Health District, before the Committee via videoconference, sworn and examined

The CHAIR: I welcome all four witnesses joining us this morning, including two representatives from the Nepean Blue Mountains LHD and two from the Central Coast LHD. My name is Greg Donnelly and I am the chair of the Committee in this inquiry. I will just cover a couple of points. The submission for the New South Wales Government, which is obviously for and on behalf of NSW Health, stands as an omnibus submission to the inquiry. It is submission No. 630 and I am sure you are all familiar with it. Respectfully, your local health districts have not been required to make a submission specifically, but I just want to confirm that there is the overarching omnibus submission and we are working within the parameters of that. I will ask a representative from each LHD to make an opening statement shortly. Obviously there is no need to cover in that material that is covered in the omnibus submission from the New South Wales Government.

We have representatives from the Opposition, the crossbench and the Government on the Committee. In fact, we have someone from the Blue Mountains, the Hon. Shayne Mallard, and he joins us via video link. One final thing—and this is a challenge for us doing the inquiries with some witnesses remotely and some in the room—it is most important when you are answering a question to identify yourself so Hansard can be very clear about who is answering the question. We will move now to opening statements. I presume Ms Hyman will make the statement for the Nepean Blue Mountains LHD.

Kay HYMAN: Correct. Thank you for the opportunity to participate in this hearing. I would like to acknowledge that we are joining you today from Dharug country. Nepean Blue Mountains Local Health District includes the lands of the Dharug, Gundungurra and Wiradjuri people. I pay my deep respects to Elders who have passed, those of today, and those emerging in the future. Nepean Blue Mountains Local Health District starts at the western edge of the Sydney metropolitan area and extends into regional and rural areas, through the Hawkesbury, and above and across the Blue Mountains to Lithgow. We span 9,179 square kilometres. Our population of over 379,000 is spread across four local government areas: Penrith, with a population of 205,000; Blue Mountains, 80,000; Hawkesbury, 69,000; and Lithgow, 20,000. Our population is increasing most rapidly in the Penrith local government area, followed by Hawkesbury and the Blue Mountains, with Lithgow projected to have a stable but aging population.

Population growth in the beautiful Blue Mountains area is limited by geography, with the majority of people living close to the Great Western Highway, which runs over the Blue Mountains to Lithgow and beyond. Every natural disaster that has occurred in the past 10 years has impacted our area. Drought, floods, bushfires, extreme heat and snowstorms all affect us. We are well versed in disaster response. Nepean Blue Mountains strives to be at the forefront of delivering innovative and sustainable models of care, but we cannot do that alone. We need to work with our partners. We work hard to develop services that reflect our community's needs with our partners. Our partners include the Nepean Blue Mountains Primary Health Network, our local general practitioners and allied health professionals, a range of non-government organisations, our Aboriginal medical service and, most importantly, our communities.

We have strong community engagement, evidenced by our consumer forum, which supports the local health district and the primary health network. We also have an online forum, Get Involved, which facilitates engagement with groups of the community that are often not well represented in traditional consumer engagement, for example, younger people and families. I am proud that the Nepean Blue Mountains Local Health District was the first local health district in New South Wales to develop a consumer and carer charter for our mental health service. Community engagement is vital to understand the issues that matter to our communities, not just the issues that we think matter to them.

Nepean Blue Mountains Local Health District is a microcosm of the health system. We have a tertiary facility at Nepean Hospital, which is currently undergoing a $1 billion redevelopment. We provide secondary level services at Springwood, Blue Mountains District ANZAC Memorial and Lithgow hospitals, and through a public/private partnership at Hawkesbury District Health Service. We also have a residential aged-care facility at Portland.

Our mental health and drug and alcohol teams provide services to our population through inpatient, outpatient and outreach services. Our community health services provide in-home and in-centre support to our population. Virtual care is playing an increasing role in service provision across all locations and all specialties. Whilst we strive to deliver care close to home, this is not possible for all conditions. Nepean Blue Mountains has and continues to develop local networks across the district. These networks are aimed at providing care as close to home as feasible and, when higher levels of care are required, ensuring that there is an escalation process to allow patients to receive the right care in the right place at the right time. Nepean Blue Mountains Local Health District's vision is "together, achieving better health". We see this regularly demonstrated in our Lithgow and Blue Mountains services. Support from community groups, hospital auxiliary and others is greatly appreciated.

Engagement with councils is also important to address population and public health issues as well as providing an additional channel for resident feedback. Our Lithgow and Portland facilities are relatively new. Feedback from the community and the Bureau of Health Information survey results indicates that service provision is highly regarded. Lithgow Hospital was very well designed. It has and will continue to allow changing models of care to be developed. We have a clinical school of Notre Dame University on campus. This allows rural students to study closer to home, but the clinical also includes onsite accommodation. Fantastic feedback is received from students, both on the quality of learning and the ability to live rurally. Blue Mountains District ANZAC Memorial Hospital is approaching its 100th birthday. Built after World War I to provide care to returned veterans, the hospital has provided excellent care ever since and continues to allow Blue Mountains residents to receive care close to home. Over time the building has been updated and adapted to meet changing needs, but the site makes it difficult to adapt further.

We have identified the development of a new hospital in the Blue Mountains as a priority in our capital investment priorities. Regardless of the age of the building, the services provided receive consistently positive feedback from users. Great support is received from community groups who have supported upgrades and enhancements of facilities. Aboriginal engagement is strong in both the Blue Mountains and Lithgow, with Elders providing valued input. Our workforce for our regional services has increased by 125 full-time equivalents since 2012. Provision of palliative care is a priority. We have dedicated beds in the Blue Mountains and Springwood hospitals, and Lithgow palliative care patients are cared for in single rooms in the one ward at that hospital. For those who choose to die at home, services are provided through our palliative care team, in conjunction with our community services team. Whilst we aim for every consumer experience to be what you would want for a loved family member, unfortunately we do not always achieve this.

We constantly aim to improve and respond to consumer feedback as an important part of this. I take this opportunity to acknowledge the staff who work in our organisation. Our clinicians, our non-clinical staff, our support staff—everybody. Everyone comes to work to do the best they can. Without their compassion and their dedication, we would not be held in the standing that we are with our communities. Our staff are very much part of our communities, and are the backbone of the Nepean Blue Mountains Local Health District. The past two years, with our response to the COVID-19 pandemic, have been challenging for our staff, but they have risen to every challenge and will continue to do so. I again acknowledge the great work that is done 24 hours a day, seven days a week. Thank you.

The CHAIR: Thank you very much. I appreciate that opening statement. It was very detailed and comprehensive. We will move now to the Central Coast. Mr McLachlan, I gather you will be making the opening statement?

Scott McLACHLAN: Thank you. I start by acknowledging that we are come from the Darkinjung country. I acknowledge Elders both past, present and those emerging in the future, and Aboriginal people across the Central Coast, a community of over 15,000 people that is growing rapidly. The beautiful Central Coast covers a population of over 350,000 people, expected to grow to 390,000 over the next 10 years. It is a beautiful country that is attracting a lot of elderly and retirees but also a lot of young people. The health of our growing community is supported by a network of hospitals, health centres and community-based services to ensure that people receive proper care where and when they need it. In addition to the public health services we provide, there is a strong network of private hospitals across the coast, as well as a very important network of primary care services that we give full commitment and partnership to.

We have two acute hospitals, two subacute hospitals, eight community health centres and other community-based services across the whole of the region. Over 7,000 skilled clinicians across the local health district provide care to patients every day of the week and support to all of our services. That has been incredibly important over the past 12 to 18 months with the COVID outbreak and the pandemic impacts that we have seen. We strive to improve our services year on year and every day to ensure they reflect the community's needs, the needs of the patients coming to our services and also the opportunities to improve. There is absolutely no doubt that our most valuable asset is our 7,000 staff providing care to support thousands of patients that come to our

services every day of the week, and we enter their homes and other services every day. Through their dedication and passion, we strive to deliver exceptional quality health care across the whole life span of the whole of the community on the Central Coast.

I acknowledge the significant impact that the pandemic has had on our staff, and thank them for their continued dedication and compassion, caring for our community and their support for the whole of the community to keep everyone safe. The environment in which we provide care to patients is rapidly changing, and we know that. We have seen that over the past two years. Our population is growing, the people within it are aging, their health needs are becoming more complex and the cost of living is rising. Constant transformation can be a real challenge, but one that we are very well equipped to rise to. New technology and new developments in techniques mean that innovation and opportunity are upon us every day. The changing ways in which we provide care to patients, the changing ways we use new technology and new drugs, and the new opportunities and virtual care solutions that are available to us have been a big transformation in the last five years and will continue to be in health care.

The wide range of patients we encounter ensures that our expertise is evolving every day with every patient. There are many things that change but the one constant is the need to work in partnership with our partners in primary care—the GPs, the NGOs, other service providers and private hospitals—but, more importantly, with our patients, consumers and the families and the community of the whole of the Central Coast. Our accountability is to provide good health care to everyone. We still have some way to go in making sure that is the case for absolutely every person, but it is the absolute dedication and determination of our organisation, our 7,000 staff, myself and our board for the whole of the community. Thank you, Mr Chair.

The CHAIR: Thank you, Mr McLachlan. We certainly hope that your move from the west to the Central Coast has gone well and that the transition is occurring as smoothly as it can. It is good to see you in your role on the great Central Coast.

The Hon. WALT SECORD: I would like to begin my questioning to Ms Kay Hyman. Ms Hyman, would you agree with the observation that the resources in your local health district, the Nepean Blue Mountains Local Health District, are concentrated on the eastern end of your local health district?

Kay HYMAN: Our tertiary facility, as I indicated, is in Penrith, where a large proportion of the population in the district is, and that provides support to our other facilities across the district. The services that are provided in the Blue Mountains and in Lithgow allow most people to receive most of their care close to home.

The Hon. WALT SECORD: Ms Hyman, in your opening statement you mentioned that the Blue Mountains population is 80,000. How many ambulances are available in the Blue Mountains on a regular basis? I am aware of the answer. I am asking you how many ambulances are currently available serving the Blue Mountains community.

Kay HYMAN: That is a question that I will need to take on notice. Whilst we have a very strong working partnership with Ambulance and they provide great support to us, I do not have those numbers immediately available to me.

The Hon. WALT SECORD: I do. Would you challenge my statement that there are only two ambulances in the Blue Mountains? That works out to one ambulance for every 40,000 residents in the Blue Mountains local government area. Does that surprise you—two ambulances?

Kay HYMAN: I do not have those numbers, so I cannot comment on that.

The Hon. WALT SECORD: Ms Milthorpe, maybe you could add to that since you are director of planning and you would be aware of the allocation of resources. Do you have any information on ambulances in the Blue Mountains and would you dispute that two ambulances for 80,000 people equals one ambulance for 40,000 residents?

Eloise MILTHORPE: Like Ms Hyman, I do not have that information at hand. I am happy to provide that information to the Committee at a later date.

The Hon. WALT SECORD: Okay. How about a question that is not numbers based: What would happen if you had a heart attack on the streets of Katoomba, Leura or Springwood? Where would you be taken if you had a heart attack?

Kay HYMAN: Residents of the Blue Mountains area in those areas you have described would be taken to Blue Mountains hospital, unless it was clear that there was an urgent need for care not available locally.

The Hon. WALT SECORD: Are you aware of the typical wait for an ambulance in Katoomba, Springwood or Leura?

Kay HYMAN: I am aware of our response time to off-load ambulances when they arrive at hospital. I am not aware and would need to take on notice anything to do with pre-hospital. It is the ambulance service that has that information; I do not have that available to me.

The Hon. WALT SECORD: You mentioned that if you had a heart attack on the streets of Katoomba you would be taken to Blue Mountains district hospital. Is that correct? You said that earlier in evidence.

Kay HYMAN: Yes, that is correct.

The Hon. WALT SECORD: Is the emergency department open 24 hours a day at that hospital?

Kay HYMAN: Yes, it is.

The Hon. WALT SECORD: Is it staffed with a doctor physically in that emergency department 24 hours a day?

Kay HYMAN: Yes, it is.

The Hon. WALT SECORD: Oh, it is? Okay. You would be aware that the Blue Mountains district hospital foundation stone was laid in 1925 and the first procedure took place in 1928. That would make the hospital, as you said in your opening statement, nearing its 100th birthday—making it 94 or 95 years old. You would be aware of that, wouldn't you?

Kay HYMAN: Yes.

The Hon. WALT SECORD: A number of years ago—I think it was two elections ago—the conservative government promised there would be a new hospital for the Blue Mountains. The most recent reference I can find to it is 21 August 2018. What is the status of building a new hospital for the Blue Mountains community?

Kay HYMAN: As I indicated in my opening statement, the development of a new hospital in the Blue Mountains has been identified and submitted as a priority in our capital investment program.

The Hon. WALT SECORD: Okay, so that was four years ago. I think you and I are referring to the same information—a NSW Health proposal from August 2018, with a local district health spokesperson saying that yes, this was a top priority. Has any funding been allocated to this? Has a site been located? Has land been purchased? Has a site been selected?

Kay HYMAN: As I have indicated, it is a priority for us and has been submitted as such as part of our capital investment prioritisation. But I can confirm that a hospital in the Blue Mountains is a priority, but in terms of site identification or the other items you have mentioned, that is not confirmed. But it is a priority for us.

The Hon. WALT SECORD: Has any funding allocation been made to the Blue Mountains hospital that was promised, I think, two elections ago? Has a single dollar been allocated in your budget?

Kay HYMAN: Given that this is identified as a capital investment priority, that remains our case, and we continue to see this as a priority for us.

The Hon. WALT SECORD: Ms Hyman, can I re-ask that question as a yes or no? Have any funds been allocated in the budget for the Blue Mountains new hospital—yes or no? Have the funds been allocated?

Kay HYMAN: There has not yet been an allocation of capital funds to Blue Mountains hospital.

The Hon. WALT SECORD: Thank you very much. So that would be two elections ago. I want to ask you a couple of other questions. You mentioned virtual care in your opening statement. Is that what we know in rural and regional areas as telehealth?

Kay HYMAN: Telehealth is included in virtual care, but it is more than just telehealth.

The Hon. WALT SECORD: Okay. So what happens in the Blue Mountains involving telehealth virtual care?

Kay HYMAN: There are a variety of activities, not only in the Blue Mountains but all throughout Nepean Blue Mountains, which are supported by virtual care. That has been particularly so in the last two years with the pandemic. A range of outpatient consultations, mental health assessments, support for people at home, vital sign monitoring—a large range of services are provided virtually.

The Hon. WALT SECORD: If you need an MRI—a medical imaging or nuclear medicine and MRI—and you lived in the Blue Mountains, where would you go?

Kay HYMAN: At the moment you would come either to Nepean or, depending on how you were referred, potentially there is an MRI at Bathurst. In the next several months there will be an operational MRI at Lithgow.

The Hon. WALT SECORD: Okay. I take it from your answer that there is nothing in Katoomba, Springwood or Leura. You would have to go to Bathurst or Penrith if you want an MRI. Is that correct?

Kay HYMAN: Correct at this time.

The Hon. WALT SECORD: Have you been able to overcome the staffing problems at Nepean Hospital? You mentioned that there is an upgrade occurring. Concerns have been expressed that there are only two medical officers on duty in the emergency department. I know that Nepean Hospital has one of the busiest emergency departments in New South Wales. Is it correct that there are only two medical officers in the emergency department overnight?

Kay HYMAN: That is not correct generally.

The Hon. WALT SECORD: Okay, that is not correct generally. What does that qualification indicate?

Kay HYMAN: So what I cannot swear to is that there has not been a single event through illness or something else unexpected—that there may have been a short period of time that that may have been the case. But I can confirm that there are more than two staff rostered and 99.9 per cent of the time that is the case. But I cannot guarantee that for a single hour on a single day what you note may not have been possible.

The Hon. WALT SECORD: Because previously Nepean Hospital had been labelled as the most under pressure hospital in the State. Has that situation changed?

Kay HYMAN: That is partly the reason that we have the $1 billion redevelopment, and we have stage one of that $1 billion redevelopment opening in the next few months.

The Hon. WALT SECORD: Now, is it still the situation where women who are in labour and ready to give birth are sitting in chairs in the maternity ward because of a lack of beds? Is that still the case?

Kay HYMAN: I do not believe that has ever been the case. And it is certainly not the case currently.

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

Kay HYMAN: I have been—this is my eleventh year.

The Hon. WALT SECORD: Okay. Well, I am going to take you to task on that. In fact, five or six years ago there were cases of women sitting in labour because of a lack of maternity beds. Has the situation changed in the last five years?

Kay HYMAN: The situation with regard to birthing?

The Hon. WALT SECORD: Yes, a lack of birthing beds, facilities. Ms Milthorpe, is there something that you could add to that about the planning for maternity beds?

Eloise MILTHORPE: Eloise Milthorpe answering. I am unaware of any instance of women sitting in chairs waiting to give birth. I have only been with the district for, I think, three or four years now, so the instances that you have referred to were before my time at the LHD. Certainly I am unaware of any instances in recent times.

The Hon. WALT SECORD: Ms Hyman, I will take you to palliative care in the Blue Mountains. What is the current situation for palliative care support in the Blue Mountains—people who want to die in their own homes?

Kay HYMAN: Kay Hyman answering. As I indicated in my opening statement, there are dedicated beds in both Springwood and Blue Mountains Hospital for those who wish hospital care. For those who wish to die at home, support is provided through our palliative care and community health teams.

The Hon. WALT SECORD: You can take this on notice. How many palliative care beds are in those two hospitals that you referred to?

Kay HYMAN: We can give you that answer in just a moment.

The Hon. WALT SECORD: Thank you. In the meantime, I will go to Mr Scott McLachlan. Are you still experiencing staff shortages at Gosford Hospital? Have they been remedied?

Scott McLACHLAN: Mr Secord, we have had some success in recruiting in across the whole of the local health district. Clearly COVID in the last 18 months has caused difficulties in recruiting in—bringing staff in from interstate and other locations. We have had some success in recruiting into the whole of the district though.

The Hon. WALT SECORD: Okay. Do you still have a shortage of kitchen staff? Was that one of the areas of recruitment that—

Scott McLACHLAN: Not that I am aware of. I know we have on a daily basis some challenges with staff being furloughed and other issues—filling all shifts. That is the challenge across health systems across the whole country as well. I am not aware of any challenges in specifically the catering department.

The Hon. WALT SECORD: Are you aware that nurses have expressed concerns that they are working, helping and supporting kitchen staff? Are you aware of those concerns?

Scott McLACHLAN: Nurses play a crucial role in all of our services in supporting patients. Sometimes they support with food and other things in their ward for the departments that they work in.

The Hon. EMMA HURST: I might go back to Ms Milthorpe. A number of submissions that we have received in this inquiry include one from Blue Mountains City Council, and also the medical staff council. They have raised serious concerns about the need to actually upgrade the Blue Mountains District Anzac Memorial Hospital. One submission described it as an ageing facility with no room for expansion that is beset with asbestos and water leakage challenges. Are there plans at the moment to upgrade the hospital? I know you said that there were plans for a new hospital, but is there a plan to upgrade the current hospital at all?

Kay HYMAN: Kay Hyman speaking. The current site and design of the hospital, which has been adapted and enhanced over its nearly 100-year life, does mean that it is very difficult to do anything significant further. The land on which the hospital sits is quite densely occupied and, like much of the Blue Mountains, is not easy geography to expand and change buildings on that piece of land.

The Hon. EMMA HURST: A serious concern by quite a few of the Blue Mountains residents is that that current hospital might get closed down and then relocated because of some of the difficulties that you have just highlighted. Their concerns are, though, that if it is relocated it could be further away from Katoomba. In particular the residents were concerned that, if the hospital was moved, they may be cut off from vital medical services during natural disasters such as bushfires. What is your response to this? Are there any current plans to shut down the current hospital?

Kay HYMAN: I can confirm there are definitely no plans to close Blue Mountains Hospital. It provides a vital service to the residents of the Blue Mountains. So I can absolutely confirm no plans to reduce or to close.

The Hon. EMMA HURST: Thanks for that. According to one of the submissions, 90 per cent of Blue Mountains local government area residents that require surgery currently have to travel out of area for their care, namely to Nepean Hospital. For some people it is a one hour drive or two hours by public transport. Are there plans to try and open more of these services to residents locally either in the short or long term?

Kay HYMAN: Kay Hyman answering. We have increased the range of surgery which is available at Blue Mountains over recent years. But there is a limit to what the current facility can actually accommodate.

The Hon. EMMA HURST: Is there any way of addressing that? Because obviously that is one of the big issues that has been brought up in this inquiry—that if somebody cannot drive there, to have to get two hours by public transport and then you have got a hospital that cannot be upgraded. How do we get around this or what are the current thoughts within the LHD on how to actually address that problem?

Kay HYMAN: Kay Hyman answering. As I have indicated, the redevelopment of our hospital in the Blue Mountains has been identified as a priority for us in our capital investment prioritisation.

The Hon. EMMA HURST: A concern that was also raised in a number of submissions is the fact that Blue Mountains Hospital is within the Sydney metropolitan zone and is not classified as a rural hospital. Therefore, it does not attract junior clinical staff for rural service. Is anything being done about this or is this something that is continuing to be a challenge?

Kay HYMAN: Kay Hyman answering. Our clinical streaming process, I think, is important in this context, because it is through that that we can allocate junior staff and specialties where we know that they have got appropriate supervision. It allows staff to get experience in places other than tertiary facilities, which is really important. We also have trainees that are interested in being general practitioners that go to Blue Mountains Hospital as well. So we do have staff in training and junior staff getting the experience at Blue Mountains Hospital.

The Hon. EMMA HURST: Just to expand on that a little bit, am I right in thinking that Blue Mountains Hospital is one of the few hospitals that does not have an onsite associated medical school? Is that right?

Kay HYMAN: That is correct. It does not have a clinical school currently associated.

The Hon. EMMA HURST: Does that present challenges for training and staff retention?

Kay HYMAN: Kay Hyman answering. I do not believe so. We do have staff that are rotated to Blue Mountains, to Hawkesbury, who are from Nepean Clinical School. Part of their employment in the Nepean Blue Mountains includes rotation to Blue Mountains Hospital. Not everyone but certainly an increasing number do have that experience.

The Hon. EMMA HURST: It has also been raised that only 1 per cent of medical staff actually live in the Blue Mountains that actually work at the hospital, whereas the other 99 per cent are commuting from other areas. Why do you think that is the case—that so many staff do not live locally?

Kay HYMAN: I do not have the numbers in front of me, but I doubt very much that it is 99 per cent, knowing how many of our staff do live locally. I can immediately bring to mind some Blue Mountains medical staff that do live in the Blue Mountains area. There are also medical staff that may live in the Penrith or Hawkesbury areas as well that may work at Blue Mountains. The percentage is very different if you look at people that live within the local health district in total versus those that may live in the Blue Mountains. I would have to take on notice the percentage that do live locally, but I am very confident it is not 1 per cent.

The Hon. EMMA HURST: If you could take that on notice—just because the information we got was 99 per cent commuting from other areas. But if you have got different data, it would be fantastic if you could give that to us.

Kay HYMAN: Yes.

The Hon. EMMA HURST: My follow-up question relates to challenges in terms of staffing, on-call rosters, or staff having to travel in from other areas. Do you find that, even if those numbers are wrong, you still have a significant number of staff travelling in? Does that cause issues?

Kay HYMAN: I cannot comment on the specifics of the number that do come in, because I would need to actually validate it and we have taken on notice the number that live locally. We do provide onsite accommodation for staff at Blue Mountains so, if somebody is not wanting to travel at the end of the shift or maybe on shift for several days and they do not live locally, they can stay on site.

Ms CATE FAEHRMANN: I want to go to the Central Coast LHD to begin with—just with a general question about nursing and midwifery vacancies. I just wonder if you know how many vacant nursing and midwifery positions there are currently within the LHD.

Scott McLACHLAN: Scott McLachlan responding here. We have got a total staff of over 7,000 staff. Approximately 3,300 nurses in headcount—2,700 are full-time-equivalent staff. But of all those, we currently have around 200 nursing vacancies. Some of that is obviously new positions that we are establishing with the Wyong redevelopment and recruiting into. Some of it is normal turnover and change, which we would expect to see, and other vacancies that we are currently recruiting to.

Ms CATE FAEHRMANN: When you said nursing, is that midwives as well?

Scott McLACHLAN: Yes, that includes midwives as well.

Ms CATE FAEHRMANN: Okay. So you are aware that recently— in fact December, before the current outbreak, which I understand is putting huge pressure on the hospitals in the Central Coast region as they are in hospitals across New South Wales—there were strikes by nurses at Gosford and Wyong hospitals? Are you aware of those strikes, Mr McLachlan?

Scott McLACHLAN: I am certainly aware there have been some concerns expressed. I would not call them strikes. There were some concerns expressed by nursing staff that we need to recruit into all of our vacant positions and fill those on an ongoing basis. That is certainly the desire and intent from the local health district.

Ms CATE FAEHRMANN: When the nurses are discussing—they are talking about unreasonable workloads. They are talking about dangerous staffing shortfalls, critical patient care being compromised. Since you have been in the position and I recognise that you are new to it—but what is being done on the Central Coast now to ensure that nurses are heard and to ensure that those nurses who are considering resigning, particularly, do not resign. Because we are hearing this right across the State. What is happening in the Central Coast to make sure that nurses who are in the job now stay in the job?

Scott McLACHLAN: Scott McLachlan here again. There are a lot of supports that we have put in place—particularly over the last three to four months with the changes that have come about due to the COVID outbreaks—to support all the staff, but in particular nursing staff in the way of additional new graduate nurses. We have brought on significant numbers of additional new graduate nurses and brought those forward to bolster our numbers of nursing staff, and recruited in additional nursing staff in the last two months in particular to provide casual support and as-needs support on different shifts. A number of additional nursing staff from the private hospitals have come in to provide support in those environments, so there has been a real bolstering of numbers of nursing staff. In terms of workload management, every day of the week we look at the numbers of patients in our beds, the complexity or circle of support that those patients need, and the numbers and types of nursing staff that are needed for those. If we do have vacancies on a daily basis, that is our absolute top priority every morning—to make sure we can fill those. We have got a casual nursing pool across the whole of the region that is agile and flexible to move into those gaps and support care where we need to.

Ms CATE FAEHRMANN: Is the LHD doing anything to address the fact that nurses are incredibly exhausted? What is being done—specifically for those nurses in the job now—to retain them, to look after their, I suppose, mental health and wellbeing as well, if you like?

Scott McLACHLAN: Thanks, Ms Faehrmann. Scott McLachlan here again. It has been a stressful time—the last three, four, five months—no doubt, with the current outbreaks and the pressure that has been on. We have done a lot to try and support staff. Both having reasonable shifts and regular breaks around those sometimes has been challenging. We have had numbers of staff furloughed on a daily basis that have needed it. Staff to be flexible—I take my hat off to all of our staff, who have been amazing, particularly since Christmas time, in helping to fill a lot of those gaps. A lot of our wellbeing supports are still in place and being offered to all of our staff. Whether it is counselling, whether it is time away from the workplace, additional leave if they have needed it, and also family considerations of having family members that might be in isolation from COVID or ill in other ways, there is a lot of the workload balancing things that we do and also care and understanding for our staff that, I have got to say, has just been exceptional in the last couple of months in particular in a pretty stressful environment.

Ms CATE FAEHRMANN: When you say "additional leave if they need it"—I am hearing stories of cancelled leave. I think that has been reported—that nurses have had their leave cancelled actually. They have had to stay and work. Have nurses in the Central Coast LHD had their leave cancelled? Are you aware of that?

Scott McLACHLAN: Thanks, Ms Faehrmann. Scott McLachlan here again. There has been a lot of flexibility from our staff in changing shifts, in changing some of their leave to make that sure we can provide support to patients, both COVID and patients that come to our services every day of the week. Yes, there has been some flexibility in staff taking leave. That has certainly been the case for a lot our senior leaders, our corporate and support staff and the whole of our team to make sure we can respond when we need to.

Ms CATE FAEHRMANN: Just to be clear, your words—the language there is "flexibility". My question was, "Had staff had their leave cancelled?" which is not a kind of flexibility, if you like. That is more having their leave cancelled. Flexibility is more on the staff maintaining the flexibility, but cancelling is more a mandatory thing.

Scott McLACHLAN: There have been times when we have needed to talk to staff about changing some of their leave and coming back to provide support for patients. That is what I call flexibility. But that is certainly a discussion that we have with—

Ms CATE FAEHRMANN: I am sure some of your staff do not call it flexibility, Mr McLachlan. It depends on what position you are in, I assume. I wanted to go to the situation in the hospitals within the Central Coast LHD in terms of separating COVID patients from non-COVID patients and whether that is being done.

Scott McLACHLAN: Yes, it is. Scott McLachlan here. We have two dedicated wards at Gosford and one dedicated ward at Wyong for the care of COVID patients, both people with COVID and admitted because of their COVID or for other health conditions. We have got a range of what we call negative pressure rooms or isolation rooms that we put people with infectious diseases in. Some of those have COVID patients in them. Likewise in our intensive care units we have got dedicated separate rooms for the care of COVID patients. So, yes, we have maintained all COVID patients within those three environments that I have just talked about. We are seeing decreasing numbers of people needing to be admitted with COVID at the moment. That is helping the management of that.

The Hon. WES FANG: Thank you to all the witnesses who are appearing today, making yourselves available to us and providing the insights that are so valuable for this hearing. Mr McLachlan, it is great to see you again. You have been a fixture, I will say, of these hearings, and you are able to provide some valuable

insights now, obviously, in the old role plus the new role. That is probably where I am going to start my questioning. I note that, obviously, you have had experience in the Far West of the State and now you are looking after the Central Coast. We have got the Blue Mountains here. We have got Illawarra and south-west Sydney appearing later today. Could you, perhaps, provide some insights to the Committee as to how, perhaps, the clinicians, the staff and the patients themselves of the Far West would consider having south-west Sydney, Illawarra, Central Coast and the Blue Mountains grouped in with rural, regional and remote health inquiries?

Scott McLACHLAN: Thank you, Mr Fang. Scott McLachlan here again. No doubt we all share some common challenges across regional, rural and remote health services. It has been well heard, I know, by the Committee around some of the workforce recruitment challenges and trying to maintain and recruit in new workforce, some of our challenges in maintaining services in those times to all of our communities—one thing that joins all of us together is some vulnerable communities that need tailored health services to their communities. That is certainly the intent, I know, from all rural, regional and remote parts of the State. The thing that we see that has varied during that is making sure that we can provide services close to home—as close to home as possible.

Utilising new technologies, new ways of providing that care and making sure that we can make those connections with patients and their families in a very compassionate and caring way—so across all of our rural, regional and remote services I know that is the intention. There are a lot of positive developments across health at the moment in stretching the opportunities to make sure we can take care to the patients as much as possible locally. There are certainly some positive developments with the advent of virtual care and the new ways of saving precious time and travel for the patients. We have worked on the Central Coast to Broken Hill, Far West of the State. I know that is something the patients do value and we are seeing a lot of opportunities.

The Hon. WES FANG: I think what we have seen throughout these inquiries has been—and I use the word demonisation, whether it be telehealth services or virtual services. I think there has been much documented but not publicised evidence that those virtual or telehealth services can actually provide a real benefit to the communities in which they are rolled out in, whether it be the Far West or whether it be in more densely populated areas such as the Central Coast. Are you seeing that they are able to provide that benefit to the communities throughout the State, given the differences between the areas that NSW Health itself has a provision of service across?

Scott McLACHLAN: Scott McLachlan here again. There is no doubt that, if you talk to patients who have received a service virtually, whether it is a specialist clinic that they did not have to travel 200, 300 or 400 kilometres or even 20 kilometres to attend, and who have had a consultation with a specialist that was valuable and happened over technology, saving precious time not having to leave home and their families—there is a benefit to that. There are certain benefits across the health system in delivering of specialist expertise when and where we need it to a lot of our small rural health services. But also in the Central Coast that happens on a regular basis to make sure we can get the specialists to the bedside of patients when we need them. There is a lot of opportunity, I would say, out of virtual health services. On the Central Coast I know there are still a lot of opportunities to improve the care we provide locally through that as well.

The Hon. WES FANG: I will turn now to the Blue Mountains district. Again, I am surprised that the Opposition and crossbench have grouped in places like the Blue Mountains and south-west Sydney in a rural-regional health inquiry. Regardless, I wanted to seek some elucidations about how COVID has impacted with the services in the Blue Mountains area and perhaps some innovative ways with which you might have been able to overcome some of the challenges with, say, staffing or providing services to patients using virtual means or any other insights around how the challenges of COVID have been met by your local health district.

Kay HYMAN: Kay Hyman answering. Like the rest of New South Wales, the rest of Australia, the rest of the world, COVID has had a significant impact. In terms of innovative responses, the one that immediately springs to mind comes from our allied health teams. People who have had joint replacement surgery require physio and some occupational therapy, and there was a concern that some of these people might be not able to receive that in a way that they would normally do when we reduced outpatient attendances. So fantastic innovative team—looking at basically what you would describe as a virtual physio class from individual people's homes. So the physio was able to observe people doing the exercises in their home in the same way that they would be able to do in a gym. One of the benefits for that was that physios and the OTs could actually see a person's home, understand the environment in which they were living, which in normal circumstances, when the person attends the hospital gym—they do not get that opportunity. They certainly saw benefits and the patients were and continue to be greatly appreciative.

The Hon. WES FANG: In effect you are saying that there has been an advantage, almost, in the rolling out of some more innovative methods around the provision of, say, physiotherapy, that would not necessarily have

happened without the pandemic. Are you looking to keep those initiatives rolling after we return to some normality? Are there any other learnings that you may have found throughout the pandemic which have actually provided an unexpected benefit to the provision of health care in your area that you would think might be able to be utilised into the future in more regular and normal times?

Kay HYMAN: Certainly and thank you for the opportunity. For Hansard, Kay Hyman answering again. It is in that virtual care space. So the allied health example I gave is but one and certainly, as we look to whatever endemic COVID looks like, we are considering which of the innovations that we have implemented will continue, which may have, you know, some slight modifications, and which of them were appropriate for the situation we were in but there are better alternatives going forward. So we have all those considerations. There is no doubt that virtual care in its broader sense will be a bigger feature of health care for us in the Nepean Blue Mountains and, I am sure, across the whole of the health service as we go forward.

The Hon. WES FANG: Looking at a quality assurance perspective, the feedback loop is obviously very important, not only for you as a provider but also for patients. Have you had an opportunity to seek feedback from patients who have had experience around the regular pre-COVID provision of health care and then had the opportunity to experience the provision of, say, physiotherapy or any other medical services during the COVID pandemic, and actually get that feedback and gauge the positives and negatives from the patients and find out which parts of that provision of service they have preferred and have perhaps found more beneficial to their recovery, so that you may look to roll that out after we return to more normal times once the pandemic has passed?

Kay HYMAN: Kay Hyman answering. I can say that that is, for us, very much a work in progress. For some people in the example that I gave of joint replacement, it is not often something that people experience, understandably, multiple times. So pre and post is not possible for everything. Certainly, anecdotally along the way, very significant positive feedback from patients and their families that we have been gathering along the way—I think we just need to complete our work in progress around that. We have got some particular clinicians with interest in this area. We will certainly be looking at that and, as I have indicated, modify what we do as we go forward—but definitely including increased virtual care as we go forward.

The Hon. WES FANG: Excellent. Thank you very much. I have not got much time left, but we touched on the training that is being provided around the Blue Mountains area for clinicians. One of the points that was raised, I think, by the Hon. Emma Hurst, the Deputy Chair, was that, because the training positions are not classed as rural, you were having difficulty attracting trainees. Can I just confirm and clarify that the trainees or intern positions, training positions that you have at the hospital—that training time does count towards their whatever specialty or, like you said, GP training requirements that they need to achieve their accreditation. It just does not account for the time that is required for the rural component of that training? Is that correct?

Kay HYMAN: Kay Hyman answering. That is correct. There is a complex series of college requirements. Depending on what the trainee is actually training for, the college has a number of requirements that they need to—both in terms of hours and experience. We need to match that against the level of experience and the trainee's requirements. So it is not a simple allocation, but certainly we aim to provide trainees with experience in the location that is appropriate to what they need and is meeting college requirements.

The Hon. WES FANG: I am just seeking the clarification that the training time is not lost, for example. It just does not count for rural exposure which—as somebody who comes from a very regional area, I would think that the Blue Mountains area is not somewhere that I would consider to be rural exposure, so I do not necessarily think that that is an issue. But I just wanted to clarify that point because I think it was perhaps a point that could have been misinterpreted had it not had that clarification by you.

The Hon. WALT SECORD: My questions will go to Mr Scott McLachlan. Mr McLachlan, I want to touch on what the Hon. Wes Fang referred to—the transition from a remote western New South Wales health system to the Central Coast. Are you experiencing the same staffing challenges that you experienced in western New South Wales on the Central Coast?

Scott McLACHLAN: This is Scott McLachlan here. There is no doubt there are workforce challenges across health everywhere across the State, the country and the world. Central Coast is not immune to that by any means. We do share some of those difficulties in recruiting into some of our roles. We would love to see more staff available in a lot of our services. We do have some difficulties recruiting in. Dr Chan will be able to talk about the extents that we go to in recruiting into a lot of our medical roles, with an extensive international medical recruitment strategy that has seen the workforce grow significantly in the last couple of years.

The Hon. WALT SECORD: In western New South Wales there were situations where you used telehealth, virtual medicine. Are you introducing those plans, those programs to the Central Coast or expanding them on the Central Coast?

Scott McLACHLAN: Scott McLachlan here again. Telehealth and virtual care exist across most urban environments as well as rural and remote services. There is nothing new in that, certainly because Central Coast has been a telehealth or virtual care service support provider across our paediatric services and a range of other specialties just within the local health district. We know a lot of our specialists provide their outpatient clinics—right through COVID but in some normal times—through technology means. There is certainly nothing new in that. We do see opportunity for growth in telehealth. To be honest, what a lot of patients are wanting is easier access to those specialist care services.

The Hon. WALT SECORD: Can I take you to a specific hospital on the Central Coast? What is happening currently at Long Jetty hospital?

Scott McLACHLAN: We have got an extensive health campus at Long Jetty that has got a whole range of services provided on the health campus from a renal dialysis centre to a palliative care support service. A mental health, drug and alcohol service—our community-based teams are both located there. For some time we have had some inpatient services provided there up until around six months ago, where those were paused with the onset of the Delta strain and the impacts that we could see coming that needed some additional public health and other services provided from that campus. We now provide vaccination and other services, in addition, to those communities from Long Jetty health campus.

The Hon. WALT SECORD: Can you give a commitment—it rightly has been used for COVID-related activity. There is concern in the community that some of the services there have ceased, been paused during COVID—that you will be reopening Long Jetty hospital with normal services resuming?

Scott McLACHLAN: Clearly, provided the current outbreak is needing us to focus to a lot of our public health services onto that campus—we have not got a crystal ball to see when that will change. There is certainly some planning going into at what stage we could return services to Long Jetty, but that is not clear at the moment.

The Hon. WALT SECORD: You do not have a target date of—you do not have the crystal ball, I guess.

Scott McLACHLAN: No, we do not.

The Hon. WALT SECORD: Can I ask you about Ettalong Ambulance Station? What is the current status of the station?

Scott McLACHLAN: As you know, we do not run ambulance services from the local health district. It is run by the statewide ambulance services. But I am aware that there is a new ambulance station proposed to be developed at Woy Woy expected to service the southern part of the local health district.

The Hon. WALT SECORD: But how is the lack of ambulance services interfacing with the services that you provide?

Scott McLACHLAN: We have got a great relationship with the ambulances services right across the coast on a daily basis. We know there are around 18 ambulances available through the day across the coast. It is something that—we work very closely with the ambulance service to make sure that, where possible, we can provide good care to patients at home that do not need to come to hospital. We talk regularly with ambulance about some of the pressures in our hospitals and the means and opportunities for making sure that patients get to the right place at the right time.

The Hon. WALT SECORD: Now, you have to excuse my ignorance here. The question was: What is the current status of the Ettalong Ambulance Station? Is it open or closed at this moment?

Scott McLACHLAN: Mr Secord, I am not running the ambulance services for the coast. I could not tell you the definite answer to that. I would need to take that on notice.

The Hon. WALT SECORD: You do not know if the ambulance station at Ettalong is open or closed? You are taking that on notice. That is fine. Can I go to elective surgery? There was an announcement this morning that elective surgery was resuming in some parts of New South Wales. Is it resuming on the Central Coast? Does it in fact fall under the announcement made today?

Scott McLACHLAN: Scott McLachlan here. All parts of New South Wales—we have paused some elective surgery in the groups of patients that that can be delayed for some time. It is not something that we want to do. We do want to resume elective surgery as quickly as possible. We have, however, had arrangements in place with the private hospitals on the Central Coast to provide some of that elective surgery that we just could not provide through the public hospitals. That is still continuing at the moment. We are planning with the private hospitals around how they also return to around 75 per cent of elective surgery that they normally provide and also to support public hospital while we manage the current COVID outbreak. That planning will continue in the

coming weeks. We certainly do not have the capacity at the moment to return to our full volume of elective surgery for our patients. We do want to do that as quickly as we can.

The Hon. WALT SECORD: One final question to Ms Hyman, please. In your answer earlier you talked about—when I asked a series of questions about the Blue Mountains Hospital and there are no plans to close Blue Mountains Hospital. Under the plans that were put forward in 2018 and two elections ago—the promise—what is the impact on Springwood Hospital?

Kay HYMAN: Kay Hyman answering. At the moment we have no particular plans to change Springwood Hospital in any form.

The Hon. WALT SECORD: Thank you.

Kay HYMAN: We took on notice earlier a question about the number of palliative care beds. I am able to provide that if you would like that now.

The Hon. WALT SECORD: Yes, please. But just be mindful of other people's time. Yes, go ahead.

Kay HYMAN: The answer is simply two at Blue Mountains and four in Springwood.

The Hon. EMMA HURST: I will move to Mr McLachlan and Professor Chan. A key concern that has been raised in this inquiry from local residents is the lack of access to general practitioners in the area. One of the submissions actually noted that she and her son drive 50 kilometres to Mount Kuring-gai in Sydney because they really struggle to get an appointment locally. Have you heard concerns similar to this or did you read that particular submission?

Scott McLACHLAN: Ms Hurst, Scott McLachlan here. I might take this question first and then hand it over to Dr Chan. There is no question that GPs in the primary care sector are crucial in the health service provision on the coast. There are some shortages of GPs—around 100 GPs are being recruited at the moment. Positions are being recruited into private practices and other services. It is something that we support extensively with the primary health network to try and help general practice grow and thrive to be able to look after patients outside of hospitals. We do provide some support to the primary health network. I might let Dr Chan also outline a bit about medical recruitment strategy that can help with that.

Steevie CHAN: Steevie Chan responding to Ms Hurst's question. Thank you for that. Just to supplement what Mr McLachlan had indicated, the Central Coast Local Health District works very closely with local GPs and the Hunter, New England and Central Coast Primary Health Network insofar as we have a regular meeting forum called the GP collaboration panel and I meet with the GP leaders on a regular basis to look at how we can provide incentive strategies together, working with the GP network in attracting GPs to the area. I do acknowledge the concerns you had raised. I do want to indicate a program called the Central Coast GP Sea Change Program. It is an incentive program provided by the primary health care network that had been successful in providing some financial incentives and support and incentives for attracting GPs to the Central Coast.

The Hon. EMMA HURST: Professor Chan, what are the incentives other than the financial incentives—so what does that program do?

Steevie CHAN: It provides support also in training and supervision as well as some social support for the families of the GP in the form of financial incentives of about $40,000 grant for the successful applicant. That provides some ability to relocate and support their change of environment.

The Hon. EMMA HURST: I am wondering as well—and this might go back to Mr McLachlan. I know that we all recognise that there is an issue with the number of GPs. I am wondering what kind of strain that puts on the hospitals. We have had submissions saying that people are going to the hospital for non-urgent matters because they cannot get to a GP. What sort of feedback have you had and what are we doing practically on the ground to address that problem?

Scott McLACHLAN: Scott McLachlan here again. There is no doubt that, when people cannot get access to good primary care and they have got an illness that needs some level of care, sometimes the hospital is their best or maybe only course of receiving and getting treatment. In the north, north-western part of our region around Wyong—a very rapidly growing population—that is the case for some of the community that do not have access to a GP. We do see higher volume or more patients there who come to our emergency departments for care—for non-urgent care in the main. That is something that—as Dr Chan was talking about, we work closely with GPs to try and help them recruit in, to try and help grow general practice numbers and the number of practices in the region to keep up with the growing population in the region.

The Hon. EMMA HURST: But have you heard of some of the strain that that is potentially causing on the hospitals and staff that are working in the hospitals? Is that adding further strain to those staff members? What is being done to support those staff members with that additional burden?

Scott McLACHLAN: We certainly do see more numbers of patients needing to come to the emergency department in and around Wyong than we would normally expect. That is, I think, directly related to some of the gaps in primary care and general practice services. We do provide a lot of support both obviously to our staff and our services to help them provide care to those patients. There is an after-hours general practice service that is on site at Wyong hospital that does provide some supplemental care for those patients that really do not need to be in an emergency department, particularly after hours when other practices are not open.

Ms CATE FAEHRMANN: I will quickly go back to you, Mr McLachlan, and what we were talking about before my time ran out last time. You mentioned that there was dedicated separate wards or rooms for COVID patients in all of the facilities and that they kind of had dedicated safe environments. I wanted to go to a particular situation that was reported in the media, which I understand there is a review into. Are you aware of the situation of Alex Wilks' wife, Kittie, who went to the Gosford Hospital's emergency department and was situated with what she understood were two COVID-positive patients. She went to that hospital with a broken ankle, a badly swollen ankle. Are you aware of that situation?

Scott McLACHLAN: Not in detail, but we do have occasions where patients come into our emergency departments and subsequently we find out that a patient is positive for COVID. Now, we take every step we can, obviously, to support the care of patients but also the safety of our staff when people have COVID in our services. If that case was in an emergency department, we do have dedicated parts of our emergency departments that do have specialist staff all kitted out with the PPE and the support to care for patients with COVID. If there was an instance in a ward—in an inpatient ward—where we subsequently found out the patient had COVID then we would move those patients to our dedicated COVID wards. There are those circumstances where we find out after a person has been admitted that they do have COVID. I will not go into the specifics of this case, but—

Ms CATE FAEHRMANN: Sure, though this specific case was actually one woman who had a badly swollen ankle in the emergency department in Gosford Hospital for three to four hours, in a room with two other patients who were all sitting on chairs. They were coughing and clearly had COVID symptoms and they were there because of COVID. Does that suggest to you that the emergency department set-up in Gosford Hospital just is not adequate to ensure that non-COVID patients are separated from COVID patients?

Scott McLACHLAN: Hospitals across the world had to deal with the dedicated, separate areas for COVID patients. I know with both Gosford and Wyong that in two brand-new emergency departments there are some good areas and support services for patients with COVID. If there have been instances where we have subsequently found out that patients have had COVID then we move those patients as quickly as possible into what we call the "red zones", or the areas of those emergency departments. If there has been a busy day in that emergency department, sometimes there might obviously be constraints in doing that. What we do in those instances, however, is to ensure that there is the best PPE and separation around patients as much as possible. Our staff take extreme measures to make sure that those patients are cared for and separated wherever possible.

Ms CATE FAEHRMANN: Okay. I understand that there is a report going to happen on that particular issue. I just wanted to go quickly, with the limited time I have left, to Nepean Hospital—the mental health centre, the outbreak that they had there in August. Ms Hyman, why was Nepean Hospital's mental health centre so unprepared for a COVID outbreak back in August?

Kay HYMAN: I believe in the system generally, not just at Nepean Hospital, that COVID patients would be presenting for their COVID conditions—and in hindsight, maybe we should have thought differently, but if a mental health patient had COVID that they would be really unwell and would need to be in the COVID ward. As it turned out, I believe we had the first outbreak, and there have been many since in mental health facilities. There was a recognition that people may have COVID but be not so unwell that they actually need COVID ward care. When we had the outbreak, we rapidly responded and put in place the requirements to ensure safe care for COVID-positive patients in a mental health environment because their mental health needs were actually outweighing their COVID needs.

The CHAIR: Thank you. We will move now to the Hon. Wes Fang.

The Hon. WES FANG: Thank you very much, Chair. Professor Chan, much like the question that I asked of the team from the Blue Mountains local health district, I am keen to know what learnings you might have had from the COVID situation on the Central Coast and how, perhaps, you have been able to be agile in that response. Are there any particular learnings, or ways of providing the medical service that you would normally have done in a face-to-face setting that are now perhaps being provided for in a more virtual setting, and you have

found that it is a more beneficial and, say, therapeutic or more preferable way for the patient to receive that treatment?

Scott McLACHLAN: Thank you, Mr Fang. I am happy to reflect on some of the learnings out of the last two, three or four months; they have been significant. Clearly the Omicron strain has surprised the world and changed a lot of things that we had prepared and were ready to enact, so we needed to adapt them. That would certainly be the case on the Central Coast. It has been a fast-paced environment, particularly over the last six weeks since the start of the outbreak. Changes to a lot of our public health testing, our accommodation, our vaccination programs, our emergency departments and inpatient services have occurred over those times.

To pick up part of your question around the support from the virtual services, there is no doubt that technology has helped play a role for patients and people in the community more generally in accessing—whether it is your banking or whether it is the whole range of daily needs. In the place of health care, that is certainly the case. Even patients who access their GP—GPs have been fantastic in adapting the ways that they provide support and advice for patients through technology.

Through the health services we have seen a lot of change, whether it is in some of our rehabilitation environments—in not being able to get groups of people together but still needing to help people on their rehabilitation journey using technology, being able to care for people in the home to be able to do that—or whether it is in our community-based clinics and a lot of our specialist community nursing teams, in particular our COVID care support team that have provided the longest support to people with COVID through technology. I think we have seen great advancements in the monitoring technology in the last 12 to 18 months—being able to monitor a patient's or a person's condition in their home, not requiring them to come into hospital for a lot of their care but triggering that if they need to. Technology has just been able to help us both keep staff and other people safe, and keep people with COVID in their homes.

One of the real developments that I think has been—the support, the specialist clinicians being able to provide advice, whether it is a cardiologist, a paediatrician or a respiratory specialist, to patients that do not need to come into a busy clinic, in their homes. That has seen quite a few developments and supports to make sure that patients can get the advice that they need, when they need it. Clinicians are currently keeping up with a lot of the new technologies to make sure that that happens. I do see a lot of opportunities out of that. To return to your question, there will be a lot of reflections out of COVID—not just on the technology front—of things that we need to adapt and do differently in the future.

The Hon. WES FANG: Thank you very much for that. I just thought I would briefly offer Professor Chan the opportunity to maybe just give us a very short—any experiences? We have only got less than a minute left now.

Steevie CHAN: Thank you, Mr Fang. This is Steevie Chan responding to your question, and to add to what Mr McLachlan just mentioned. I do also resonate with his comments about the benefits of virtual care. The COVID season has I guess converted, both from the health system staff and the consumers, the acceptance and understanding of the benefits of virtual care. To your question about what are the learnings, I would like to add that I also learnt about the resilience of our staff, not just the medical staff but nurses, allied health professionals—in fact, the whole health system staff have worked really hard in the last two years. I do want to thank and acknowledge all the hard work that every health service has put in to deal with COVID.

The Hon. WES FANG: Thank you very much for providing those valuable insights to us. Certainly we know that technology has played a role not only in the medical field but also in allowing this Committee to continue its valuable work. I know that we are out of time. I thank you for providing your insights today.

The CHAIR: Thank you, the Hon. Wes Fang. That brings us to the conclusion—right on the dot, so thank you for that—of this session.

The Hon. WES FANG: I am punctual.

The CHAIR: On behalf of the Committee, I once again express our sincere thanks to all of you not just for making yourselves available today—that has been an impost on you, in terms of other commitments, so carving out that time we know has been difficult and we appreciate that you have done that. But more broadly speaking, we thank you all for the outstanding work you do in your respective local health districts, for and on behalf of the citizens who reside there. We pass on our thanks to all of the people who work in your LHD day in, day out looking after our people in New South Wales. Thank you very much.

(The witnesses withdrew.)

(Luncheon adjournment)

MARGARET LOUISE BENNETT, Chief Executive, Southern NSW Local Health District, before the Committee via videoconference, sworn and examined

ELIZABETH MARY MULLINS, Executive Director of Medical Services, Southern NSW Local Health District, before the Committee via videoconference, sworn and examined

The CHAIR: Welcome to our afternoon session of this hearing into health services and health outcomes in rural, regional and remote New South Wales. We have two groups of witnesses this afternoon: one group until a short break at two o'clock and then a group from two o'clock, concluding at 3.35 p.m. today. I welcome our first set of witnesses this afternoon. Thank you both for making yourselves available. We know that you are very busy with a number of commitments and have had to carve out some time for us, and we much appreciate it. We will now move to the offering, which I am sure you will take up, of an opening statement to get things underway. Once that is complete, we will move into the questioning. I gather, Ms Bennett, you will do the opening statement?

Margaret BENNETT: Thanks, Mr Donnelly. Dr Mullins, our Executive Director of Medical Services, and I are pleased to provide this opening statement, which will take just under five minutes.

The CHAIR: Thank you.

Margaret BENNETT: I would like to start by acknowledging the traditional custodians of the land encompassed by the Southern NSW LHD: the Gundungurra, Ngunnawal, Ngambri, and Ngarigo Indigenous people. The southern LHD serves a population of approximately 220,000 people across a vast geographical approximately 45,000 square kilometres. Southern has a high proportion of elderly people, particularly along the coastal area. Aboriginal people account for 4.2 per cent of our population and are a younger and growing demographic, with 45 per cent of this community living on the South Coast. We also welcome and care for many of the five million tourists that visit our region each year.

The district covers seven LGAs and operates across 20 main service sites. We have eight acute hospitals; three MPSs; five community health services along mental health, alcohol and other drug service sites; and integrated care services. Southern does not have a tertiary referral hospital. However, a well-established, longstanding referral partnership is in place with the Canberra Hospital, which fulfils the dominant tertiary referral service for Southern. Southern's budget for this financial year is $489 million. A 4 per cent to 6 per cent growth in funding has occurred over the last three years, and this has enabled much renewal to take place. This renewal is happening despite the significant trials of the last three years, with drought, devastating bushfires, floods and the ongoing pandemic. The bushfires in particular saw a dedicated and invested focus on the provision of bushfire recovery, mental health and wellbeing support.

The challenge of COVID has seen the acceleration and establishment of the virtual care service. We are now expanding this capacity to augment service delivery in a range of settings. We are focused on increasing clinical capacity and capability. This has been enabled in part by Southern's substantial capital works program. Late last year we opened the new $165 million clinical services building and established a new level 4 ICU service at Goulburn Base. Current works also include new emergency departments at Cooma and Crookwell hospitals, and a new simulation centre will open mid this year at South East Regional Hospital Bega.

The new $260 million Eurobodalla Regional Hospital is at schematic design stage. Importantly, the new hospital will be a pilot site for the culturally sensitive connecting with country design that will enable birthing of babies on country. We have just opened a new close observation unit at Moruya hospital. This is a very key step in increasing care capability for intensive care unit-type patients as we expand our services and workforce in readiness for our newest regional hospital, which will open as a level 4 service in three years' time. Funding has also just been announced for a new purpose-built $20 million HealthOne facility at Batemans Bay.

The development of our clinical leadership and services has been supported by the appointment of 14 district medical leads over the last 18 months. The district-wide leadership provided by these specialist doctor leaders is enhancing clinical service delivery and supporting workforce development. The recruitment and retention of rural generalist GPs in the community and medical and nursing staff for our hospitals is a significant issue for Southern, as it is across rural Australia. We are actively seeking permanent appointments to areas of traditional medical locum usage. We have made a number of new appointments, including a director of ED and a director of ICU at Goulburn, and we will soon announce the appointment of two specialist obstetricians and gynaecologists to be based at Moruya. We are currently in the process of welcoming 80 new nursing graduates, an increase of 22 on the previous year.

Southern employs 2,398 full-time equivalent staff, equating to a headcount of 2,966 people at November 2021 figures. Our people are dedicated and committed, and I take this opportunity to recognise with gratitude and with pride the work they do every day. I particularly recognise the toll the last three years have taken on so many.

As someone who has worked extensively—initially as a clinician and subsequently as an executive—in remote, rural and regional communities in three States for four decades, it has been an extraordinary privilege to be the chief executive of this district for the last 23 months. I welcome this inquiry and the opportunity it presents. I am hopeful the inquiry delivers recommendations that are meaningful and achievable, and can support continued positive change in Southern and indeed throughout rural and regional New South Wales. Thank you.

The CHAIR: Thank you very much, Ms Bennett. We appreciate that. It adds, of course, to the Government's omnibus submission, which is submission No. 630 to the inquiry. For the remaining time that we have—we are going until two o'clock, so I was proposing that we do 15 minutes each; that is half an hour.

The Hon. WES FANG: Forty-five minutes.

The CHAIR: Sorry, yes. Let us do 15 minutes each and split the last bit. Are members okay with that?

The Hon. WES FANG: Yes.

The Hon. WALT SECORD: It sounds very fine.

The CHAIR: It gives you a good run. Thank you. We will move now to the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you very much. I am Walt Secord and I represent the Labor Party. Eurobodalla Hospital: It is the biggest and most pressing issue in the community. It has been a long-running matter, a matter of utmost importance. Can you tell me what services are available at a level 3 hospital and what services are available at a level 4 hospital? There is much community concern about the uncertainty in this area.

Margaret BENNETT: Thanks for your question, Mr Secord. I will give just a quick starting point around what will be happening with the opening of the level 4 in three years' time and what we are doing now to get to that stage. The new regional hospital is at schematic design, as I said before, at the moment—$260 million. Notably, the enhancements in that new hospital that do not exist at the moment in the combined Moruya and Batemans Bay hospitals include—there will be an eight-bed ICU, which currently does not exist. There will be a six-bed paediatric unit; currently there is no paediatric unit. There will be an MRI; currently that is not the case. There will be four mental health beds, which is currently not the case. There will be a 17-place treatment space in the emergency department, plus consult rooms. Currently in the two hospitals combined there are eight treatment spaces and two resus rooms. The bed count, Mr Secord, will go to something between 137 and 147 beds. Currently there are 80 beds available between the two hospitals. That just gives a sense of the enormity of the change and what the $260 million will enable.

The other thing that is really important to note is what we are doing now. I mentioned before in my address that we have just opened a new observation unit at Moruya and established increased staffing to support that. That is a key first step along the way of being ready and able, and having the processes and the staffing ready to go for a level 4 ICU at the new hospital. Importantly, what does that mean? Well, that means that there needs to be an intensive care—it is a level of care that means that you can safely care for ventilated patients—patients on life support—and that you have got an intensive care specialist and intensive care-trained nurses available. I will just see if Dr Mullins wants to add anything more to that.

The Hon. WALT SECORD: May I stop you there, Ms Bennett? You were very careful; you said "a level 4 ICU". Are we talking about a fully level 4 hospital or are we talking about just parts of it being level 4? The Minister and the Government have been very clear: They say it is a level 4 hospital. But the community is wise to you. They say that you are using weasel words and saying things like "level 4 ICU". Will the entire hospital be level 4 or just parts of it?

Margaret BENNETT: No, thank you for giving me the chance to clarify that further. I focused on ICU because it has been a particular area of focus for the community. The Minister has been very clear in his announcement that the new regional hospital will open with level 4 services on day one. That means ED, maternity and ICU, and some of the—

The Hon. WALT SECORD: But Ms Bennett, I have correspondence here from the Minister to the department saying that some of the services—this is dated 22 December. It says—

The Hon. WES FANG: Sorry, December?

The Hon. WALT SECORD: It was 22 December 2021.

The Hon. WES FANG: Thank you.

The Hon. WALT SECORD: It says that some of the clinical services will remain at level 3. That is in complete contradiction to what you have just told us here, so you understand why the community is concerned.

How can you claim today that all services will be level 4 but I have correspondence here from the Minister—which I will table—signed by the Minister that is saying that some of the clinical services will remain at level 3?

The Hon. WES FANG: Can I just—

The Hon. WALT SECORD: What is the difference between those two statements?

The Hon. WES FANG: Can I just ask that you perhaps read that paragraph to the witness, just so that she is able to have context?

The Hon. WALT SECORD: Yes, I will read it slowly. This is 22 December 2021, signed by the Minister, Brad Hazzard, to the New South Wales Parliament and to the Clerk of the Legislative Assembly. It states: "At the time of completion of the new Eurobodalla Regional Hospital some of the clinical services will remain at level 3". How do you reconcile your claim that everything will be level 4 when the Minister has written to this very Parliament saying that it will be level 3?

The Hon. WES FANG: Are we able to send a copy to her?

The Hon. WALT SECORD: To assist, if you need to send it—

Margaret BENNETT: Thank you.

The Hon. WALT SECORD: Thank you. I also have questions about the land acquisition if you could do this, please?

Margaret BENNETT: Yes, certainly. What I can say, which will give great comfort, I think, to the community and the staff, is that the Minister in a recent visit has made very clear that his direction is that the new regional hospital will open with level 4 services when it opens in three years' time. The matter with regard to the land acquisition: I am happy to say the site selection has been completed. An announcement of the preferred site was made, in fact, on 7 December 2020. Health Infrastructure is currently finalising—

The Hon. WALT SECORD: Sorry, Ms Bennett, can you start again? You are going too fast for me and the sound is a bit patchy. Can you give me the time line again, please?

Margaret BENNETT: Site selection has been completed and an announcement of the preferred site was made on 7 December 2020. Health Infrastructure is currently finalising the sale agreement with the landowner.

The Hon. WALT SECORD: Okay, can I take you to that? The site has been selected; has the site been purchased?

Margaret BENNETT: I can only repeat that Health Infrastructure is currently finalising the sale agreement with the landowner.

The Hon. WALT SECORD: But the Government is claiming that the site has been purchased. Last night—another contradiction—at a town hall meeting at Tuross Head sponsored by the progress association, in their candidates' forum, the Liberal candidate for Bega stated: "So the negotiations on the land purchase are underway. The site has been developed, identified and agreed, and those are expected to be finalised by about April." What is the status? What is happening with this project? What is the truth? Is it going to be level 3? Is it going to be level 4? Has the land been purchased? Has the land not been purchased? Will this in fact actually occur?

Margaret BENNETT: Thanks, Mr Secord. With regard to any further questions you would like answered with regard to the acquisition, I would take that on notice and direct that to Health Infrastructure. But I reiterate that the site has been selected and that Health Infrastructure is currently finalising the sale agreement, and that the Minister has been very clear in his direction with regard to the level 4 service.

The Hon. WALT SECORD: Have you provided advice to the Minister? When did the Government decide that level 3 became level 4? When did the Government decide to do that?

Margaret BENNETT: The Minister made the announcement with regard to level 4 service on his recent visit, which was focused on the announcement of a $20 million development of a HealthOne facility for Batemans Bay and the broader conversation about the strengthening of health service delivery across the Eurobodalla as part of the coastal network.

The Hon. WALT SECORD: Did you provide any advice involving the decision to go from level 3 to level 4? You are the CEO of the local health district. Did you provide advice on changing it from level 3 to level 4?

Margaret BENNETT: I have provided regular briefings through to the ministry with regard to what will be required, with regard to the progressive evolution of service delivery in the Eurobodalla, and the significant changes in moving from the two smaller district hospitals to a more sophisticated hospital in three years. Of course, this is guided by the clinical services plan that was developed some time ago with a lot of input from staff, community and, of course, the ministry.

The Hon. WALT SECORD: The clinical services plan—you raised that. I understand there was much consternation amongst the medical staff and medical people who work for the local health district about lack of access to the clinical services plan and input into that plan. Can you respond?

Margaret BENNETT: First of all, I think the input of the clinicians and their staff more broadly into service development in the Eurobodalla is very strong and very focused. That is greatly appreciated and will be very necessary, particularly in the next three years with the amount of work in service development, staff recruitment and capacity-building that we need to do to be ready for this new regional hospital. We appreciate all of that input. I think the amount of clinical engagement and the passion shown was something that we are actually very, very proud of.

Obviously you move from a clinical services plan now into more detailed planning in terms of the workforce steps and the configuration of services that will be going into the new facility. The clinical services plan in and of itself is one document—and it is a core initial document—but there is so much more, as the Committee would be aware, that needs to go into the detail development of services, particularly now. The announcement of the HealthOne facility at Batemans Bay—

The Hon. WALT SECORD: Okay, but I am—

Margaret BENNETT: —brings about an opportunity.

The Hon. WALT SECORD: Ms Bennett, I am concentrating on the Eurobodalla—the confusion and the sleight of hand that is occurring from the Government here. Level 3—

The Hon. WES FANG: Point of order: I think I have to take a point of order on the categorisation, Chair. I think there have been a number of times that the Hon. Walt Secord has used descriptions which are probably not accurate and unhelpful to the Committee's work.

The Hon. WALT SECORD: Okay.

The CHAIR: Okay, I think the—let the question continue. I think we understand your point.

The Hon. WALT SECORD: I am mindful of my time and the point of order. Ms Bennett, can you give a guarantee that we will not see a repeat of the dysfunction that occurred at Bega South East Regional Hospital, where you had a brand-new hospital where the waits in the emergency department and waits for elective surgery were longer in the new facility than the old facility? Will you give a commitment today that we will not see a repeat of the crippling fiasco that occurred at the very beginning of the opening of Bega hospital?

Margaret BENNETT: I can give an absolute commitment. I am very clear that the capacity and capability of the new Eurobodalla Regional Hospital will provide service access and service throughput that is very significantly different to what is currently available on the Eurobodalla.

The Hon. WALT SECORD: Are you confident that you will end the confusion in the community, that it will be a level 4—not just parts of it level 3, but entirely level 4—and that you have secured the land—

Margaret BENNETT: Yes.

The Hon. WALT SECORD: —and that you will purchase the land? There is confusion. Someone is saying the land has been secured, others are saying the land has been purchased and the candidate last night said that negotiations are underway. Can you understand why the community does not believe the Government on Eurobodalla hospital?

Margaret BENNETT: I think that the announcement that was made recently with regard to level 4 service will give great comfort to the community.

The Hon. WALT SECORD: Thank you. What were the steps that the Government took to change it from level 3 to level 4? What was the advice that you based that decision on?

Margaret BENNETT: At all stages in the conversation and planning with regard to the new Eurobodalla Regional Hospital there has been a focus on moving to level 4 service. The Minister's more recent announcement confirming that that development that was already underway, with regard to service development and workforce development, will be expedited to ensure that it is not soon after—the plan always was for that to

be as soon as possible after we opened the new facility, but the Minister's direction makes it clear now that that work will have to be done and completed within the next three years, and that the new Eurobodalla Regional Hospital will open at level 4 on day one.

The Hon. WALT SECORD: Ms Bennett, one final question—I am mindful of my time. You keep using the phrase "expanded to level 4 services". Why will you not give a simple, ironclad commitment—no weasel words, no qualifications—to a level 4 hospital? Why are you refusing to give an assurance without qualification?

Margaret BENNETT: No, Mr Secord, in my opening address I referred to it as a level 4 regional hospital that will open in three years' time, so I am very clear in that regard.

The Hon. EMMA HURST: Thank you both for coming this afternoon. Concerns have been raised during this inquiry that at the moment women in Yass Valley cannot deliver their babies at the local hospital. They are having to travel to Queanbeyan, Goulburn or Canberra. I am sure you probably heard some of those horror stories that have come forward during this inquiry about women having to deliver on the side of the road. What is being done to provide more maternity services for the people in that specific area?

Margaret BENNETT: Thanks, Ms Hurst. It is the case throughout rural Australia and New South Wales, and certainly in this district, that birthing services are not available at every single hospital. It is the case that birthing, as you have said, is not available at Yass, and as you have said those women have their birthing experience in Canberra, Queanbeyan or Goulburn. The absolute focus and investment has been on the appointment of a full-time experienced midwife who provides antenatal support and postnatal support. This service has been very well received and we will continue to focus on that investment.

The Hon. EMMA HURST: Groups such as the New Yass Hospital with Maternity Working Group have been arguing for the midwifery continuity of care model to be implemented in the LHD. That continuity of care, needless to say, [inaudible] better experiences for women and is also actually more cost effective. Is that part of that focus that you have on [inaudible], that continuity of care model?

Margaret BENNETT: Just clarifying, Ms Hurst, you are meaning in the district more broadly?

The Hon. EMMA HURST: Yes, correct.

Margaret BENNETT: Thank you. Yes, I think at the moment I have mentioned the main focus in service delivery is one of renewal. Most recently we have appointed a new nurse manager of maternity services across the district and also a new district medical leader of obstetrics and gynaecology. The work that they will do now with the obstetricians, with the GP obstetricians and with the midwives will be to look more broadly at service delivery, caring for mothers and babies across the district and what opportunities there might be to look at some additional or alternative models. That is an exciting possibility, one that will be embraced by our midwives, GP obstetricians and specialist obstetricians.

The Hon. EMMA HURST: Part of that could be—

Margaret BENNETT: Sorry?

The Hon. EMMA HURST: Part of that review will include consideration for continuity of care with [inaudible]?

Margaret BENNETT: Yes. That is a model I am very familiar with myself, as a former midwife. Certainly, yes, that will be something that will be looked at.

The Hon. EMMA HURST: That is good to hear. In November 2021 Dr Holland, who is the only obstetrician in Eurobodalla Shire, gave evidence before this inquiry and said that he was resigning after 19 years. He cited serious concerns for the state of maternity services in the LHD. I understand he is finishing up in February 2022—very, very soon. Has his position been filled?

Margaret BENNETT: First of all, I would note that Dr Holland gave extraordinary service for 19 years and we are all very grateful to him for that. Dr Holland fulfilled two roles: He was the district medical lead of obstetrics overall and also, as you have said, a specialist obstetrician in Eurobodalla. The district medical lead for obstetrics has been appointed and that is now Dr Andrew Woods. In terms then locally, we are in the process at the moment and have finalised interviews for two new obstetricians and gynaecologists to serve the Eurobodalla, so the answer to that question is yes.

The Hon. EMMA HURST: Has Andrew Woods started that role? He is already in the role?

Margaret BENNETT: Yes, that is right. I should have clarified that. Yes, Dr Woods is already in the role.

The Hon. EMMA HURST: Dr Holland also spoke about the strain of how much he required to be on call. He said it was 96 hours on call continuously for a routine week, and there would be one or two months being on call for 264 hours continuously. Has anything been done to try and resolve this so that the new staff that are coming in are not going to be put under the same level of pressure?

Margaret BENNETT: I think that is such a relevant question. For specialist doctors and GPs working in solo life throughout rural New South Wales, the issue of wellbeing and workload is a key consideration. One of the ways that we are trying to address the matter you raise is the appointment of not one but two obstetricians. That does not fix the problem in and of itself, but it does mean that you are not there as a solo specialist. I think that we need to look at other arrangements, including some rotation of some of our specialists in rural areas through to metropolitan environments, so that this is done in a more organised way and a stronger-partnership way and so there is the assurance of time out and collegial support.

The Hon. EMMA HURST: There was a report that actually related to what Dr Holland stated led to his resignation: the Resilience Assessment of Eurobodalla Maternity Services. Is that document publicly available?

Margaret BENNETT: There were 19 recommendations in that report. It is a report that has been shared with the midwives and with the GP obstetricians in the Eurobodalla.

The Hon. EMMA HURST: Is that a report that can be shared with the Committee?

Margaret BENNETT: Yes, I am sure we could make that happen.

The Hon. EMMA HURST: Thank you. I understand that report found that maternity services in the region were "not unsafe". This directly conflicts with what Dr Holland is saying as the long-time sole obstetrician in the area. How do you reconcile these inconsistencies? It does not quite seem to make sense.

Margaret BENNETT: I think it is important to listen very carefully to what the experience of staff on the ground is. I think some of the key points that Dr Holland has raised—particularly with regard to working as a solo obstetrician and with regard to the development of more specialist services on the coast and in the Eurobodalla in particular—are very well made and certainly are a key focus for us as we develop our new service and move towards this new level 4 regional hospital. That is one point.

Equally so, the resilience review looked overall and we were very pleased to have the external eyes of the CEC. We have engaged the CEC, the ACI and other bodies regularly to come in and to have a fresh-eyes, external, expert look at a whole range of things we are doing as we try to take Southern forward. I think their recommendations are very helpful. It is obviously very reassuring that they see the service as being safe, but they were also very clear about a number of recommendations that we need to take on board—and indeed, we are—to further strengthen the provision of service delivery in the Eurobodalla. We will ask them to do similar reviews for us in other of our maternity places around the district.

The CHAIR: That was the bell. I pass the call to Deputy Chair Cate Faehrmann.

Ms CATE FAEHRMANN: Thank you, Chair. I want to turn to some questions about Goulburn Base Hospital and the staffing levels over the Christmas-New Year break. Was it true that the maternity unit in particular was very understaffed over that period?

Margaret BENNETT: I will take that, Ms Faehrmann. Thank you. It is the case that over Christmas and, in fact, right through to today the absence of sufficient nurses and midwives across our district presents a challenge every day. It is the case that we are utilising a number—in fact, our average use of agency nurses a fortnight is 34.8. We are very challenged with regard to staffing a number of our locations, including Goulburn. Obviously the holiday/Christmas environment—exhausted staff, given the ongoing additional pressure of COVID, is a real issue for us every day. Yes, it is the case that the maternity service at Goulburn was very stretched. They have also had periods recently where we have had to have the maternity service at Cooma on the bypass with those women coming through to Queanbeyan because of the—we have had up to 108 staff, and obviously some of the midwives, who have been furloughed due to COVID. Yes, it is not just Goulburn challenged but across the district more broadly.

Ms CATE FAEHRMANN: Thank you for that comprehensive response. Was the situation so bad that you had to call in paramedics to assist in the maternity unit?

Margaret BENNETT: One of our contingencies—obviously we have had to do, as other LHDs have had to do, a lot of considered planning about workforce to get through the pandemic period. Ambulance are our key partners in service delivery and, helpfully, they have a number of dual-qualified staff who are nurses—some in some cases are also midwives—and paramedics. We have an arrangement with Ambulance that in times of

absolute duress—and there has been a case recently also at Yass with the emergency department—where part of our broader contingency planning to maintain service delivery safely is to work with partner agencies, such as locum agencies, obviously, but also, under the Health umbrella, with Ambulance. If they have any available dual-qualified paramedic staff who are sufficiently experienced and willing to come and do some work with us, we see this as a very positive way of working in partnership to maintain service delivery.

Ms CATE FAEHRMANN: Was it Yass hospital as well where that was put in place over the break?

Margaret BENNETT: Yes. It was critical that we maintain emergency service delivery at Yass and we were able to do so with the fabulous cooperation of the ambulance service.

Ms CATE FAEHRMANN: In other words, there were not enough—and I hear what you have said throughout your evidence today of the severe pressures facing your region in terms of nurses and midwives, so I am acknowledging that, but that sounds like there are a number of hospitals that simply were not able to cope. If you had to rely on paramedics over the Christmas-New Year break that is almost an indication of your maternity units not being able to cope. You just did not have the qualified staff. You did not have the nurses and midwives at that point.

Margaret BENNETT: I think that in periods of duress like that COVID environment where, as I have said, we have had up to 108 staff furloughed—these are extraordinary times—that some special measures need to be considered. Working in partnership with the Ambulance to have the occasional support—I think at Yass it was two shifts to support the emergency department, serviced with a highly skilled critical-care paramedic who was available to come and work with us from Sydney—was a really appropriate solution to that escalated issue. But yes, I do not move away from the broader issue of nursing recruitment and midwifery recruitment across the district. Although we have taken on these 80 new graduates and that is fantastic—and we want to take on at least that many next year—it is the case that we are recruiting to about 100 nursing positions in our district, and that includes midwifery staff. Yes, recruitment of nurses, midwives and critical-care nurses is a major focus for our district.

Ms CATE FAEHRMANN: I hope—yes, I have got the time for another question.

The CHAIR: Yes, proceed.

Ms CATE FAEHRMANN: It is difficult to hear the bell. In your planning for COVID—in your planning for a potential outbreak—did the LHD plan for this number of nursing staff and healthcare workers to be furloughed? I am asking that question because it seems as though because the outbreak—we kind of "let it rip", if you like—that the impact on healthcare workers was in some ways unforeseen. Or did your LHD model the fact that you could have that many staff off at any given time?

Margaret BENNETT: I think it would be fair to say, in the evolution of the pandemic over two years and with the very tight coordination and planning at a State level and a SHEOC level—and how that has then encompassed every LHD—that there has been an intense amount of planning and forecasting. It would be fair to say that at different stages of the pandemic, different areas of focus have been highlighted. Earlier in the pandemic we were intensely focused on making sure that we upskilled significant numbers of nursing staff to be able to look after the expected high number of ventilators. Then at other stages of the pandemic there has been an intense focus on "Do we have enough immunisers to be out running all these clinics?" and so forth.

Omicron has presented a different challenge again because the hospitalisation, as you would be aware, has tracked at the best level that we could have imagined, really, and at the optimistic level. But certainly the impact on staffing—yes, this was planned for, but in an LHD, even with good planning, it is the very unpredictable nature of who is going to be a close contact and a positive next. There has been a disproportionate impact at different times. The other day—if I could give the example—of 108 staff off, 64 of those were over on the coast. So the planning has occurred, but it is fair to say that providing that level of redundancy when the whole State is pressured certainly presents an extraordinary challenge.

The Hon. WES FANG: Thank you very much, Ms Bennett and Dr Mullins, for making yourselves available today. It is very pleasing and it is wonderful to have your experience, to be able to present the views of your local health district. I firstly note that there are obviously some events happening very shortly which have probably overtaken some of the focus of this inquiry, which is unfortunate. Ms Bennett, do you say that you have been involved in the health administration in that area for a while? More broadly, what is your other experience around the State?

Margaret BENNETT: Yes. As I said, I am from a background as a nurse and a midwife and critical care nurse. I have worked in three States and for the last 28 years or so as a general manager or chief executive.

The Hon. WES FANG: How long have you been in the region that you are in now, the southern region?

Margaret BENNETT: Twenty-three months, Mr Fang.

The Hon. WES FANG: Thank you. Turning back to pre-2011, do you know how many level four services were available in the Southern NSW Local Health District?

Margaret BENNETT: Pre-2011?

The Hon. WES FANG: Yes.

Margaret BENNETT: I would say probably none, pre-2011, because the ICU service at the new Goulburn is only just a level four at this point and, of course, South East Regional in its current fabulous form would not have come online at that time. There has been a significant amount of growth and development, Mr Fang, in Southern over that time.

The Hon. WES FANG: Okay, so pre-2011, we had no level four services in that local health district.

The CHAIR: Sorry, I think the evidence was probably—I do not think Ms Bennett was sure. I just need to have that clarified, whether or not it was a statement of fact. I thought you said "probably did not", so just clarify that.

The Hon. WES FANG: My understanding is that there was not, and I just wanted to confirm that. That has been the evidence, but my understanding is that there were no level four services at all pre-2011. Obviously since 2011, with the change of government to The Nationals and Liberals, we have seen level four services come to the southern region. Is that correct?

Margaret BENNETT: Certainly, level four services have been growing at Eurobodalla, at Bega—South East Regional—and at Goulburn in recent times, particularly with the investment in both those new facilities.

The Hon. WES FANG: Just referencing Mr Secord's questions earlier, he put to you some written advice that the Minister had given. I am assuming, Mr Secord, it was an answer to a question on notice or a written answer?

The Hon. WALT SECORD: No, it was to the massive community petition demanding an improvement in health services in Eurobodalla, and the Minister was compelled to respond.

The Hon. WES FANG: Thank you for the clarification, Mr Secord. Mr Secord raised some evidence that I believe was from December 2021. Ms Bennett, the Minister has since been able to provide an update. I have a press release from 21 January 2022 that would supersede the previous advice, and that is that the new Eurobodalla hospital will be level four on the day it opens. Is that correct?

Margaret BENNETT: That is correct.

The Hon. WES FANG: So any attempt to create a fear campaign around what services may or may not be available is probably unhelpful and perhaps somewhat political.

The CHAIR: I think we need to just—

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

The Hon. WES FANG: It is pretty clear, is it not, that the only people who have actually brought level four services to the southern region are the people that are in government now. The only people that have committed to bringing level four services to the new Eurobodalla hospital are members of the current Government. Is that correct?

Margaret BENNETT: Mr Fang, I can only repeat the Minister's announcement as you read it.

The Hon. WES FANG: Thank you very much for that. Turning to other matters, while the by-election is approaching, we are obviously talking about the provision of rural, regional and remote health care in New South Wales. In your area, have you had the ability to find some innovative ways of dealing with the COVID pandemic? Given the challenges and perhaps some of the solutions that you have found, have there been some learnings that you might be able to share with the Committee, so that we can better understand what the health districts are doing to counter the COVID pandemic and also some of the innovative ways which they have found to resolve distance issues and some of the other challenges that it has posed for the community?

Margaret BENNETT: Thanks, Mr Fang, and this is certainly something that we are talking about in the district, and indeed with the ministry and all the other rural chief executives. Despite the fact that we are all still battling to get through the pandemic at this stage, it is very clear that there are a number of silver linings. There are a couple that I would point to in our district, most notably the establishment of virtual care. This has enabled us to manage the accelerated development of virtual care at the beginning of the pandemic in partnership

with Illawarra and with Coordinare, the primary health provider. But this development has enabled us to look after very significant numbers of COVID patients in the community, even quite sick patients, with 24-hour monitoring.

Without any doubt, this has enabled us to get through the pandemic as well as we have in terms of meeting the needs of our community. Obviously, that now sets us up to be looking at how best could we use this capacity. The things we are looking at are: How might we further develop virtual care now to better manage, monitor and support patients with chronic illness? How might we use virtual care to support the clinical governance and clinical support in isolated emergency departments, where there might be a sole doctor or a sole nurse? So, yes, I think that is one key area.

The other thing I would say that we are talking about—and we need to evaluate this carefully—is that the necessity of care during the significant challenge of the pandemic has brought us into closer and tighter care with a number of patients, a significant number of vulnerable patients in our community, who often previously have been disengaged from health service delivery. The necessity of the pandemic has brought them into closer connection with us, and we feel that there is an opportunity to build on this now—to actually go back to all of these vulnerable patients who have not previously accessed traditional services and see what it is that they might want from us, building on the care that was provided during the pandemic. That is two things. I think the other thing that health services will find—it will take time to get through the exhaustion and everything that exists at the moment, but the extraordinary, above-and-beyond commitment and the agility of our staff, I think, demonstrates despite the current challenges that there is extraordinary resilience amongst our people.

The Hon. WES FANG: Thank you very much for those really valuable insights. I think that you are right that the learnings that we have had from the COVID pandemic are such that we will be able to use them not only across your local health district but also across the State. It is really important that this Committee hears from all those local health districts and we have that shared knowledge and experience about the learnings, as well as the innovative ways that we can tackle problems like COVID and actually use technology and other means to overcome the problems that we have. Just right at the end there, you touched on the staff and how they have been resilient and providing exemplary service in what is obviously, for everybody, quite a difficult set of circumstances. How do you find the maintaining of morale in your local health district? Do you find that perhaps attacks that happen on the services, perhaps politically motivated or the like, might actually affect the morale of staff who are really just doing their job?

Margaret BENNETT: How do I find morale? I think that the last couple of years have demonstrated the over-and-above service and commitment of our staff to the community by serving your patients—and, in fact, with one another. I would, however, say that in Southern it is my experience—and I know other rural chiefs share this with me and we discuss it regularly—that so many of our staff are incredibly exhausted. In Southern, that is compounded not just with the pandemic that we are talking about but also, in our case here, the fires and the drought before that. So many of my staff have had pretty much three years of trauma, so that takes a toll and that will take some time to recover from. But, yes, my staff are no different to any rural staff in the fact that they give so selflessly, and having the respect and support of the community is very central to their wellbeing.

The Hon. WES FANG: And so it is really important that community leaders are supportive and are seen to be supportive of the staff and are not using them in order to campaign or send messages that would actually create more harm for them. Have you had any experience of that occurring? Do you have any insights as to what effect that does have on the staff?

Margaret BENNETT: I would just reiterate the importance of staff receiving, certainly, constructive feedback. That is something that families of patients need to give. That is important and expected. But, more broadly than that, it is very essential that the health staff who give the very best they can every day receive the support and the respect of the community broadly—all aspects of that community.

The Hon. WES FANG: Thank you for that. I have one minute left. I have so many more questions I could be asking, but I am limited by the time. Just in relation to the staff themselves, and the feedback, are you able to receive from staff and patients—in a feedback quality assurance loop—some of the understandings of what is working well during your COVID response, things that perhaps could be done better and things that have cropped up that were unexpected? Obviously, that feedback loop is important for providing the service moving forward.

Margaret BENNETT: Yes, Mr Fang, thank you. Yes is the answer. That mechanism is every day, and it is both formal and informal. For example, we have these pandemic operations meetings that involve the site manager, directors of nursing and a very wide range of our staff. The purpose of those meetings—you take time for the meeting every single day, seven days a week. At other times when things are a little bit more settled they are three times a week, but they are ongoing. That provides an opportunity. It has got a real structure to it, but everyone has got a voice. It is a chance to say, "What is going well? What are we worried about? What are our

pressure points? Looking ahead to the next few days, where are we going to need staff? What is our immunisation rate? What additional clinics are we opening up? Where are our bed pressures?" et cetera. So the answer to your question is most definitely yes. In point of actual fact, without such a strong structure—both at an informal and a formal level throughout the district—we would not have been able to have coped as well as we can in meeting the care of the community during this extraordinarily difficult time.

The Hon. WALT SECORD: Thank you, Ms Bennett.

The CHAIR: Thank you, Ms Bennett. We have about 4½ or five minutes each, so it will be a quick round of one question from each of the groups at the table. The Hon. Walt Secord.

The Hon. WALT SECORD: Ms Bennett, I want to take you to the *Clinical Services Plan* of 20 March by your local health district. Page 9 says that 165 beds are needed at Eurobodalla hospital, but in your answer to my very first question you said there will be 137 to 147. That is a cut, so how can you continue to make the claim that it will be a level four hospital when it will have fewer beds than the *Clinical Services Plan* proposed by your very health district? It has fewer beds.

Margaret BENNETT: Thank you for your question. The 137 to 147—bearing in mind that it is a schematic design—is inpatient beds. I would be happy to provide additional detail to the Committee of the planning that we are undertaking. In addition to that, of course—

The Hon. WALT SECORD: Ms Bennett, I want to concentrate on the beds issue.

The Hon. WES FANG: I think Ms Bennett needs the opportunity—

The Hon. WALT SECORD: You said, "in hospital beds". Are you counting people in their homes as beds? You said very specifically, "in hospital beds". What do you mean by that?

Margaret BENNETT: I will start my response by saying that this is something you might like more detail on, separately to this one-minute conversation. But the work underway can take somewhere between 137 and 147 ward beds—medical ward, surgical ward et cetera. Additionally to that, spaces in the hospital for treating patients include, for example, the 17 beds in the emergency department and other treatment spaces in the hospital. I would be happy to provide that additional detail if that—

The Hon. WALT SECORD: Okay, I would like that on notice. Thank you very much.

The CHAIR: We have literally three minutes. The Hon. Emma Hurst is forfeiting her time to Ms Cate Faehrmann. Cate, do you have a question?

Ms CATE FAEHRMANN: Thank you, Chair. Just one quick question: Ms Bennett, we have heard of many nurses in tears, many nurses threatening to resign and some on the brink of leaving a profession that they care so passionately about. What is the LHD doing right now to retain those nurses who are on the brink of walking away?

Margaret BENNETT: I think that is an incredibly relevant question and certainly a key focus for us all on the executive. Some of the things we need to do—we actually need to give these nurses hope that things are going to improve, so we need to be very realistic about the current environment and recognise what they are saying to us and not gloss over that. They are exhausted. Many of the casual and part-time staff—and, in fact, the full-time staff—have been working incredibly hard, much harder than they should or than they would want to. I think that there will be some sense from the nursing staff that even the broader symbolism of 80 new grads joining us and settling in—the additional nursing education that is going into supporting them is helpful.

Another thing that is helpful is the fact that we have now got fully appointed site managers/directors of nursing in every one of our sites. Having a very experienced, stable, steady, visible team of nursing leaders is a key thing in giving the nursing staff a sense that there is appropriate leadership, people are listening to them and we are going to do whatever we can to get out of the incredibly difficult environment we are in at the moment. But recruitment is the key. Something the staff are heartened by, particularly in some of our areas, is the recent announcement of $15 million to support staff accommodation. In some of our towns, it is the addressing of practical things like that that will make a key difference to recruitment.

The Hon. WES FANG: I have just noticed that it has already gone two o'clock. I was going to ask Ms Bennett if you could just address that misinformation about the *Clinical Services Plan*, but noting that you have decided to take the question on notice and you will address that misinformation that was just presented, I will cede my time and we can finish on time.

The CHAIR: That brings us to the time to conclude. I am sure we could easily spend another half-hour-plus, but we have had our opportunity to speak to you both. It has been very helpful to have some

specific information from your neck of the woods, which adds to the Government's submission to the inquiry. That specific information is most helpful. On behalf of the Committee, I thank you both very much for carving some time out of your day. We know you are very busy. On behalf of the Committee, I also thank you very much for the most important work you have done and continue to do for the citizens of your part of New South Wales.

Margaret BENNETT: Thank you. We appreciate the opportunity.

MARGOT MAINS, Chief Executive, Illawarra Shoalhaven Local Health District, before the Committee via videoconference, affirmed and examined

MARGARET MARTIN, Executive Director Clinical Operations, Illawarra Shoalhaven Local Health District, before the Committee via videoconference, affirmed and examined

CAROLINE LANGSTON, Executive Director, Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven Local Health District, before the Committee via videoconference, affirmed and examined

AMANDA LARKIN, Chief Executive, South Western Sydney Local Health District, before the Committee via videoconference, sworn and examined

The CHAIR: We will get our last session for the day underway. I thank you all, first of all, for joining us this afternoon. We know that you are all very busy in your respective roles and you have had to carve out about an hour and a half for us this afternoon, so we are very appreciative of that. We will move on to opening statements. There will be two, the first one for the Illawarra Shoalhaven LHD. I presume you will present that, Ms Mains?

Margot MAINS: Yes, thank you, Mr Chair.

The CHAIR: Thank you, please proceed.

Margot MAINS: Thank you, Mr Chair, and thank you for the opportunity for us to participate in this hearing today. I am proud to be living amongst the oldest living culture in Australia, the culture of the Aboriginal people, who have survived in this country for over 65,000 years. It is always an honour to pay my respect and to acknowledge the traditional custodians of the lands on which we meet today. I would also like to acknowledge all Elders, both past and present, and all Aboriginal and Torres Strait Islander people joining us today. I feel incredibly privileged to work in the Illawarra Shoalhaven, with over 7,500 colleagues who are dedicated to the health and wellbeing of our communities. We live and we work here because we love the lifestyle, the people and the landscape that envelops us between the mountains and the sea. We care for a growing and ageing population of over 400,000 people, spread across all the local government areas of Wollongong, Kiama, Shellharbour and Shoalhaven.

The district extends around 250 kilometres from Helensburgh in the north to North Durras in the south. In that area, we operate a network of eight hospitals and we provide community health services in 58 locations across our district. The Illawarra Shoalhaven region is the traditional home of the Dharawal and Yuin nations. The Aboriginal communities represent around 3.4 per cent of our population. People who were born overseas are about 18.4 per cent of our population, with also a growing number of refugees in our region. In our district, people aged under 65 years are our fastest growing age group. We recognise that we cannot raise the health and wellbeing in our communities in isolation. We are truly grateful for the many partnerships we have, including the Primary Health Network, residential aged-care facilities, disability accommodation providers and our Aboriginal health partners, to name but a few. The importance and the effectiveness of these relationships has been demonstrated throughout our joint COVID management.

Aboriginal people have an inherent right to access ethical health services that are culturally safe and are welcoming, and it is our duty and responsibility as LHDs to ensure that we make a positive impact. Our health services have made progress in moving towards creating more safe and more welcoming environments for Aboriginal people to access care and support, but we know there is so, so much more to be done. The Shoalhaven Cancer Care Centre is a comprehensive care centre for full-time medical oncology and radiation oncology services for our Shoalhaven residents. Our long-time partnership with Waminda has meant that we were able to engage Aboriginal health workers in clinical placements at the centre, which has paved the way for further opportunities to provide targeted care for Aboriginal people. Currently, we are also working on cancer clinical trials towards partnerships with Canberra Health Services, Murrumbidgee LHD and Southern NSW LHD on the regional, rural and remote program grant to enable us to grant access to clinical trials to these communities in all specialties clinics.

We recognise as a district that we cover an extensive range of coastlines and their communities and that health care is not one size that fits all. We cannot provide every service in every location. We need to plan as a district and to network our services accordingly, ensuring that decisions about services are based in quality and safety assessments and standards. The last few years have also been an important reminder that we respond not only to the ongoing needs of our population but that we must also be ready to act in the event of a disaster or pandemic. From adversity, some of the most amazing things grow, and one of the standouts for us—and there were many in the LHD—was the commencement of the SEED Program, which was created to support our staff at Milton Ulladulla Hospital to help them deal with the devastating bushfires that tore through their community

in 2020. It encompasses staffing initiatives that promote healing, wellness, belonging and connection, and it is a part of our overall LHD workforce wellbeing approach that continues and grows.

Since 2020 we have also sustained a significant focus on mental health services following the bushfires, and we have been really fortunate to have gained positions that have enabled us to better support the community in disaster recovery, rural counselling, our suicide prevention outreach team and a mental health ambulance police project, to name a few. We have also, over the last number of years, been planning for the development of the Shoalhaven precinct, providing new and extended services in the next four years. It will see more emergency and elective surgery at Shoalhaven, a cardiology ward and a teaching service, an MRI, a new paediatric assessment centre and theatres. Endoscopy will significantly increase and we will have a dedicated palliative care ward with increased numbers, so that we are now more able to actually care for more people in our local district. We also, at the same time, are planning for significant developments at Shellharbour.

In November 2020 we had the privilege of opening Ulladulla HealthOne, which provides many community services including dental, drug and alcohol, community mental health, community nursing, and child and family to the Milton Ulladulla community. The aim is to reduce the burden of chronic disease and to ensure we provide as many services as close to home as we can. With these extensions to services comes the challenges of attracting or maintaining a workforce, particularly in a rural setting. At times these challenges can shape the services the district provides. We have been working on sustainable strategies that mitigate risk and provide certainty. We have been able to actually increase the orthopaedic surgeons from two to four at Shoalhaven, allowing a 24/7 on-call service. We have been able to increase the presence of medical oncology at our Shoalhaven cancer centre and we have worked closely with our PHN to deliver a collaborative model for the management of COVID patients, both clearing pathways from the ED to GP respiratory clinics.

We have also evolved to provide many solutions to support patient care virtually, like our Telestroke Service at Shoalhaven—an innovative service that provides 24-hour access to life-saving stroke diagnosis, treatment and thrombolysis, connecting patients and local doctors with specialist health physicians via video. Our Telestroke Service now has the fastest door-to-meeting time of the Telestroke Service in New South Wales. Finally, I would like to recognise the many brilliant people we get to work with every day—our dedicated volunteers, our carers, our health partners, our community and business partners—that enable us by working together to deliver far more effective services. We cannot achieve excellence without partnering with those that experience this journey with us. And my thanks and a critical part of our gratitude to all of our staff, who are the backbone of our organisation. Their dedication and their tenacity make me incredibly proud to be a part of it. As chief executive, I welcome this inquiry and the opportunity it represents to us to reflect on another series of experiences to learn and to share information. Thank you.

The CHAIR: Thank you, Ms Mains, for that detailed opening statement. Ms Larkin.

Amanda LARKIN: Thank you, Chair. If I can just make a brief opening statement from my perspective, South Western Sydney is a large and a complex mix of both metropolitan but also rural health services. We service a population of approximately 1.1 million people and we extend from Liverpool, Bankstown and Fairfield in the north to Bowral—really down to Marulan, to the trucking station on the Hume Highway—and then out to close to Warragamba Dam and then out to Woronora in the east. As part of the district, there are six hospitals. Liverpool is the tertiary hospital for the district and Bowral Hospital, which is in that rural area, is part of the network of services that we provide in the south-west. There are over 14,000 staff who service that community. The structure of the services is set up with general managers and operational services at each of the sites, together with clinical directorates that cover the whole district and look at quality, safety and clinical practice across the whole district. That network arrangement is essential in providing safe, high-quality care across the district.

Places such as Bowral are inherently involved in those structures and service provision, like the larger facilities. We have a comprehensive strategic and clinical services plan that clearly outlines and articulates service development over the next five years, and we are currently in the process of revising that strategic plan to take the organisation into the mid-2020s. I think the other important thing to understand is that South Western Sydney has a very large capital investment program, over $3 billion. That includes significant redevelopment at Campbelltown, Bowral, Bankstown and Liverpool. The investment in Bowral over the last couple of years has been significant. Stage one was completed with the new clinical services building, which saw a significant upgrade in the services—when I say services, the environment—that is available in Bowral. There is a stage two program that is in place to take that service forward.

We have seen significant investment in services, and Bowral's ability to operate in its current structure is very much linked to high-level services both in Campbelltown and at Liverpool—so the patients access that work for higher level services and then return once they are in a safe condition. Over the last five years there has been

a significant increase in services across the district, from dialysis to cancer to a range of services, to which our rural partners in Bowral have access.

The CHAIR: Thank you very much. Before we proceed to questions, I invite everyone when asking a question or responding to a question and providing the answer to identify who you are. We have Hansard remotely taking down is being said, but they may not be actually seeing who you are. To get our record as accurate as possible, if you identify yourself when you ask a question and when you provide the answer then that will allow the best possible record we can have of the exchange. If you could do that, that would be helpful. We will roll through our questioning in 15-minute blocks, sharing it between Opposition, crossbench and Government. We will do that until we exhaust at 3.35, which is the scheduled finishing time. With that brief overview, I invite the Hon. Walt Secord to commence.

The Hon. WALT SECORD: My very first question is to the chief executive of the Illawarra Shoalhaven Local Health District, Ms Mains. There was quite a bit of excitement this morning with the announcement that elective surgery in some form was going to begin in New South Wales today. But it was probably frustrating and infuriating to read a statement from the Illawarra Shoalhaven Local Health District welcoming the announcement but saying, "Our hospital teams are now working through the development of a reimplementation plan, taking into account local circumstances including the availability of staff." Has elective surgery started in the Illawarra? If it has, what is the capacity and what is occurring?

Margot MAINS: Thank you for your questions. Currently, at this point in time, we are providing urgent and emergency—urgent elective surgery and emergency surgery—and we are providing day surgery. As the statement I put out and provided today says, we have been asked to look at recommencing. Depending on our individual circumstances, we will add surgery up to 75 per cent as of 7 February. The reality is that the team, in the light of that decision—which we do welcome, as you have said—are actually currently also looking at our ability to do that based on demand and also our capability and staff availability. At the present time we can have up to 150 staff furloughed each day due to COVID—getting COVID or being a close contact—and we need to weigh up, every day, what services we can actually provide.

Today, for example, we had 100 furloughed staff. At the same time, every LHD is experiencing different effects of COVID, and it is most—generally, regional and rural areas are slower to see an impact than metro areas. So, for example, at the moment we have increasing presentations of people with COVID. We are also having increasing presentations of patients who are having the impacts of COVID past the positive. We are also getting increasing presentations of people with injury and other illness. So what the team are currently doing, in response to the announcement today, is looking at when it is feasible for us at all three sites to actually re-establish surgery, and then we hope to be able to make a further announcement in the near future. But I will need to take into account all of those factors.

The Hon. WALT SECORD: Ms Mains, I want to dig into your answer little bit. So elective surgery did not begin today in the Illawarra.

Margot MAINS: No, the elective surgery is to commence—the announcement is that we would be looking to commence this from 7 February, and we would each make our own—to look at what was actually possible, moving forward.

The Hon. WALT SECORD: Okay, so it did not begin today, but you hope that you will be back up to 75 per cent on 7 February.

Margot MAINS: I honestly cannot say that, because we have a lot of pressures. We will be doing our best, but we actually need to look at what staff we have got available and also what the capacity of our hospitals is. At the present time, a number of our wards are taken over as COVID wards and a number of our staff have been redirected to support the COVID wards when they are asked to. So we need to look at what capacity we have actually got to enable us to do that as of next Monday, and I am not in a position yet to be able to answer that question.

The Hon. WALT SECORD: Ms Mains, the Premier said that elective surgery would begin today, so that is a misleading of the community. Elective surgery in the Illawarra is not beginning today. He was on radio this morning and in print media saying that it would begin today. In fact, that is not your experience on the ground.

Margot MAINS: Basically, there has been a statement that private hospitals are currently looking at—we are looking to the private hospitals to provide some of our elective surgery, and they are looking to move now to doing that. I would need to go back and further clarify our statement.

The Hon. WALT SECORD: Okay, but I do have your statement and you say it depends on, quote, "the availability of staff". You are very clear; you are being honest with the community. You are telling the community

that elective surgery cannot begin until we have the availability of staff, but the Premier this morning was telling everyone that elective surgery was beginning today.

The Hon. WES FANG: Is that what the Premier said? My understanding is it was from Monday 7 February.

The CHAIR: Order!

The Hon. WALT SECORD: That is what she said. May I ask a question to Ms Larkin? Ms Larkin, I turn to a similar inquiry into health services in south-west Sydney. I think it was in 2020 and was chaired by my colleague the Hon. Greg Donnelly—a very good committee. There was evidence from your local health district, South Western Sydney, and it was reported in May 2020 that healthcare expenditure in South Western Sydney is $800 less per person than other regions in New South Wales. Has that disparity been addressed since that report?

Amanda LARKIN: Thank you for your question. In relation to the funding for South Western Sydney, we received in the last budget cycle the highest growth rate for the State in relation to funding for the district and delivery of services. That has been true for the district over at least the last five years. The distribution of that growth in expenditure is to ensure the provision of services and increase in services across the district, and that will continue in this current financial year.

The Hon. WALT SECORD: You mentioned earlier in your opening statement about Bowral being linked to Campbelltown and Liverpool. How does that actually work? This inquiry is an inquiry that emphasises rural and regional outcomes, and I think even my colleague the Hon. Wes Fang would agree that Bowral is a regional centre.

The Hon. WES FANG: Only just.

The Hon. WALT SECORD: How does the linking work with Campbelltown and Liverpool?

Amanda LARKIN: The district has a clinical services plan that looks at the relationship of all services across the district. Bowral is a district level three hospital, so it provides for the Wingecarribee Shire a broad range of district-level services for that community—medical, surgical, paediatric, maternity and ICU. As part of that plan, there is a very clear network arrangement. If patients require higher level services, they are linked to either Campbelltown or to Liverpool, in terms of people transported to those services for the higher level tertiary services that they may require, and then are transferred back. Depending on the condition of the patient, et cetera, they may step down from Liverpool back to Campbelltown, then back to Bowral. But there is a good network of arrangements—very strong relationships between clinicians—where they can get support and guidance if required. They can transfer patients to those higher level services if required.

The Hon. WALT SECORD: We have taken evidence involving a number of smaller district hospitals and MPSs in country areas, particularly rural and remote areas. Two hospitals are of particular interest in your LHD, Bowral and Camden Hospital. In 2020-21, did those two hospitals have a doctor on duty at all times during their operation?

Amanda LARKIN: Yes.

The Hon. WALT SECORD: When I say "on duty", I mean a doctor not on the telephone or on a camera but physically in the hospital.

Amanda LARKIN: Correct.

The Hon. WALT SECORD: Okay, thank you. Now I would like to go back to Ms Mains. Ms Mains, Shoalhaven hospital has—depending on who is addressing the question—some people would say the worst performing emergency department in your LHD. Over the past 10 years it is consistently one of the one, two or three emergency departments under the most pressure outside of Sydney. What steps are you taking to improve waiting times at Shoalhaven?

Margot MAINS: I will initially start this question, and I will also ask Margaret Martin to help me with this. Yes, this is an area that has seen increasing presentations and is predicted to grow by 12 per cent before 2031. So there is a number of things that we are planning and doing now to actually do that. That is, we have got to significantly increase our staff, for example, with our places, and seeing doctors that we employ. We have just employed access and flow nurse managers to enable us to enhance access and flow from either the EDH community or the emergency department into places within the hospital. We have been looking at doing that. We also set up an ESSA, an emergency short stay unit, to enable us to actually manage people there and then be able to discharge them back into the community after a short stay. We are also, of course, doing a lot of planning together to enable us to grow the emergency department of the new Shoalhaven hospital that we are developing. That will significantly increase the space and the capacity at the emergency department.

The Hon. WALT SECORD: May I ask a quick question about short stay units? It has been put by various committees and by the medical profession that short stay units are actually way of gaming the system. You pull someone out of the emergency department and put them in a short stay unit and you take them off the books. The clock stops running but, in fact, they are not in a hospital room with a bed. They are actually just outside the emergency department. So are you predicating that you will cut emergency wait times by setting up short stay units to game the system?

Margot MAINS: That is not the intention of the short-stay unit. The short-stay unit there is to promote getting patients to the right place, to get the care they needed, and they have been shown to be very successful in patient management. I will get Margaret Martin to give us the detail.

Margaret MARTIN: I am responding to that question.

The Hon. WALT SECORD: Thank you.

Margaret MARTIN: This has been commented on before. What we do track is the number of patients that are admitted to the emergency short-stay unit. They are being discharged home rather than moved into a hospital bed. I think in the past short-stay units have been used as a holding place and that is not the model that so we have implemented at our hospitals and we do track them.

The Hon. WALT SECORD: Thank you. Ms Mains, I would like to ask a couple of questions about the smaller hospitals within your purview: the David Berry, Milton Ulladulla, maybe Coledale Hospital. I have a similar question to ask Ms Larkin: Being smaller hospitals, in 2020 and 2021, did those hospitals have a doctor physically on duty throughout the year?

Margot MAINS: So our hospitals, yes at Wollongong, Shellharbour, Shoalhaven, Milton Ulladulla—do have doctors that are definitely available 24/7, although we do get some challenges with our medical staffing in the ED at Milton. At the current time we do not have doctors—we do not need doctors 24/7. They are on-call. At our subacute units at Coledale and at Port Kembla, we have a doctor available from another site.

The Hon. WALT SECORD: When you say you have challenges at Milton Ulladulla, do you mean that there were times in 2020 and 2021 when there was not a doctor physically in the hospital? I am using your word, "challenges".

Margot MAINS: No, no. We always work to make sure we get a doctor in our hospital. A particular challenge at Milton Ulladulla lies with our ED on GP VMOs and of course we are looking and working with the GP VMOS to provide sustainable model—working with them to enable us to always have staff. They are always available so we are not looking to locum agencies at short notice at the last point in time.

The Hon. WALT SECORD: Now what is happening—

Margot MAINS: We usually go to—

The Hon. WALT SECORD: Sorry, ma'am: I interrupted you.

Margot MAINS: We have been able to staff at the present time but the current utilisation at the emergency department at Milton hospital was 60 per cent of locums and working with GP VMOs. We have a series of groups working together with GP VMOs to actually find the right options to get us a more sustainable workforce going forward. For example, we also went out and advertised for career medical officers. We are looking at a range of workforce initiatives.

The Hon. WALT SECORD: Can I ask you this question? Have you actually done a deep dive on why the Shoalhaven Hospital appeared repeatedly over the last 10 years since I have been watching Health as being in position one, two or three of the longest waits for its emergency department? What is so unusual about that hospital that it consistently has one of the longest waits in emergency departments? I will ask one last question: Why does it also consistently have some of the longest waits for elective surgery, too?

Margot MAINS: So I think what Shoalhaven has been facing, as I have said before, is increasing hospitalisations—I mean, I am sorry—increasing population growth and of course we have over 6.8 million tourists, I understand, who are coming to the beautiful south each year because people love to come and stay here. That does present us with particular challenges and we do have action plans around that, but the number of presentations at Shoalhaven ED is increasing year on year in terms of what is actually happening. So what we try to do is to work over that period of time with more FACEMs, more SMROs. We have appointed more nurse unit managers to manage access and flow as I said previously from an ESSA. Sometimes we also place a number of patients that are waiting in our ED to access beds and we are working on that because there is, with the new Shoalhaven Hospital, significantly more beds, and that, to actually enable us to better meet the needs of that population.

The Hon. WALT SECORD: Very good.

Margot MAINS: We are also looking at what we can do to actually [inaudible] community in terms of the long waits for elective surgery. I will ask Margaret Martin to respond.

Margaret MARTIN: So we have had some shortages of experienced nursing staff and anaesthetists for our operating theatres and that has impacted our ability to run at 100 per cent. We have successfully recruited into those positions and they will come on board by the end of February. So that has had an overall impact. The other area that has impacted Shoalhaven, like many of the other hospitals, is the impact of COVID and the cancellations and the high number of category C patients that have ended up waiting. We are working with our private hospital—the Nowra private—to provide some of those services to complement what we can do at Shoalhaven.

The CHAIR: Thank you very much. We now move our questioning to the crossbench. We will commence with Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you. Thank you, Chair. I will stick with Ms Mains. Just in regards to women living in Milton Ulladulla, [inaudible] and further south, we have had one of the submissions to this inquiry note that women have no choice but to travel for an hour or an hour and a half to have their baby delivered in a hospital with obviously carries a high risk morbidity and mortality for both mother and child. Since the redevelopment of the Shoalhaven Hospital is obviously not going to resolve the travel time, are there any other efforts being made to provide maternity services closer to these [inaudible], or at least to provide these women with access to a local midwife?

Margot MAINS: Thank you for your question. Basically, in relation to women who travel to Shoalhaven for birthing. In relation to that we did set up a new Midwifery Antenatal and Postnatal model of care, which is called MAPS. We introduced that in April 2020. That is a dedicated tool that was established at Milton Hospital. It is made up of six midwives in two teams of three. They focus on continuity of care during pregnancy, antenatal care and postnatal care. We are in the future, though, also going to take that a step further with the Shoalhaven midwifery group practice, which will extend to Milton. This is something we are focusing on for the future. That will enable further continuity of services with hopefully the same group of midwives who will be able to follow the women through to the Shoalhaven maternity ward.

The Hon. EMMA HURST: Thank you. My next question is raised with Ms Langston, who will correct me if I am wrong, but a number of submissions expressed concern that there is no inpatient detox centre in Shoalhaven. Are there any plans for a detox centre in the future, either in the hospital, or the redevelopment, or in other plans within the LHD?

Caroline LANGSTON: Thank you for the question. With this program it is possible to do this within the hospital. There really is no specific dedicated program but the detox team are very experienced dealing with that. There is quite a number of withdrawals that happen within the Shoalhaven Hospital. There is also access and we support and fund Oolong House for our alcohol referrals, so alcohol withdrawal services, plus there are home-based alcohol withdrawal services that are provided by—there is a whole team supported by community nursing teams. There are plans within the new Shellharbour Hospital to establish a withdrawal service modelled on a very similar model operating out of St Vincent's. We are planning for that in the Shellharbour Hospital.

The Hon. EMMA HURST: If somebody was going to go into inpatient detox right now, how far would they have to go? Where would they go if they were living in the Shoalhaven area?

Caroline LANGSTON: I am sorry. Could you please just repeat that?

The Hon. EMMA HURST: If someone was in the Shoalhaven area right now and they wanted to go to an inpatient detox centre, where would they go? How far would they have to travel to get into that?

Caroline LANGSTON: Well, they can take them to an inpatient detox centre. We can provide detox at the Shoalhaven Hospital. Oolong House is an option but beyond that it would be Sydney.[1]

The Hon. EMMA HURST: So how far would they have to travel to get to an inpatient detox?

Caroline LANGSTON: We can detox people quite successfully and do a lot of that at the Shoalhaven Hospital. That is an option. Oolong House is in the Nowra area, if people are eligible for that program. Community

[1] In correspondence to the committee, dated 3 February 2022, Caroline Langston, Executive Director Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven Local Health District, provided a clarification to her evidence.

services can do a home or inpatient program. Beyond Oolong House and Shoalhaven Hospital, you would have to travel to Sydney.

The Hon. EMMA HURST: Thank you. Ms Larkin, in April last year there were further reports about serious staffing problems at Liverpool Hospital. There was a story of an 80-year-old man who was numb on one side and could not get an MRI for several days because there was no staff actually rostered to operate the machine. Have there been more staff hired at the Liverpool Hospital in the last 12 months to actually address this issue?

Amanda LARKIN: Yes. Could I just take on notice, though, for the Committee that percentage increase? I do not have that in front of me just because of the focus of this particular inquiry; but, if you are comfortable, I will.

The CHAIR: That is fine.

The Hon. EMMA HURST: Yes, thank you. If you could take that on notice, that would be great. In our inquiry into health services in South Western Sydney in 2020, staffing, recruitment and retention of staff, including junior doctors, was raised as a general sort of ongoing issue. Have there been any strategies put in place to actually recruit and retain staff within the LHD?

Amanda LARKIN: Look, over the last year, could I say South Western Sydney, and I am sure you are as aware as everyone, has been significantly focused on managing the COVID outbreak, it being very much at the centre of that. So in terms of the focus of our work overall, we have been managing that issue and ensuring the safety and provision of services for our community over that time. We have worked with and talked with our JMOs and our junior staff around issues of recruitment, retention, et cetera; but I would take on notice if we have put any of those strategies further in place over the last year, only because of the focus we have had on COVID.

The Hon. EMMA HURST: Yes. That is fine, thank you. How would you say that the hospitals in the LHD are coping at the moment with the current COVID-19 outbreak and additional strain on their resources? I mean, it almost sounds like some other important issues, like recruitment and retaining, have had to take a back seat because of the COVID outbreak. How are the hospitals coping at the moment in the LHD?

Amanda LARKIN: If I can comment on it from the current wave and then the previous wave in 2021, I think the ability for the district, in collaboration with our other colleagues including very much Illawarra, our ability to service the community has been pretty phenomenal. We have continued to provide services. We have redirected resources, redeployed staff and reorganised very much our inpatient services to manage the needs. I think they have done remarkably over that period of time. In this current phase, it has been a different challenge. ICU has very much been challenged in terms of the number of patients that we have had. In terms of furloughed staff, if I could just share with you, we have had over a thousand furloughed staff in the last couple of weeks.

So, we have literally redeployed staff and focused on two main things: obviously maintaining care for our COVID patients but also the critical service delivery in terms of our emergency care—all of that has been incredibly maintained because of the statewide networks that have been put in place, as I explained, but also how the district has worked in its networked model to ensure that services were moved, changed, to maintain service delivery for the community. Has it been stretched? Without question but provision of services has absolutely been maintained in a framework of safety and quality to the very best of our ability.

The CHAIR: Thank you, Ms Larkin.

The Hon. EMMA HURST: Am I out of time?

The CHAIR: Sorry, Deputy Chair, but we will be coming around again. Ms Cate Faehrmann?

Ms CATE FAEHRMANN: Thank you, Chair. I just want to go just below that line of questioning, Ms Larkin. You said that services have been stretched, but are there enough nurses to maintain safe nursing staff levels within the South Western Sydney LHD? A couple of thousand, I think you said, still of healthcare workers and nurses are furloughed, so are there any safe nurse-to-patient levels within the LHD at the moment?

Amanda LARKIN: So if I can just qualify—

Ms CATE FAEHRMANN: What does "stretched" mean?

Amanda LARKIN: I beg your pardon. I am so sorry.

Ms CATE FAEHRMANN: No. That is often happening.

Amanda LARKIN: The thousand furloughed staff are not only nurses. So if we could just be really clear that that is across the board. There has been a whole range of staff that have been impacted by COVID. That is the most important thing. The second thing though, when we are looking at our staffing levels, ensuring the

safety for staff and patients is obviously critical. Then in the last couple of weeks as we have seen those numbers increase, we have actually redeployed staff into a whole range of different roles to put the nurses so that they can be in the inpatient areas and so that they could focus on patient care delivery—so runners, all of those kinds of things, to minimise other things that the nurses need to do. We have put all of those things in place. And we have watched it carefully in terms of growth at a site level and at a district level and talked regularly around those nursing levels and ensuring safety across the district, yes.

Ms CATE FAEHRMANN: Thank you. I will ask you first, Ms Larkin, and then go to the Illawarra LHD on this as well. Have changes been made to discharge protocols to free up beds during this latest outbreak?

Amanda LARKIN: Just in relation to the nature of your question, are you asking—if I could just qualify, through you, Chair?

The CHAIR: Yes. Please.

Amanda LARKIN: Are you asking have we changed the way that we discharge? I am not quite sure of the nature of your question. Could you explain it for me?

Ms CATE FAEHRMANN: There are two elements. The first thing is: Have staff been asked to discharge patients sooner, I suppose, and therefore has there been any instruction to kind of discharge patients sooner? I will start with that then.

Amanda LARKIN: No, no. That is fine. I just wanted to be sure of the nature of your question. Absolutely not. Patients are discharged when they are safe and appropriate for discharge. What we are seeing, though, in the current phase of COVID is that people are coming in for other health issues and then COVID has been identified. So what we have to be careful of is that we manage people for both of those illnesses and that, when we discharge, that they have got supports in place not only to recover but they have a broader networks component. So, no, there have not been changes. I think the focus on ensuring people are discharged when they are safe and appropriate is the most critical thing.

Ms CATE FAEHRMANN: Okay.

Margot MAINS: I would like to—

Ms CATE FAEHRMANN: Yes, Ms Mains?

Margot MAINS: We are seeing there is definitely no pressure to discharge patients. Patients need to be discharged appropriate to their condition. We have, however, transferred patients from the public hospital into private hospitals in order to enable us to manage the increased presentations that we have seen. Also, because of our virtual enhanced community centre, where we actually can virtually monitor people in their own homes, we are able to also manage high numbers like South Western Sydney has—high numbers of patients in their own homes. I have said that is monitoring, but we follow up each patient and action plans. We also have been working to ensure that we work with assistants in nursing. We have worked with nursing graduates to actually come back to work to start earlier.

We have worked with trainee interns. We have paid assistants in medicine to help us throughout this time. We also have quite a considerable number of allied health staff working to actually support in areas where we have found staffing challenges and we are very thankful there. We also put out, like South Western Sydney, we put out an expression on interest for administration staff to go and work in places that would support front line staff to focus on service delivery and for us to give them the support required at the back end.

Ms CATE FAEHRMANN: Thank you. I might just stick with you, Ms Mains. Just in relation to the story that the ABC covered a couple of weeks ago that said that in relation to Wollongong Hospital in particular, it had reached capacity with its two dedicated coronavirus wards and had opened two additional wards. Where is the hospital at, at the moment, with capacity?

Margot MAINS: I will just ask Margaret Martin to give an update on this.

Margaret MARTIN: Thank you for that question. We currently are consolidating our COVID wards because we have been fortunate to have a position where we have had a number of patients cleared of COVID, even though they are still admitted. So, at the moment, we have two dedicated COVID wards at Wollongong. We opened a specific ward at Bulli for aged cared patients who were confused and wandering, and that is still functional at the moment. We have the capacity to overflow although we are consolidating our two COVID wards at Wollongong. We also have COVID capacity at Shellharbour still and at Shoalhaven Hospital in dedicated wards at the moment.

Ms CATE FAEHRMANN: By consolidating, what—

Margaret MARTIN: So we had three wards open at Wollongong still. Because we had a number of patients who are COVID free now, we are now creating some non-COVID capacity because that has been a high pressure point for us at Wollongong. So if I consolidate, we will have two dedicated COVID wards at Wollongong that we will have capacity to admit into and because we can move those cleared patients into a normal ward, that gives us more capacity within those two wards to accept COVID positive patients.

Ms CATE FAEHRMANN: Okay. How many patients are being treated under the Hospital in the Home program within the Illawarra LHD? Do you have those figures there?

Margot MAINS: We do, but I will ask Caroline Langston to—we have this but numbers have gone up. Last week the figures had not gone up to a thousand before but we have been working with the groups. I will ask Caroline Langston to explain.

Caroline LANGSTON: If we are talking COVID patients, we look after those as a community program. At the moment we have, say, 1,650-odd—not 1,650-odd but 1,650—community patients, most of whom are in the self-management stream and we have approximately 150-160 acute patients we have been managing actively. That number alters on a daily basis, depending on people coming in and out.

Ms CATE FAEHRMANN: Sorry, I did not quite hear that at the end. Was it 150 people are what? Sorry. I did not hear.

Caroline LANGSTON: Sorry. High risk—they are the highly intensive management and it is almost 90 per cent of people in the program are on the self-managed pathway, so they are able to look after themselves and call us if they need support. The intensive work is for those people who have complex conditions, who might be immunocompromised, or chronic conditions that need support—certainly under 75, those who have not had booster shots. We are particularly concerned about them and we watch those more intensively.

The CHAIR: Thank you. We will be coming back again, Ms Faehrmann.

Ms CATE FAEHRMANN: I can come back to that.

The CHAIR: We move on now to the Hon. Wes Fang.

The Hon. WES FANG: Thank you very much, Chair, and thank you all for coming this afternoon and sharing your valuable insights with the Committee. On with valuable insights: Ms Mains, I note the questioning from the Hon. Walt Secord a little bit earlier about elective surgery and its return. He was, I will say, adamant that the Premier said that it would be returning today. Now, I have been fortunate enough to have access to a press release and the information. Are you able just to share with us what date the elective surgery will be returning?

Margot MAINS: Yes. Next Monday, 7 February.

The Hon. WALT SECORD: Seventy-five per cent.

The Hon. WES FANG: Okay.

The Hon. WALT SECORD: She said 75 per cent.

The Hon. WES FANG: I have got the questioning, Mr Secord. I am sure you will have the opportunity to ask more questions later.

The Hon. WALT SECORD: Okay.

The Hon. WES FANG: Ms Mains, while the elective surgery will be returning next Monday, there has still been surgery occurring. Is that correct? Can you provide the Committee with some insights as to what sorts of surgery have still be occurring within the NSW Health areas across the State?

The Hon. WALT SECORD: Emergency.

Margot MAINS: Just so I can comment, thank you, and I will ask Margaret Martin to give some detail, but certainly we are providing full emergency surgery across all our operating sites—at Shoalhaven and Wollongong. We are providing urgent elective surgery across the Shoalhaven and Wollongong and we are also providing all day surgery as well, particularly our focus on in Shellharbour. So, if you want to understand what is involved with that with some examples, I will ask Margaret Martin to respond.

The Hon. WES FANG: Thank you.

Margaret MARTIN: We have been continuing, as Margo Mains said, the urgent surgery. That is surgery that is classified that needs to be undertaken within 30 days. That work has still been occurring and many of what we classify as semi-urgent, category B, that needs to have surgery within 90 days. So more urgent patients

are still being operated on and we have been working with our private hospitals to provide some of our other surgery as well. Day surgery in all classifications has been continuing during this period of time.

The Hon. WES FANG: Thank you very much for that. Ms Larkin, is it a similar situation in your local health district?

Amanda LARKIN: Correct.

The Hon. WES FANG: Thank you. So, in reality, it has only been the elective surgery with overnight stays that has been postponed and is returning from next Monday.

Margot MAINS: Certainly that is what we are talking about because, as I said, we are looking at what we can actually start to work with next Monday, depending on our local demand, and the rest that we have got the staff for.

The Hon. WES FANG: Thank you very much for that clarification. I think it is important to put those issues into context as opposed to a sound bite or a grab.

The CHAIR: I must ask you to refrain from making comments.

The Hon. WES FANG: I was going to move on to some other topics, if that is okay. I have been looking to ask a lot of the local health districts about some of the lessons that they have had with combating the difficulties around the COVID pandemic and maybe some innovative learnings that they have been able to garner from the solutions that they have employed around the challenges that I guess have been thrown up by the pandemic. I wonder if there is an opportunity to share some of those learnings with the Committee and things that you think are working well that may be able to be carried into the future of health provision in the State. I will start with Ms Mains, if that is possible, and then I will go to Ms Larkin.

Margot MAINS: Thank you for that question. Certainly COVID is a time of reflection and I think it is with surprise that I have seen many developments that have actually occurred and the differences as well as the different ways of thinking of how we have actually provided services. I think what it has also taught us is, firstly, that it is the ability of people to pull together, to step up and to provide many services at very short notice. I talk about essentially aspects [inaudible]. I talk about setting up 30 testing hubs. We set up a Virtual HQ community. These centres have enabled us to manage at least a thousand people per day in partnership. We upscaled our public health unit. We undertook considerable sets of contract tracing and education and outbreak management. We set up COVID wards, now across three of our hospitals—four if one counts Wollongong. We actually set up the ability to upscale four intensive care units. We actually built up our emergency departments and set up particular zones.

We saw a number of significant building up of service delivery and changes in service delivery in an incredibly short period of time and at a pace. We also set up through this time building on the relationships that we had when we worked together. I refer to South West Sydney where we moved to partnership to actually support each other at times of considerable stress and patients load. We set up and built upon a fantastic relationship with residential aged care facilities and disability support providers that has enabled us to be more effective in how we manage the challenges together. We worked with our Aboriginal health partners in terms of the nature of vaccination outpost clients and in terms of outpost testing for COVID. As I said, we also brought in alternative staffing models when people respond to us from sources [inaudible] in the community earlier. We worked to put our nursing schools to bring in our nursing graduated earlier. We worked with our supporting corporate staff and we actually worked together, supporting our front line staff.

What it has really taught me is about the ability of a centre to respond and believe me there have been huge challenges. But it has been the passion of the people that work in this sector and other sectors every day and it is their tenacity and their commitment to actually respond so incredibly positively to the community. Thank you.

The Hon. WES FANG: Thank you very much, Ms Mains. I love that word "tenacity". I think it goes to the heart of what the metropolitan Health staff have been doing. Ms Larkin, can you perhaps share some insights about the agility that your local health district has employed to tackle the COVID pandemic?

Amanda LARKIN: Thank you. I think I said earlier in a statement that the impact of the COVID pandemic in the south-west has been significant and the workload and demand that we have needed to carry over this period has been more than significant. That is really a underselling of what we have been able to do. So I think, in answer to the question have the health services pivoted, changed, become flexible both in its operational work, how it provides services, the staffing models that have been applied, its relationship with the primary care environment, with the broader community, I think have changed fundamentally. There will be a number of elements—because your question is what will go forward. We have able, I think, as a system and as a State to be

able to demonstrate that we have responded to the pandemic and fared for the community through some of the most challenging times. I think we need to really recognise the resilience of the system and its capacity to work together in order to provide care to the community between rural regional metros with service and we have done that at every point that we have been asked in terms of stepping up in that regard.

Many things have changed, but I think a couple of the things that we would take forward, other than the things that are very much talked about broadly, such as Virtual HQ care arrangements, those thing which we have put in place, but I think one of the key ones that has been really critical for us is that we have had a good working relationship with our aged care facilities. Over the pandemic period the need to work shoulder to shoulder to ensure that most importantly that those patients, or rather, residents of those homes have been supported and the staff of those residential facilities have been supported I think it has been pretty incredible. We are meeting daily with our residential aged care services on their pandemic management plants, et cetera. So that relationship and what we have been able to do there has also been really supportive of our geriatric outreach service, which I know runs in other LHDs. But we established that in the first wave of the pandemic. We have maintained that going forward and it has grown from strength to strength in order to provide not only support to other nursing homes but broadly aged care in the community as they were very much at the front line of the pandemic.

I think, taking forward those relationships that we have developed with the aged care facilities, them understanding the support that we have been able to provide through public health units, et cetera, and then that in-reach, so that they keep people in situ, because it is their homes, and supporting them to do that has been great for the residents. But obviously they would have not seen that influx into the hospitals and allowed the acute care services to maintain a focus on care delivery but also focus on the sicker level of COVID patients. I think that is something that has really grown and matured extensively over this period and will go forward into the future, and I think that whole relationship with our aged care facilities can only grow better.

The Hon. WES FANG: Thank you very much for that.

Margot MAINS: I wonder if I could go further and mention just a couple of other learnings?

The Hon. WES FANG: I would love it and I was actually just about to come back to you, Ms Mains, because I was just going to say that that was a very comprehensive answer from Ms Larkin but it also interested me because it mirrored some other comments that we have had from some other LHDs today about aged care facilities and that integration between the local health districts and the aged care providers. I was going to ask you, Ms Mains: Are you able to provide some insights about your LHD with that, and also whatever other learnings you might be able to provide to us?

Margot MAINS: Certainly. Thank you. So, we have a very close relationship with residential aged care facilities and we have been meeting over the last 18 months at least twice a week and just working through issues together about how we can fit with each other and sharing outbreak management abilities, how we can support the staffing or PPE or equipment, and that means also using expert advice on ventilation. So, for example, we have had three-hour meetings about the ventilation [inaudible] in hospitals. We are fortunate to have a very passionate doctor, who led the charge and made sure that we have appropriate methods of ventilation of our wards and our staff rooms, and making sure we have adequate set-ups outside for staff so that they could have a break out of their PPE and get fresh air because tearooms are vulnerable areas for outbreaks. We were able to [inaudible] to a small number of areas.

The second thing is the power of leadership. We had a task force that oversaw clinical leadership: Wollongong, Shellharbour and Shoalhaven participated. That provided the leadership with the necessary clinical decisions and we have a clinical reference group that is made up of infectious diseases, infection management and control, who gave us tremendous advice for safety of patients and staff and what we needed to do. It enabled me to communicate to the staff we had about what was the most appropriate—whether it was from PPE or isolation or current practices—and that all worked. I think that set us up with a very strong position for following safety procedures.

The Hon. WES FANG: Thank you so much for those insights. I think we can see very much the work that has gone into not only, I guess, development of the plan but also the implementation that has led to the success of the examples that you have provided today. I might pass my time over, but I will add 45 seconds on at the end.

The CHAIR: It is now 25.

The Hon. WES FANG: Chair, noting that there are only about 25 seconds left, I will not seek to use that time. What I will do is just allow the questioning to pass over to the next person. With that, I will pass the call back to you and you might allow somebody else to ask another question.

The CHAIR: Thank you, and, as Chair, for the honourable man that you are, thank you.

The Hon. WES FANG: I am good like that, you know.

The CHAIR: We are now back to our start and it is around eight to nine minutes approximately or thereabouts. The Hon. Walt Secord?

The Hon. WALT SECORD: Firstly, I actually will agree with the Hon. Wes Fang. I did check, and the report that was given to me was slightly inaccurate. So, yes, the Premier said that elective surgery would return on 7 February. So, Ms Mains, yes, I understand that, I acknowledge that, and I correct the record. But I do note that you said it would be at a 75 per cent rate. How long do you expect that it will take before it will be back to, how do we say, "normal" activity?

Margot MAINS: Could I please take it on notice because I think what is really important is we need to look at our reimplementation plan and refer to the effects that are in that plan.

The Hon. WALT SECORD: Okay. Ms Mains, earlier in the proceedings—now, I am not sure whether it was you or Ms Larkin but I think from memory it was you—and you said 1,000 staff were on furlough. Is that correct?

Margot MAINS: No, that was Ms Larkin.

The Hon. WALT SECORD: Oh, Ms Larkin. Thank you. Sorry. Ms Larkin, when you say furlough, what do you mean by that?

Amanda LARKIN: They were not in the workplace due to either being close contacts or positive COVID cases.

The Hon. WALT SECORD: So 1,000 staff out of an overall workforce of how large?

Amanda LARKIN: Fourteen or 15,000.

The Hon. WALT SECORD: Oh, a significant number.

Amanda LARKIN: Yes.

The Hon. WALT SECORD: How did that impact on the workload? Did it result in overtime, or did it result in a curtailing of services?

Amanda LARKIN: Over the period—well, a couple of things, in answer to your question. In relation to how to maintain service delivery, I think important things to consider, firstly, was overtime applied. Staff were redeployed across the district. Where it was considered we could change services or reduce services in an appropriate manner from the community's point of view we did that. That included not only clinical staff—when I say "clinical", nursing and allied health staff but also admin staff—so wherever possible we redeployed staff to provide support in critical areas. Also, over that time, surgery had been reduced. So in those areas where we could redeploy, say, people who would normally work in areas like theatre, we did that. So all opportunities to redeploy staff and maintain service delivery in critical areas were put in place in order to support that. Just today, be aware, though, we are down. Our position has significantly improved and we are down to about 250-260 furloughed staff, so our position is significant.

The Hon. WALT SECORD: Is that because the time away has been reduced, or because fewer people actually have contracted COVID?

Amanda LARKIN: There are fewer people. All over that period, people were going, were being furloughed, but also come back based on the time that they needed to remain in isolation. So that has been given. That number has fluctuated on a day-to-day basis. But fewer people and now people are coming back into the workplace.

The Hon. WALT SECORD: Thank you, Ms Larkin. Ms Mains, I would like to return to the Bulli urgent care centre, which was temporarily closed on 23 December so that staff could be redeployed to emergency teams and other activities. When will the Bulli urgent care centre be returned to normal activities?

Margot MAINS: We will be reviewing our situation as we committed to in mid February and then a decision will be made to expedite return as quickly as possible but it will be dependent on where we're at in mid-February.

The Hon. WALT SECORD: Can I ask you a couple of questions and I think that if you take them on notice, I will not be offended. How many people are on elective surgery waiting lists in the Illawarra Shoalhaven Local Health District as of today?

Margot MAINS: I might ask Margaret Martin because she has more specialist information.

The Hon. WALT SECORD: Thank you.

Margaret MARTIN: I will answer that question, thank you. We have 7,700 patients on a wait list across the whole district as of this—

The Hon. WALT SECORD: As of today?

Margaret MARTIN: As of today.

The Hon. WALT SECORD: And I would assume that the longest list would be at Wollongong Hospital. Is that correct? Do you have a breakdown?

Margaret MARTIN: The largest wait list is at Wollongong Hospital, which is just over 3,300 patients.

The Hon. WALT SECORD: How many people are at Shoalhaven?

Margaret MARTIN: Shoalhaven had just over—or 2,100 patients on their wait list.

The Hon. WALT SECORD: And Shellharbour?

Margaret MARTIN: And Shellharbour Hospital has just over 2,200. I have done some rounding.

The Hon. WALT SECORD: I realised you did some rounding there on that. The Bureau of Health Information [BHI] also indicates the longest percentile—I think it is 10 per cent of people who are waiting longer than more than a year, I think; usually about 360 days. How many of those people—of these 7,700—have been waiting for more than a year?

Margaret MARTIN: I am looking at two categories of patients. Our category B patients, we have 11 patients at the moment, across the District that have waited longer than a year. Of our category C patients, I will just have to give it to you by hospital, if that is okay.

The Hon. WALT SECORD: Yes. That would be wonderful.

Margaret MARTIN: I cannot get that done in my head as quickly as I would like to. At Shoalhaven, we have 85 patients who are category C, non-urgent, waiting over a year. Taking into account that the appropriate wait time for those patients is 365 days. At Shellharbour, we have 42 patients who are category C waiting for over a year. At Wollongong Hospital, we have 326 patients that are waiting over one year. The majority of those are orthopaedic patients waiting for over a year.

The Hon. WALT SECORD: Thank you. Ms Mains, could you also give me a bit of an idea on this? How has COVID impacted on the treatment of the provision of kidney dialysis in the Illawarra? How has that impacted on patients?

Margot MAINS: I will take that question on notice because I do not have the exact impacts here.

The Hon. WALT SECORD: Thank you. Ms Larkin, could I put a similar question to you on the impact of kidney dialysis of COVID on patients in your local health district? What have been the responses? What strategies have you taken to ensure that they continue to receive kidney dialysis?

Amanda LARKIN: Yes, happy to give some response to that.

The Hon. WALT SECORD: Thank you, ma'am.

Amanda LARKIN: Dialysis services have been maintained, although we have had a number of outbreaks of COVID in our dialysis centre. So there has had to be some moving of patients and some consolidation of patients to ensure that patients are being kept as safe as possible. There has been quite a lot of pressure on dialysis services so there has been some purchase of some chairs for private, but there is considerably—or there will be—more services when services are about to open: six chairs at Bowral. Sorry, it has a chair at the moment so we will be opening an addition five to take it to six chairs.

The Hon. WALT SECORD: Yes.

Amanda LARKIN: So it has been quite a lot of intensive work to ensure people have been able to maintain services and also to ensure that they are safe when there have been COVID clusters.

The Hon. WALT SECORD: Thank you, Ms Larkin. My time is up.

The Hon. EMMA HURST: Thank you. Thank you, Chair. I will stay with Ms Larkin. One of the key concerns raised at our previous inquiry was around the kidney dialysis, particularly in Fairfield Hospital. Have any changes been made in the last 12 months to increase access to this service in the Fairfield Hospital?

Amanda LARKIN: No, but can I clarify that, in terms of dialysis services, they are operated on a network basis so patients are moved in terms of where chairs, et cetera, are available. Obviously we do it as close to home as possible because the patients are unwell, but we maximise utilisation of the chairs, so Fairfield is part of that network arrangement in the district.

The Hon. EMMA HURST: Could you explain that to me further? If somebody was going to the Fairfield Hospital as a kidney patient, would you transfer that to another hospital? Is that what you are saying?

Amanda LARKIN: No. If a chair was available at Fairfield Hospital based on their location, et cetera, absolutely we would provide it there. But we do move patients, if required, based on the number of chairs that we have got. But the aim is to treat them as close to home as possible.

The Hon. EMMA HURST: But there has not been any change in the last 12 months for kidney dialysis?

Amanda LARKIN: Not specifically at Fairfield, which was the focus of your question.

The Hon. EMMA HURST: Yes. Thank you. I just want to get an update on the Bankstown-Lidcombe Hospital and whether there has been any delays in the construction by the COVID-19 outbreak?

Amanda LARKIN: We are awaiting the resolution in terms of the location of the new hospital at this point and it is going through a process with Government on that.

The Hon. EMMA HURST: So you do not have a time line on that?

Amanda LARKIN: Not at this point.

The Hon. EMMA HURST: Thank you. I just want to ask a similar question to Ms Mains as well, if you are able to give any kind of an update on the planned redevelopment of the Shoalhaven Hospital and whether we have any kind of expected date when that will be operational, and whether that time line has been affected by COVID?

Margot MAINS: No. The Shoalhaven Hospital is proceeding to plan on the concept design and schematic design process. Construction on the new Shoalhaven community resource we are expecting to start later this year. By the end of the year we expect that it will be putting tenders out for construction on the acute care building with an anticipated date of 2006 and hopefully earlier than that. I am sorry—2026. My apologies.

The Hon. EMMA HURST: No, no; that is okay. Will the hospital be operational by that date?

Margot MAINS: We would certainly be aiming to operationalise the hospital in 2026.

The Hon. EMMA HURST: Thank you. Are you aware of significant community support for petitions for moving the new hospital to a greenfield site near Porters Creek? What has been the LHD's response to these views from the community?

Margot MAINS: A very key point is that the plans for this actually started in 2011 when the Shoalhaven City Council reaffirmed the support for the establishment of a master plan for a medical precinct on the existing site. Further confirmed by the health precinct being announced by the Minister. Jillian Skinner in 2012 and that was also reconfirmed by Shoalhaven council in 2020 to provide support for the acquisition of Nowra Park. What we have been saying very clearly to the community is that we have been working on the basis that there has been a commitment for the last decade to build on the site and the fact that there is $65 million of development of new facilities on the site, including the Shoalhaven Cancer Centre at $31 million, the Sub-Acute Mental Health Unit at $10 million, the car park at about $12 million, the GP Plus at about $7 million, and also upgrades to the emergency department and the endoscopy suites. At the same time, also using the same site it has given us the ability to provide more services as we are able to refurbish the existing buildings and use them for services as well as develop services within the acute services building.

The Hon. EMMA HURST: Thank you, Chair.

The CHAIR: Ms Cate Faehrmann?

Ms CATE FAEHRMANN: Through you, Chair. I will just go back to the questions that I was asking Ms Langston in relation to the Hospital in the Home. Thank you for providing us with data on that before my time expired. Can you go back to what you were talking about—the 150 patients currently under hospital and part of the Illawarra LHD who were, I think your words were "high risk"? What are some of the reasons why those patients are at high risk?

Caroline LANGSTON: Thank you for the question. Can I just clarify we are talking COVID patients and we are talking about Virtual HQ care services, not Hospital in the Home?

Ms CATE FAEHRMANN: This is COVID.

Caroline LANGSTON: Okay. So what we are concerned about, in particular higher risk areas, is a risk classification that we put on all the patients that come into the service. The particular high risks, I am sorry, are those people over 75 years of age, ones with comorbidity—so have heart disease, diabetes—other complex chronic conditions, maybe immunocompromised, maybe needing cancer treatments, and also those who had more than four months since their booster dose. That is a particular high risk group. There are others that come into that high risk group that Virtual Community Care team manages including our Aboriginal clients. They are not always high risk but they also manage a lot of Aboriginal patients. So it is a risk classification as we talk to those patients to see what their personal circumstances are and what care we need to provide.

Ms CATE FAEHRMANN: Thank you. Do you have the data on how many people within the LHD have died from COVID outside of the hospital environment?

Margot MAINS: We would have to take that on notice.

Ms CATE FAEHRMANN: Okay, thank you. I might ask you, Ms Larkin, the same question in relation to how many COVID positive patients the LHD is treating under Hospital in the Home?

Amanda LARKIN: In the revised model for care in the home, we got up to—just so you understand—you know, a couple of thousand patients or more than that. So in the revised model the self-management, as Margo Mains and her team have outlined, is the same principle that has been applied in the South Western. Our COVID numbers at the moment are only at 45 people who were in that high risk category. We keep monitoring and managing. We have also got a group of Aboriginal patients that we also formed on an ongoing basis, but the number has dropped considerably for us. We are available, obviously, for support if people are concerned about their own self-management, et cetera, and we received a number of calls into the public health unit and into a central contact point called Triple I on a daily basis about concerns, et cetera. But the model now has moved considerably to serve that.

Ms CATE FAEHRMANN: When you say the model has moved considerably into kind of self-management within the home, this model is obviously to try and free up hospital beds as well, to try and make sure that those hospital beds are available to those who need them as much as possible. So this model, when was that changed? Not when it was changed, but when did this come into practice?

Amanda LARKIN: In the last three weeks we have seen a change in the model.

Ms CATE FAEHRMANN: What is the model called specifically, Ms Larkin?

Amanda LARKIN: This is what I call it. Probably the districts have a slightly different name but this is, for COVID patients, community care—so, care at home. We were providing contact tracing, follow-up, et cetera. Now with the self-management model, high-risk patients are referred to us and we provide ongoing contact care on a daily basis for that high-risk group. It changed about three weeks ago.

Ms CATE FAEHRMANN: Has it changed in terms of allowing more people to be treated at home than in hospitals? Has it seen a difference in hospital admissions?

Amanda LARKIN: The group of patients that we would have managed and cared for at home, the whole aim of the program was that those patients did not come into hospital.

Ms CATE FAEHRMANN: Yep.

Amanda LARKIN: So you would not see a significant impact there. So the model really allows self-management. The number that we were calling every day, that we were following up, was just significantly increasing. As immunisation has improved people getting their visitors, all that self-management that people are able to do at home, that is what the model has shifted to and the focus there for what we call care in the community has shifted to that high-risk group. Those people who may have chronic conditions, there is good risk assessment model that the State put together around that. So they are the focus now of care in the community.

Ms CATE FAEHRMANN: Thank you.

The CHAIR: I apologise, but we need to move to the Hon. Wes Fang now.

The Hon. WES FANG: Thank you, Chair. Look, I do not intend to use all my time, if it is with the consent of the members of the Committee, because I think the witnesses have been very generous in their time and they have been here for pretty much an hour and a half. I was just going to ask very briefly about the success of the vaccination programs in each of your LHDs and if you had any thoughts on the success or otherwise of that vaccination program, and then, with the rollout of the boosters, if you have been able to apply any of that learning

from the vaccination program into the booster program? Ms Larkin, have you got any insights on that, or Ms Mains?

Amanda LARKIN: I am happy to commence from South Western's point of view. The investment by Government for vaccinations in the south-west, I am sure you are aware, was significant and it was such a critical part of the overall program that was put in place for COVID. So I was only looking at figures the other day. We would have vaccinated well over 60,000 people just in the south-west through our centres. That then, remember, is in combination with GPs and now with pharmacies. So I think it has been incredibly successful. We also changed the model so that it was not only centre-based for groups that we knew were at risk, such as our at risk communities, some of our Arab communities. We did a lot of outreach and we did some home-based work to actually support them and we supported our Aboriginal Medical Services to provide immunisation in situ for people, where people were not comfortable to come in.

So this has been, I think, a great collaboration. We worked very closely with the PHNs and the GPs and so for the south-west I think it has been incredibly successful. Then we are utilising that going forward so more work to do around our boosters and encouraging our [inaudible] families with the other group to come in. We are just working on a lot of stronger messaging and campaigns about that going forward. For the south-west, I think it has been a cornerstone for our work over the last nearly 18 weeks.

Margo MAINS: It's Margo Mains speaking. Much the same as what Amanda Larkin has spoken about. The outreach focus for people will be crucial for getting to our vulnerable communities. We have been in partnership with our AMSs, and our Aboriginal communities are vulnerable communities and that has been really important. Also we are looking at other partners, such as GPs through the PHN and working with residential aged care facilities. That has essentially helped with residents, staff and also with local pharmacies. So it has been a partner approach to maximise it, but certainly we have found the outreach [inaudible] have gone to our vulnerable communities. Thanks.

The Hon. WES FANG: Thank you both very much for that valuable information. I think there is no doubt that New South Wales has led the way in vaccinations and I would say that is down to the work of people like yourselves and the staff who are working within the local health districts. So thank you. Chair, with that, I am happy to grant an early mark to our witnesses, if you consent?

The CHAIR: It is the Chair who creates the early mark.

The Hon. WES FANG: As I said, yes.

The CHAIR: Thank you. That does bring us to the completion of this session. I thank you all very much for making the time available. We know that you are busy all the time but even busier in the current context of what we know is happening with respect to public health in New South Wales presently. Thank you very much for coming and for your time. I also thank you very much, on behalf of the Committee, for all the great work you are doing for and on behalf of the citizens of New South Wales in your local health districts in oversighting the care, the health and in meeting the published medical orders. Thank you very much.

The Hon. WES FANG: Thank you.

The Hon. WALT SECORD: Thank you.

(The witnesses withdrew)

The Committee adjourned at 15:32.