yass valley council

the country the people

Ordinary Meeting of Council

Thursday 26 May 2022
4.00pm
Council Chambers
209 Comur Street, Yass

ATTACHMENTS TO REPORTS
ITEMS UNDER SEPARATE COVER

Ordinary Meeting of Council

Attachments to Reports
Items Under Separate Cover

Page No.


OWEN LANE
DICK'S CREEK ROAD
MURRUMBATEMAN ROAD
NANIMA ROAD
GLENGYLE ROAD
0 200 400 600 800m


yass valley council
the country the people
Important Notice!
Map Scale: 1:18855 at A4

DPS
Diverse Project Solutions
10 Crago Street
Yass NSW 2582
Postal PO Box 5 Yass NSW 2582
Telephone 02 6226 3392
Fax 02 6100 9968
Email info@dpsyass.com.au
www.dpsyass.com.au

STATEMENT OF ENVIRONMENTAL EFFECTS

PREPARED BY:

DPS YASS PTY LTD
10 CRAGO STREET
YASS NSW 2582

PO BOX 5
YASS NSW 2582

PROJECT:	Relating to the Development Application for the Filling/ Rehabilitation of an existing Quarry on Lot 10 DP 878725, 1170 Murrumbateman Road, NANIMA.
CLIENT:	Mr Geoff Hewatt
OUR REFERENCE:	3575_SEE2
DATE:	July 2020
AUTHOR:	Jamie Bush
SIGNATURE:	

CONTENTS

1. INTRODUCTION

This Statement of Environmental Effects has been prepared for Mr Geoff Hewett by DPS. This Statement is to accompany a development application to Yass Valley Council to fill/ rehabilitate an existing unused quarry at 1170 Murrumbateman Road, Nanima.

1.1 OWNER AND APPLICANT DETAILS

The Applicant

Geoff Hewatt
c/- DPS
PO Box 5
YASS NSW 2582

Contact: Jamie Bush
Phone: (02) 6226 3322
Email: jamie@dpsyass.com.au

The Owner/s

Winjarra Pty Limited (ACN 106 134 150)
Susi Bauer (Sole Director)
c/- DPS
PO Box 5
YASS NSW 2582

Site Address

The subject site of this application is identified as Lot 10 DP 878725, 1170 Murrumbateman Road, NANIMA.

1.2 SITE AND LOCATION

Site Description

The subject site is located on 1170 Murrumbateman Road, Nanima within the Yass Valley Local Government Area. The site is bounded by rural properties to the, East, South and West with Murrumbateman Road to the North. The land is currently one lot and is zoned RU1 Primary Production in the Yass Valley Local Environment Plan (YVLEP) 2013.

Figure 1.1 demonstrates the location of the site

Figure 1.1 Location Map (SIX 2016)

Existing Easements and Restrictions

- Easement for Transmission Line 20 Wide (DP878725)
- Restriction on the use of the land (DP878725)

Proposed Development Summary

The applicant seeks Council consent for the importation of certified Virgen Excavated Material/ Excavated Natural Material (VENM/ ENM) to fill/ rehabilitate the eroded quarry at Lot 10 DP 878725, 1170 Murrumbateman Road, Nanima. The quarry is not an operational quarry, historically the quarry was a source of materials for road construction and maintenance activities in surrounding areas by Yass Valley Council.

It is the applicant's intention to rehabilitate the site to create an improved visual amenity and a land use more consistent with the surrounding low intensity agricultural land-use. This will include the importation of up to 38,150m^3 or 57,225 tonnes of certified VENM/ ENM to the site to reinstate the eroded quarry back to its previous hill like formation. In doing so this will reduce the risk for any further erosion to occur and deliver considerable environmental and farm productivity benefits.

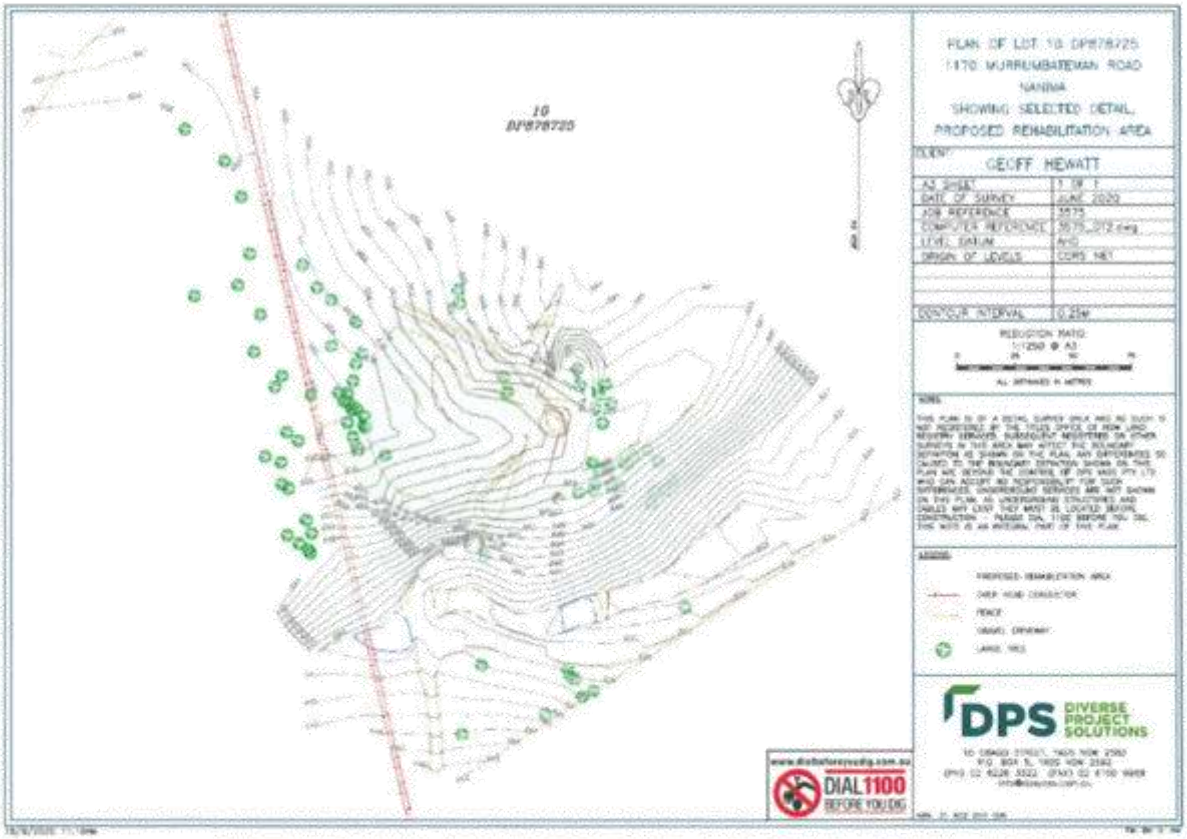


Figure 1.2 Plan Showing Selected Detail, Proposed Rehabilitation Area

2. ASSESSMENT

This section deals with the proposal's consistency with the various statutory and non-statutory provisions.

2.1 ENVIRONMENTAL PLANNING INSTRUMENTS

Yass Local Environmental Plan 2013

The following details the proposal against the zone objectives and clauses 6.1, 6.3 – 6.7 of the Yass Valley Local Environmental Plan 2013 (YVLEP).

Zone RU1 Primary Production

1. ***Objectives of zone***

   - *To encourage sustainable primary industry production by maintaining and enhancing the natural resource base.*
   - *To encourage diversity in primary industry enterprises and systems appropriate for the area.*
   - *To minimise the fragmentation and alienation of resource lands.*
   - *To minimise conflict between land uses within this zone and land uses within adjoining zones.*
   - *To protect and enhance the biodiversity of Yass Valley.*
   - *To protect the geologically significant areas of Yass Valley.*
   - *To maintain the rural character of Yass Valley.*
   - *To encourage the use of rural land for agriculture and other forms of development that are associated with rural industry or that require an isolated or rural location.*
   - *To ensure that the location, type and intensity of development is appropriate, having regard to the characteristics of the land, the rural environment and the need to protect significant natural resources, including prime crop and pasture land.*
   - *To prevent the subdivision of land on the fringe of urban areas into small lots that may prejudice the proper layout of future urban areas.*

2. ***Permitted without consent:***

   Environmental protection works; Extensive agriculture; Forestry; Home-based child care; Home businesses; Home occupations; Intensive plant agriculture; Water storage facilities

3. ***Permitted with consent:***

   Air transport facilities; Airstrips; Animal boarding or training establishments; Aquaculture; Bed and breakfast accommodation; Boat launching ramps; Boat sheds; Camping grounds; Caravan parks; Cellar door premises; Cemeteries; Charter and tourism boating facilities; Community facilities; Correctional centres; Crematoria; Depots; Dual occupancies; Dwelling houses; Eco-tourist facilities; Environmental facilities; Extractive industries; Farm buildings; Farm stay accommodation; Flood mitigation works; Function centres; Helipads; High technology industries; Home industries; Industrial retail outlets; Industrial training facilities; Information and education facilities; Intensive livestock agriculture; Landscaping

material supplies; Markets; Open cut mining; Places of public worship; Recreation areas; Recreation facilities (major); Recreational facilities (outdoor); Restaurants or cafes; Roads; Roadside stalls; Rural industries; Rural supplies; Rural workers' dwellings; Serviced apartments; Signage; Timber yards; Transport depots; Truck depots; Turf farming; Waste or resource management facilities; Water recreation structures; Water supply systems.

4. ***Prohibited:***

Any development not specified in item 2 or 3.

It is proposed to import VENM/ ENM material to fill/ rehabilitate the eroded existing quarry at 1170 Murrumbateman Road, Nanima. It is the applicant's intention to rehabilitate the site to reinstate a stable gently undulating landscape. The rehabilitation measures proposed are designed to create a stable landscape with no offsite impacts and with minimal ongoing maintenance requirements. The proposed measures will provide for an improved environmental and aesthetic outcome by promoting the natural regeneration of native trees and shrubs in conjunction with active revegetation of pasture/ grass species and some strategic native tree and shrub plantings to mitigate erosion risk/ improve agricultural productivity.

The final land use of the proposed area includes livestock grazing and environmental enhancement through natural regeneration.

Clause 6.1 Earthworks

1. *The objective of this clause is to ensure that earthworks for which development consent is required will not have a detrimental impact on environmental functions and processes, neighbouring uses, cultural or heritage items or features of the surrounding land.*
2. *Development consent is required for earthworks unless:*
    a) *The earthworks are exempt development under this Plan or another applicable environmental planning instrument, or*
    b) *The earthworks are ancillary to development that is permitted without consent under this Plan or to development for which development consent has been given.*
3. *Before granting development consent for earthworks (or for development involving ancillary earthworks), the consent authority must consider the following matters:*
    a) *The likely disruption of, or any detrimental effect on, drainage patterns and soil stability in the locality of the development,*
    b) *The effect of the development on the likely future use or redevelopment of the land,*
    c) *The quality of the fill or the soil to be excavated, or both,*
    d) *The effect of the development on the existing and likely amenity of adjoining properties,*
    e) *The source of any fill material and the destination of any excavated material,*
    f) *The likelihood of disturbing relics,*
    g) *The proximity to, and potential for adverse impacts on, any waterway, drinking water catchment or environmentally sensitive area,*
    h) *Any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.*

The rehabilitation of the quarry has been proposed to utilise imported VENM/ ENM to fill the existing excavation and reinstate a natural undulating landscape. Because the VENM/ ENM material provides the flexibility to create whatever landform best suits the landscape, through filling and shaping, the final rehabilitated will have a vastly improved aesthetic appeal. This will include the importation of up to 57,225m^3 of certified VENM/ ENM to the site to reinstate the unused quarry back to its previous hill like formation. In doing so this will deliver considerable positive agricultural and environmental/ biodiversity outcomes as well as improving the land options available to the site.

As attached in Appendix B a Quarry Rehabilitation Proposal has been prepared by Franklin Consulting Australia dated 30 June 2020 to assist Yass Valley Council in assessing the proposal including extensive information regarding the local landscape, design principles and rehabilitation goals for the project to improve landscape function and agricultural productivity, the type and amount of certified material to be used, truck movements and plant operations and a project lifecycle of approximately two years from commencement.

The proposal will not adversely impact any surrounding neighbours, all appropriate measures to avoid, minimise and mitigate any perceived impact of the development will be implemented and have been highlight throughout the attached document in Appendix B.

Clause 6.3 Terrestrial Biodiversity

1. *The objective of this clause is to maintain terrestrial biodiversity by:*
    a) *Protecting native fauna and flora, and*
    b) *Protecting the ecological processes necessary for their continued existence, and*
    c) *Encouraging the conservation and recovery of native fauna and flora and their habitats.*
2. *This clause applies to land identified as "Biodiversity" on the Natural Resources Biodiversity Map.*
3. *Before determining a development application for development on land to which this clause applies, the consent authority must consider:*
    a) *Whether the development is likely to have:*
        i. *Any adverse impact on the condition, ecological value and significance of the fauna and flora on the land, and*
        ii. *Any adverse impact on the importance of the vegetation on the land to the habitat and survival of native fauna, and*
        iii. *Any potential to fragment, disturb or diminish the biodiversity structure, function and composition of the land, and*
        iv. *Any adverse impact on the habitat elements providing connectivity on the land, and,*
    b) *Any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.*
4. *Development consent must not be granted to development on land to which this clause applies unless the consent authority is satisfied that:*
    a) *The development is designed, sited and will be managed to avoid any significant adverse environmental impact, or*
    b) *If that impact cannot be reasonably avoided by adopting feasible alternatives – the development is designed, sited and will be managed to minimise that impact, or*

c) *If that impact cannot be minimised – the development will be managed to mitigate that impact.*

As can be seen on NRB_005 large areas of the subject land have been identified as having Biodiversity concerns to the north and the east of the site. The subject site is predominantly cleared, and the current vegetation will remain. The potential for the rehabilitation activities impacting on the biodiversity values of the area will be limited and mitigated by using the access road that is existing with no additional vegetation to be damaged/ removed or destroyed as part of the rehabilitation activities. Natural regeneration will be encouraged and supplemented with strategic revegetation of locally endemic native species of trees and shrubs improving the biodiversity and fauna habitat of the subject area. benefits.

It is expected that the finished area of fill material will be topsoiled with 150mm of suitable loam overlaying 100mm of clay loam material. The topsoiled area will then be seeded with a suitable pasture seed mix and fertilised with a starter type fertiliser as per the recommendations in the Quarry Rehabilitation Proposal attached as Appendix B.

IMPACT IN RELATION TO THE BIODIVERSITY CONSERVATION REGULATION 2017 AND BIODIVERSITY CONSERVATION ACT 2016

Quarry Site

The quarry is dormant and not currently being used as an active extraction site. Historically the product from the quarry has been excavated and stockpiled for use in local roadworks. It is proposed to rehabilitate the quarry to create a more stable non-eroding landscape with improved visual amenity and a land use more consistent with the surrounding low intensity agricultural land use.

Biodiversity Offset Scheme and Biodiversity Development Assessment Report threshold

The proposed rehabilitation of the quarry does not meet the Biodiversity Development Assessment Report threshold as the proposal does not exceed the allowed clearance of 1ha. There will be no negative impact to the biodiversity of the site because of this proposal. The potential for the rehabilitation activities impacting on the biodiversity values of the area will be limited and mitigated by using the access road that is existing with no additional vegetation to be damaged/ removed or destroyed as part of the rehabilitation activities. Natural regeneration will be encouraged and supplemented with strategic revegetation of locally endemic native species of trees and shrubs improving the biodiversity and fauna habitat of the subject area.

There is remnant native vegetation surrounding the quarry site as shown on the Biodiversity Map (NRB_005) within the YLEP, however the potential for any of the rehabilitation activities impacting on the biodiversity values of this area will be limited and mitigated by:

- Using the existing access road which in turn means no additional vegetation will be damaged/ destroyed
- Encouraging natural regeneration by revegetating the area with locally endemic native species of trees and shrubs

Clause 6.4 Groundwater vulnerability

Clause 6.4 Groundwater vulnerability

1. *The objectives of this clause are as follows:*
   a. *To maintain the hydrological functions of key groundwater systems,*
   b. *To protect vulnerable groundwater resources from depletion and contamination as a result of development.*
2. *This clause applies to land identified as "Groundwater vulnerability" on the Groundwater Vulnerability Map.*
3. *Before determining a development application for development on land to which this clause applies, the consent authority must consider the following:*
   a. *The likelihood of groundwater contamination from the development (including from any on-site storage or disposal of solid or liquid waste or chemicals).*
   b. *Any adverse impacts the development may have on groundwater dependent ecosystems,*
   c. *The cumulative impact the development may have on groundwater (including impacts on nearby groundwater extraction for a potable water supply or stock water supply),*
   d. *Any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.*
4. *Development consent must not be granted to development on land to which this clause applies unless the consent authority is satisfied that:*
   a. *The development is designed, sited and will be managed to avoid any significant adverse environmental impact, or*
   b. *If that impact cannot be reasonably avoided – the development is designed, sited and will be managed to minimise that impact, or*
   c. *If that impact cannot be minimised – the development will be managed to mitigate that impact.*

Clause 6.5 Riparian land and watercourses

(1) *The objective of this clause is to protect and maintain the following—*
   (a) *water quality within watercourses,*
   (b) *the stability of the bed and banks of watercourses,*
   (c) *aquatic and riparian habitats,*
   (d) *ecological processes within watercourses and riparian areas.*

(2) *This clause applies to all of the following—*
   (a) *land identified as "Watercourse" on the Riparian Lands and Watercourses Map,*
   (b) *all land that is within 40 metres of the top of the bank of each watercourse on land identified as "Watercourse" on that map.*

(3) *Before determining a development application for development on land to which this clause applies, the consent authority must consider—*
   (a) *whether or not the development is likely to have any adverse impact on the following—*
      (i) *the water quality and flows within the watercourse,*
      (ii) *aquatic and riparian species, habitats and ecosystems of the watercourse,*
      (iii) *the stability of the bed and banks of the watercourse,*
      (iv) *the free passage of fish and other aquatic organisms within or along the watercourse,*
      (v) *any future rehabilitation of the watercourse and riparian areas, and*

(b) whether or not the development is likely to increase water extraction from the watercourse, and

(c) any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.

(4) Development consent must not be granted to development on land to which this clause applies unless the consent authority is satisfied that—

(a) the development is designed, sited and will be managed to avoid any significant adverse environmental impact, or

(b) if that impact cannot be reasonably avoided—the development is designed, sited and will be managed to minimise that impact, or

(c) if that impact cannot be minimised—the development will be managed to mitigate that impact.

As can be seen on CL2_005, all of the subject land has been highlighted as having groundwater vulnerability with Murrumbateman Creek running across the road on the Northern boundary. As specified in the Quarry Rehabilitation Proposal all 'Soil and Water' Management measures will be implemented during rehabilitation limiting the potential impacts on downstream water quality in the minor 1st and 2nd order stream watercourses adjacent to the quarry. Fill material will be restricted to VENM/ ENM which is certified and contains no contamination. As a result, there will be no adverse effects felt upon the groundwater vulnerability of the land.

Clause 6.6 Salinity

(1) The objective of this clause is to provide for the appropriate management of land that is subject to salinity and the minimisation and mitigation of adverse impacts from development that contributes to salinity.

(2) This clause applies to land identified as "Dryland Salinity" on the Natural Resources Land Map.

(3) Before determining a development application for development on land to which this clause applies, the consent authority must consider the following—

(a) whether the development is likely to have any adverse impact on salinity processes on the land,

(b) whether salinity is likely to have an impact on the development,

(c) any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.

(4) Development consent must not be granted to development on land to which this clause applies unless the consent authority is satisfied that—

(a) the development is designed, sited and will be managed to avoid any significant adverse environmental impact, or

(b) if that impact cannot be reasonably avoided—the development is designed, sited and will be managed to minimise that impact, or

(c) if that impact cannot be minimised—the development will be managed to mitigate that impact.

Clause 6.7 Highly erodible soils

(1) The objective of this clause is to provide for the appropriate management of land that has highly erodible soils or has the potential to be affected by the process of soil erosion.

(2) This clause applies to land identified as "High Soil Erodibility" on the Natural Resources Land Map.

(3) Before determining a development application for development on land to which this clause applies, the consent authority must consider the following—

(a) whether the development is likely to have any adverse impact on soil erosion processes on the land,

(b) whether soil erosion is likely to have an impact on the development,

(c) any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.

(4) Development consent must not be granted to development on land to which this clause applies unless the consent authority is satisfied that—

(a) the development is designed, sited and will be managed to avoid any significant adverse environmental impact, or

(b) if that impact cannot be reasonably avoided—the development is designed, sited and will be managed to minimise that impact, or

(c) if that impact cannot be minimised—the development will be managed to mitigate that impact.

As can be seen on NRL_005 no part of the subject land has been identified as having salinity or erodible soils. The development has taken into consideration the possible concerns and we are confident that it will not have any detrimental effect on the environment with correct measures in place. Appropriate erosion and sediment control methods will be implemented for the proposal along with revegetation of groundcover on all areas of disturbance, reducing the potential for erosion and saline scalding as per the 'Quarry Rehabilitation Proposal' in Appendix B

2.2 THE LIKELY IMPACTS OF THE DEVELOPMENT

There are minimal physical works required for this development. These physical works are likely to have minimal impact on the environment.

Vegetation Removal

It is expected that no vegetation removal will be required as part of this development.

Dust, Noise and Odour Emissions

The development will involve some noise due to the maintenance of the track and movements of trucks and machinery. The impact to surrounding neighbors will be reduced as a result of restricted operating hours and once completed there will be no long-term impact felt. As the subject land is within a rural area the distance to adjoining dwellings is already substantial, no significant amount of noise should be created.

A water cart will be located onsite 100% of the time while there is fill being imported to the site. This will ensure that dust is always suppressed.

Dust, noise and odour emissions from works associated with the proposed development will comply with the provisions of the Protection of the Environmental Operations Act 1997.

Signage

It is expected that 'Truck Entering' (W5-22C) signs will be installed on the approaches to the development site warning motorists along of heavy vehicles. The signs will be maintained while trucks are entering and exiting the site.

it would be expected that a fold up sign would be placed on either side of Murrumbateman Road by the Site Supervisor at the beginning of any day of operation when trucks are going to be on Murrumbateman Road. This is so that local residents are aware when there will be trucks on the road for the use of the filling project.

Sediment and Erosion Control

Refer to Appendix B, the Quarry Rehabilitation Proposal prepared by Franklin Consulting Australia Pty Limited dated 30 June 2020.

Murrumbateman Road Driveway

Measures will be applied, to the satisfaction of Yass Valley Council, to prevent site vehicles tracking sediment and other pollutants onto Murrumbateman Road for the duration of the development.

The applicant wishes to impose the following onto this intersection to ensure the safety of residences, truck drivers and the public is always observed. The following will be implemented:

1) Cameras at the front gate and on the quarry site to observe any operations
2) Minor maintenance/ upgrade required to the length of the access track to the quarry to ensure a suitable all-weather surface
3) The entrance from Murrumbateman Road will be upgraded to ensure security can be maintained whilst providing safe access/ exit of vehicles onto the shared access and public road network without disrupting other road users
4) A Locked Gate located at the property entrance to restrict access

Truck Movements

Refer to Appendix B, the Quarry Rehabilitation Proposal prepared by Franklin Consulting Australia Pty Limited dated 30 June 2020.

Material Importation to the site

The material used for the filling of the site will be suitable for the proposed application and will be:

a) Sourced from a suitably licenced facility
b) VENM as defined in the Protection of the Environment Operations Act 1993 or
c) ENM as defined in the Protection of the Environment Operations (Waste) Regulation 2014 – Excavation Natural Material Resource Recovery Exemption 2014

The document titled certification: Virgin excavated natural material as published by the Environmental Protection Authority in September 2013 is considered a suitable form of certification to achieve compliance with this condition for VENM.

The use of ENM will be in accordance with the requirements of:

a) The Protection of the Environment Operations (Waste) Regulation 2014 – Excavated Natural Material Resource Recovery Exemption 2014 and
b) Protection of the Environment Operations (Waste) Regulation 2013 – Excavated Natural Material Resource Recovery Order 2014 (as modified or superseded)

It is expected that the soil will be imported from the ACT. It is expected that a 'Fill Delivery Record' will be

established and must record the following:

a) The source address of the fill
b) Whether the fill has been certified as VENM or ENM
c) The volume of material delivered
d) The name, contact details and organisation or affiliation of the person delivering the material
e) Vehicle registration
f) The date of delivery
g) A copy of the 'Fill Delivery Record' must be submitted to Council upon request

Operating Procedures

The following operation procedures will be implemented by the applicant and induction will be carried out to all people entering the site. This will include:

1) All people and trucks entering the site will report to the Site Manager
2) A 'Fill Delivery Record' will be kept by the Site Manger
3) No 'Jake' brakes are to be used by the trucks
4) All trucks will be restricted to going 80km/h on Murrumbateman Road
5) Trucks are to only use Murrumbateman Road between the hours of 8am to 5pm weekdays
6) All vehicles existing the site will be required to use the shakedown grid onsite
7) A traffic counter will be placed at the entrance to the property to keep track of movements in and out of the property

Hours of Operation

Site works to be conducted only between the following hours:

- Weekdays 8.00am to 5.00pm

It is expected that the hours of operation outlined above will minimise noise impacts on neighbours and limit traffic during peak vehicle movement times associated with school buses and commuter traffic.

2.3 THE SUITABILITY OF THE SITE FOR THE DEVELOPMENT

The proposal is consistent and compatible with the surrounding land uses of the Murrumbateman district. The development fits in with the existing land uses and these will be maintained with this development. Therefore, the site is considered suitable for the proposed development.

3. CONCLUSION

The proposed quarry filling project has been prepared having regard to the environmental sensitivities of the site and will have negligible environmental impacts. The proposal has been designed to create a stable landscape with no offsite impacts and with minimal ongoing maintenance requirements. The proposal will provide for an improved environmental and aesthetic outcome through promoting the natural regeneration of native trees and shrubs in conjunction with active revegetation of pasture/ grass species and some strategic native tree and shrub plantings to mitigate erosion risk and improve agricultural productivity.

APPENDIX B

QUARRY REHABILITATION PROPOSAL

SOIL AND WATER

QUARRY REHABILITATION PROPOSAL

NANIMA

Lot 10/DP 878725
1170 Murrumbateman Road
NANIMA NSW 2582

Version 2
30 June 2020

Mobile: 0490 393 234
soil.land.water@gmail.com
www.soilandwater.net.au

FRANKLIN CONSULTING AUSTRALIA PTY LIMITED
ABN: 59 611 394 953
GPO Box 837
CANBERRA ACT 2601
www.soilandwater.net.au

CONTENTS

INTRODUCTION

Soil and Water has been engaged by Geoff Hewatt on behalf of Winjarra Pty Ltd to develop a proposal for the rehabilitation of the existing Quarry at 1170 Murrumbateman Road, Nanima NSW. The quarry is located on Lot 10 DP878725, which is land owned by the Winjarra Pty Ltd.

The quarry is not an operational quarry. Historically the quarry was a source of road base and sub-base material for road construction and maintenance activities in surrounding areas, principally by the Yass Valley Council.

The owner of the land wishes to rehabilitate the quarry to create stable non-eroding landscape with improved visual amenity and a land use more consistent with the surrounding low intensity agricultural (grazing) landuse.

The rehabilitation measures proposed are designed to create a stable landscape with no offsite impacts and with minimal ongoing maintenance requirements. The proposed measures will also provide for improved environmental and aesthetic outcomes through promoting the natural regeneration of native trees and shrubs in conjunction with active revegetation of pasture/grass species and some strategic native tree and shrub plantings to mitigate erosion risk and improve agricultural productivity.

The rehabilitation measures include the use of Virgin Excavated Natural Material and Excavated Natural Material (VENM/ENM) generated by the Canberra construction industry, to enable a suitable sympathetic topographic profile to be achieved which will improve the visual amenity and maximise the landuse options for the site.

The use of this type of material for the rehabilitation of the quarry is also considered appropriate as it demonstrates a "whole of life" approach to waste management, with the Virgin Excavated Natural Material (quarry product) being extracted from the site as a resource, and similar material (VENM/ENM) from the waste stream, being returned to the site for use in rehabilitation.

This plan details the rehabilitation measures proposed for Murrumbateman Road Quarry including how imported material will be integrated into the process and options for landuse of the final rehabilitated landscape.

SCOPE OF THIS PLAN

The scope of the plan is designed to provide the information necessary for Yass Valley Council to properly assess the proposal and includes the following:

- Current landuse and quarry extent
- Rehabilitation goals and design principles
- Environmental constraints and considerations, including
    - Surface water
    - Groundwater
    - Dryland salinity
    - Biodiversity
    - Erodible Lands
- Proposed rehabilitation measures, including:
    - Soil and water management works required to enable rehabilitation activities to proceed without impacting water quality
    - Methodology for filling using imported VENM/ENM
    - Sequencing of works
    - Final rehabilitation measures to stabilise the site
    - Progressive revegetation
- Staged Rehabilitation Works Program
- Type and amount of imported (VENM/ENM) material to be used in rehabilitation including:
    - Source and certification of material
    - Estimated volumes required to rehabilitate the gullies
    - Stockpiling and material management
- Truck movements and plant operations including:
    - Truck configuration and expected movements per day
    - Plant and equipment to be used in rehabilitation activities
    - Hours of operation
    - Site supervision and security
- Monitoring and maintenance including:

- Surface and groundwater monitoring
- Soil and water management structure maintenance
- Vegetation monitoring and management (including revegetation)
- Weed and feral animal control

CONSULTANT INFORMATION

This evaluation has been undertaken by John Franklin who is a Certified Environmental Practitioner with over 30 years' experience in natural resource management in the ACT and Murrumbidgee region. This experience includes site and soil assessment around the southern tablelands, south-west slopes and upper Murrumbidgee region. John has provided extensive soil and water management advice to State and Local Government and the urban / rural residential development sector across the region.

John also has extensive experience in erosion control and wrote the *Gully Erosion Assessment and Control Guide* (Franklin, Glover and Parker, 2004) for the NSW Department of Infrastructure, Planning and Natural Resources.

Inspection location	Date	Consultant
Lot 10 DP 878725 1170 Murrumbateman Road Quarry Nanima, NSW, 2582	3 April 2020	John Franklin M App Sc, BSc, EIANZ CEnvP (No 1320)

SITE DESCRIPTION

Locality

Figure 1: Regional Location

The quarry is located at 1170 Murrumbateman Road, Nanima NSW 2582, refer **Figure 1**. The site is accessed by an existing all-weather unsealed road which extends 564 metres south from the Murrumbateman Road access, refer **Figure 2a**. The access road is in good condition and is in regular use for the dwelling on the lot. Minor upgrades may be required to enable safe access by truck and dog combination and associated earth moving plant and equipment, particularly the watercourse crossing immediately east of the quarry. There is an secondary internal access road which is considered less suitable for heavy vehicle access however may be used as an alternative means of access/egress in case of emergency, refer **Figure 2b**.

The site access is located 11.71 km southeast of Murrumbateman Road / Barton Highway junction, refer **Figure 3**.

Figure 2a: Internal Access Road

Figure 2b: Alternative/Emergency Internal Access Road

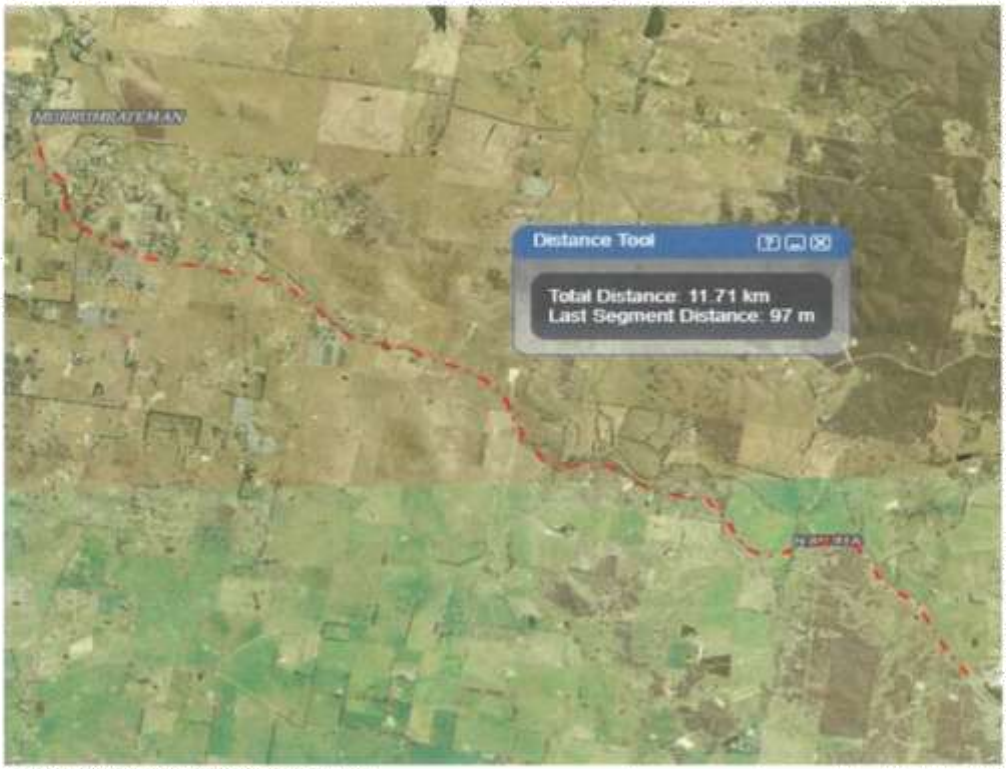


Figure 3 Links to Barton Highway

Figure 4: Lot 3 DP 869801 Layout

CURRENT AND PROPOSED LANDUSE

The quarry is dormant and not currently being used as an active extraction site. Historically the product from the quarry has been excavated and stockpiled for use in local roadworks. The quarry site is under the ownership and management of the landowner and there are no arrangements with any third parties to operate or extract product from the site. There is no formal Development Consent or other approvals associated with the quarry.

The landholder proposes to rehabilitate the site to reinstate a stable gently undulating landscape which approximates the landform and productivity of surrounding grazing paddocks. This will require that fill is imported onto the site to fill the existing excavation to a point that a gently undulating landform can be achieved.

The final landuse proposed for the area includes livestock grazing and environmental enhancement through natural regeneration.

The rehabilitated area will be topsoiled and revegetated with suitable groundcover pastures and grasses to prevent erosion and reinstate grazing productivity. The surrounding remnant native trees will provide adequate seed stock for the natural regeneration of canopy trees overtime. This will ensure that trees that do establish are locally endemic to the site and therefore ideally suited to the landscape. Strategic planting of endemic native species will supplement natural regeneration and create a more sustainable and stable landscape.

ENVIRONMENTAL CONSTRAINTS AND CONSIDERATIONS

There are several environmental issues identified in the Yass Local Environment Plan (Yass LEP 2013), which need to be considered in the design and implementation of an appropriate rehabilitation strategy for the Nanima Quarry. All issues highlighted in the Yass LEP 2013, and relevant to the property, are addressed below.

SURFACE WATER

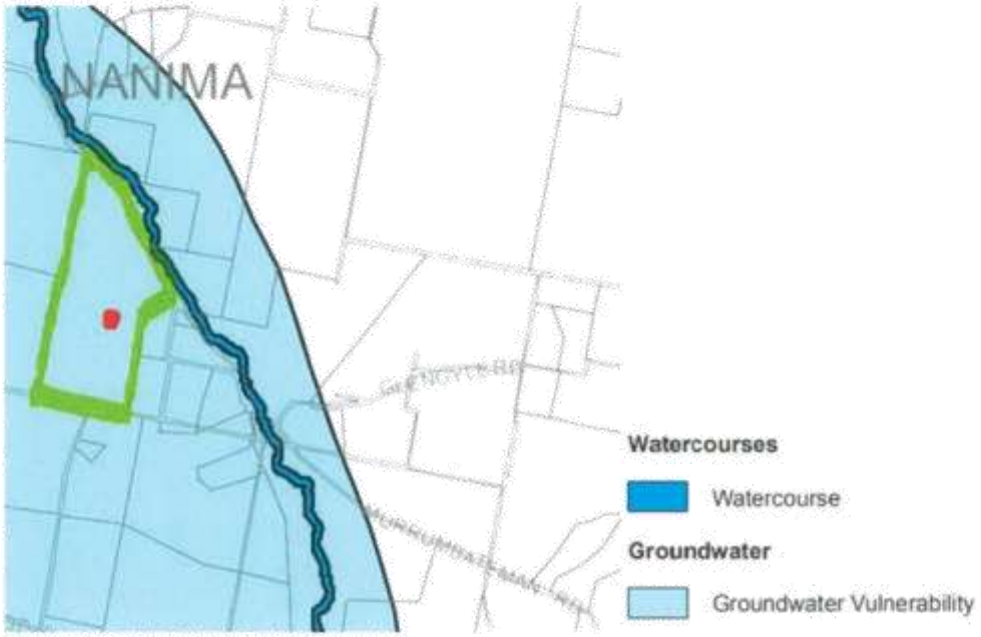


Figure 5: Riparian Lands and Watercourses Map

The quarry site and surrounding property are not mapped on the riparian area and watercourse map in the Yass LEP, refer **Figure 5**. The northern property boundary parallels the Murrumbateman Creek which is mapped as a watercourse in the Yass Valley LEP (2013). The property does include numerous minor 1st and 2nd Order watercourses including the 2nd Order Stream which is crossed by the access track which will be used during quarry during rehabilitation activities, refer **Figure 6.**

Potential surface water impacts resulting from the proposed rehabilitation activities will be limited and mitigated by the following:

- There are no major watercourses in the vicinity of the quarry with the nearest mapped watercourse being 741 m north of the site, refer **Figures 5 & 9**
- Soil and Water management measures implemented during rehabilitation will limit potential impacts on downstream water quality in the minor 1st and 2nd Order Stream watercourses adjacent to the quarry
- Fill material will be restricted to Virgin Excavated Natural Material and Excavated Natural Material (VENM/ENM) which is certified and contains no contamination

- The minor 2nd Order Stream crossed by the quarry access track will be not be impacted as the access track and crossings are existing and stable and will only require minor maintenance upgrades to remain suitable to support the rehabilitation activities proposed.
- Surface water used for dust suppression will be sourced from existing farm dams.

1st Order Streams 2nd Order Streams

Figure 6: Riparian Lands and Watercourses Map

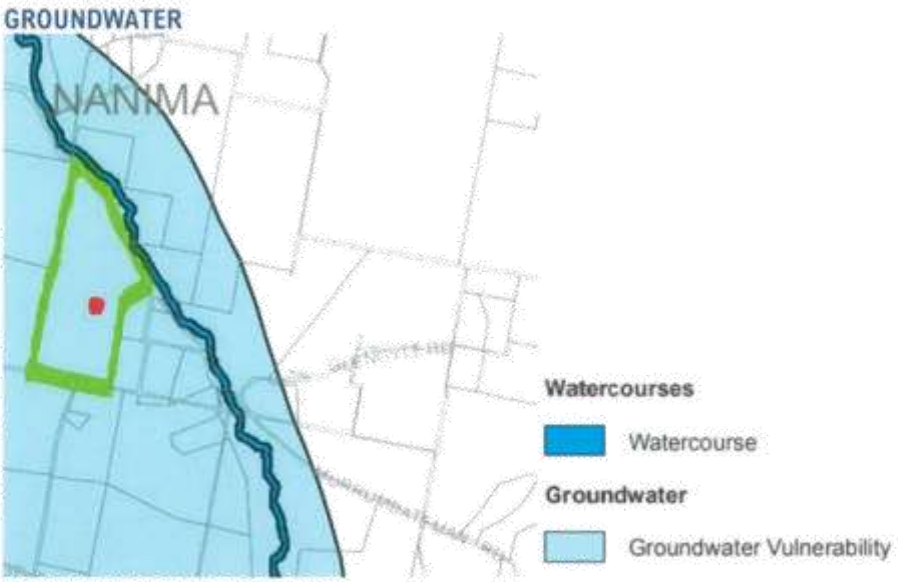


Figure 7: Groundwater Map

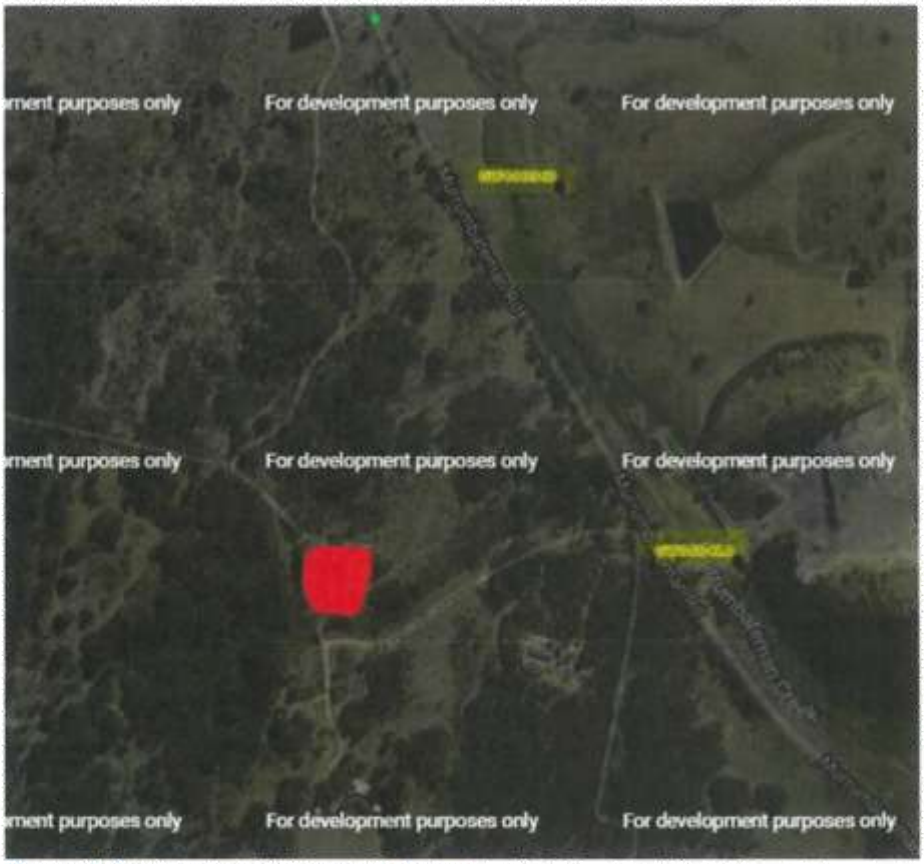


Figure 8: Surrounding Groundwater Bores

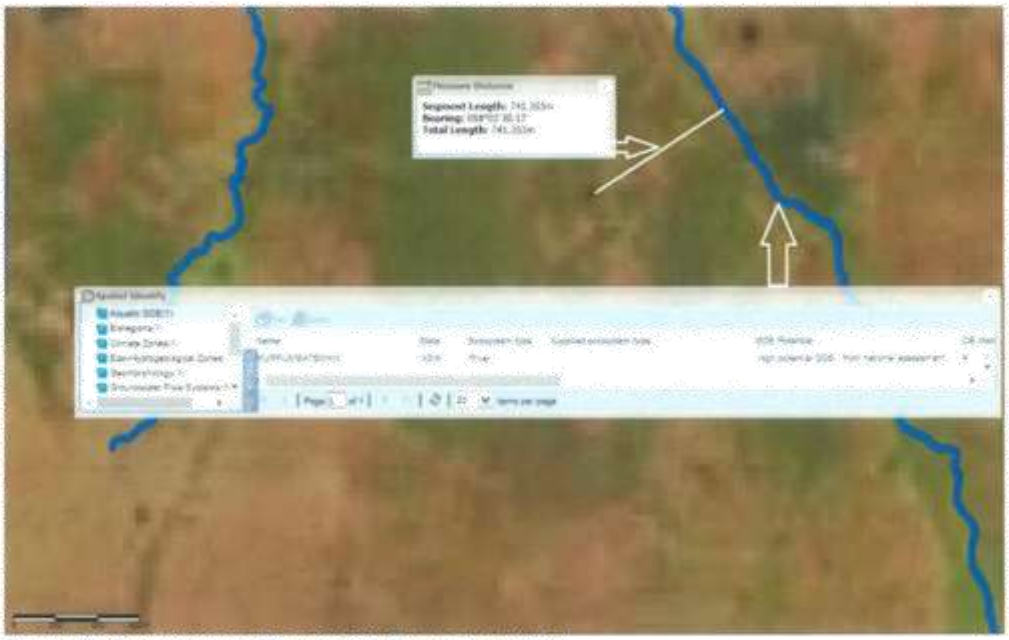


Figure 9: Groundwater Dependent Ecosystems Map

The quarry site and surrounding property is mapped on the groundwater map in the Yass LEP, refer **Figure 7**.

There are no groundwater bores located on the property and the closest bore is located 680m to the east of the quarry, refer **Figure 8**. The closest bore (GW060410) has a depth of 33.8m, yield of 1.25L/sec and Water Bearing Zones at 3.1-28.6m. This bore is a monitoring bore associated with the Glenlee Quarry (Murrumbateman Road) which is why the casing is open between 3.1 and 28.6m. The main water bearing zones in local groundwater systems are located 15-15.5/27-28m depth as demonstrated in bore data for GW403969 which is a Stock and Domestic bore 727m northeast of the site.

There are no groundwater dependent ecosystems mapped in the vicinity of the quarry. The downslope drainage feature (Murrumbateman Creek to the northeast) has a high potential for associated Groundwater Dependent Ecosystems (GDEs), refer **Figure 9**.

Potential groundwater water impacts resulting from the proposed rehabilitation activities will be limited and mitigated by the following:

- Rehabilitation activities will not impact groundwater systems and no groundwater will be extracted to support the rehabilitation activities
- There are no bores within 500 metres of the quarry site
- The nearest bore (GW060410) is 680 metres from the quarry and is a monitoring bore
- The vertical separation between the surface and water bearing zones of the groundwater system in this vicinity is >15 m
- There are no groundwater dependent ecosystems in the area and the downslope drainage systems (Murrumbateman Creek) which has a high potential to support

groundwater dependent ecosystems, will not be adversely impacted by the rehabilitation of the quarry

- The fractured rock groundwater aquifer which underlies the area has low transmissivity
- The rehabilitation activities will reduce local accessions to the groundwater system through capping and revegetating the areas of exposed parent material which are typically areas of high groundwater recharge

DRYLAND SALINITY

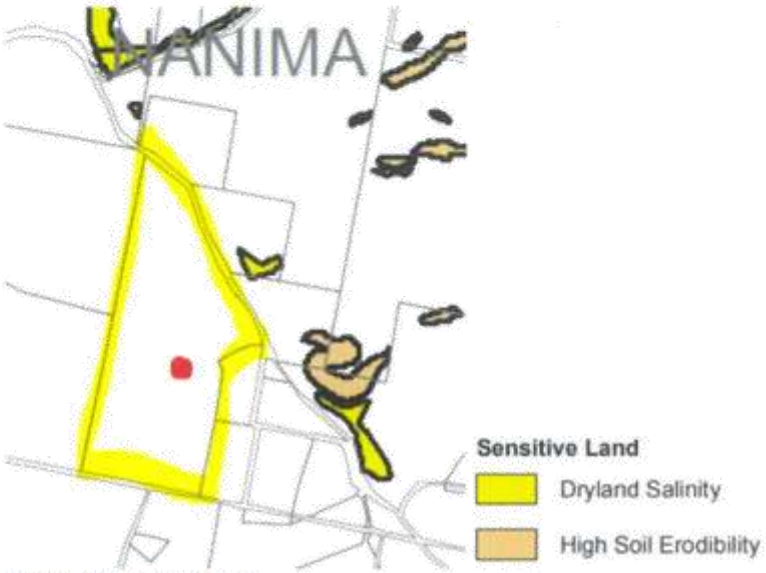


Figure 10: Salinity Map

The quarry site and surrounding property is not mapped on the dryland salinity map in the Yass LEP, refer **Figure 10**.

The potential for the rehabilitation activities to either impact on, or be impacted by dryland salinity will be limited and mitigated by the following:

- The quarry is located high in the landscape in an area of groundwater recharge. Recharge into the groundwater system, which drives local dryland salinity, will be reduced by the capping of exposed bedrock, which has high recharge potential, with VENM/ENM material, subsoil and topsoil
- The natural regeneration of trees and shrubs, combined with strategic revegetation, will increase the amount of deep-rooted perennial vegetation in the landscape and further reduce groundwater recharge
- Revegetation of groundcover on all areas of disturbance will reduce erosion potential and saline scalding

ERODIBLE LANDS

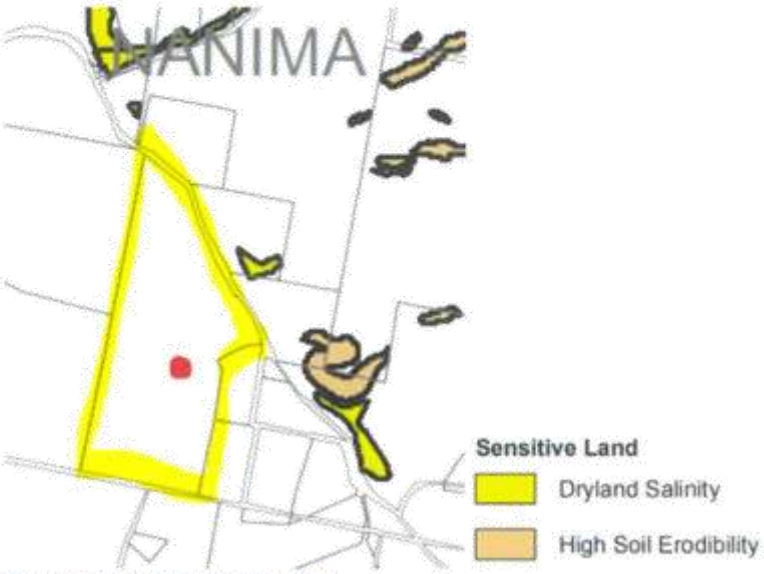


Figure 11: Soil Erodibility Map

The quarry site and surrounding property is not mapped on the soil erodibility map in the Yass LEP, refer **Figure 11**.

The potential for the rehabilitation activities to either impact on, or be impacted by areas of high soil erodibility will be limited and mitigated by the following:

- Soil and Water management measures implemented during rehabilitation will limit the potential for soil erosion
- Spatial separation between areas of high soil erodibility and areas of disturbance associated with rehabilitation activities
- The revegetation of all areas of disturbance with suitable groundcover species including the lining of all areas of concentrated flows with geotextile or similar material, will reduce the potential for soil erosion on the site.

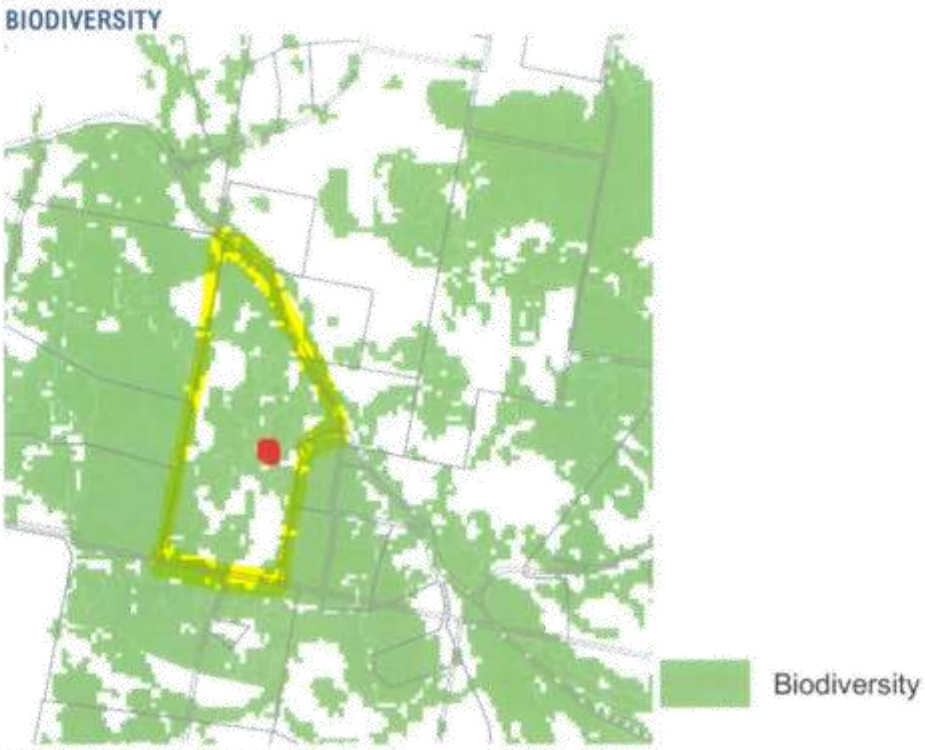


Figure 12: Biodiversity Map

The remnant native vegetation surrounding the quarry site is mapped on the biodiversity map in the Yass LEP, refer **Figure 12**. The mapped vegetation extends to the north and east of the site and is part of large and regionally significant area of native vegetation.

The potential for the rehabilitation activities to impact on biodiversity values of the area will be limited and mitigated by the following:

- The quarry and access road are existing, and no additional vegetation will be damaged or destroyed as part of the rehabilitation activities
- Natural regeneration will be encouraged, and supplemented with strategic revegetation of locally endemic native species of trees and shrubs

REHABILITATION GOALS AND DESIGN PRINCIPLES

The goals for rehabilitation are designed address the environmental constraints and deliver the following desirable environmental, land management and landuse outcomes:

- **Environmental**
  - Improved biodiversity and fauna habitat by
    - promoting natural regeneration of endemic trees and shrubs
    - strategic revegetation with locally endemic native species
    - weed control and
    - feral animal management
  - No impact to groundwater or salinity by
    - managing accessions to the water table by capping areas of potential high recharge with subsoil/topsoil
    - natural regeneration and strategic revegetation of deep-rooted trees and shrubs and revegetating of groundcover species to maximise use of rainfall by evapotranspiration and
    - managing surface water runoff to maintain the run-off/infiltration balance
  - No impact to surface water quality or quantity by
    - managing surface water runoff to maintain the run-off/infiltration balance
    - retaining internal site drainage pattern during rehabilitation to direct all surface run-off to sediment detention basin prior to discharge into surrounding surface water systems
    - managing discharges from internal drainage to ensure appropriate water quality prior to discharge
    - revegetating all disturbed areas and maintaining groundcover to reduce erosion and sediment movement and
    - reducing grades on finished landscapes to lower slopes to reduce erosion potential (utilising VENM/ENM as appropriate).
- **Land Management**
  - Stable landscapes requiring minimal maintenance by
    - installing temporary and permanent soil and water management works to manage surface water flows and reduce erosion potential
    - reducing grades on finished landscapes to lower slopes to reduce erosion potential (utilising VENM/ENM as appropriate)
    - revegetating all disturbed areas and maintaining groundcover to reduce erosion
- **Land Use**
  - Improving the agricultural utility of the site by
    - creating a gently undulating landscape (utilising VENM/ENM as appropriate)
    - promoting the natural regeneration of locally endemic native trees and shrubs and active revegetation with productive groundcover species
  - Improving the aesthetic and land use value of the site by

- creating a gently undulating landscape with final topographic profile which blends into the surrounding landscape features (utilising VENM/ENM as appropriate)
- promoting the natural regeneration of locally endemic native trees and shrubs

The following design principles are intended to minimise potential adverse environmental impacts and optimise the effectiveness of rehabilitation:

- Quarry rehabilitation activities will be confined to a 2 year rehabilitation timeframe (commencement to completion), to minimise long term impacts on neighbours local road users
- Sediment and erosion control measures (temporary) will be installed prior to commencement of works and will be maintained until rehabilitation and revegetation has established an adequate groundcover
- Clean upslope run-on water will be diverted around the quarry and all disturbed areas
- Drainage from the quarry and all disturbed areas will be internalised and directed to a sediment detention basin with adequate capacity to ensure the sediment retention prior to discharge.
- Sediment basins will be flocculated (dosed) if required to remove sediment prior to discharge into the downslope environment
- Any fill material used in rehabilitation activities will be certified VENM/ENM
- Any material stockpiled for use in rehabilitation (topsoil/subsoil) will include downslope sediment control measures
- All disturbed areas (fill and/or shaped) will be topsoiled, fertilised and seeded on completion.
- Steep areas and or areas of potentially concentrated flows, will be lined with geotextile or similar to reduce erosion potential and promote revegetation
- All revegetation species will be productive pasture/grass species suited to the climate and soils
- Native tree and shrub regeneration will be encouraged to ensure locally endemic species suited to the site and providing maximum habitat value
- Strategic revegetation will include suitable locally endemic native trees and shrub species.

STAGED REHABILITATION PLAN

The rehabilitation plan includes the following stages which will be implemented in the sequence shown. The type and/or sequence of works detailed should only be varied in consultation with the author of this report and may be subject to Council approval.

STAGE 1 – IMPLEMENT SEDIMENT AND EROSION MEASURES

1. Minor maintenance / upgrade access track to quarry – surface will be inspected to ensure suitable all-weather surface exists for the length of the access track. Resurfacing / shaping will be conducted as required, sediment fence will be installed at the discharge point of any mitre/table drains as may exist or be installed along the access track, refer standard drawings in **Appendix 1**.
2. Entrance upgrade - The entrance from Murrumbateman Road will be upgraded to ensure security can be maintained whilst providing safe access / exit of vehicles onto the shared access and public road network without disruption to other road users. Warning signs will be installed east and west of the entrance indicating turning trucks.
3. Construct sediment and erosion control measures:
    a. Install stabilised site access – in the location shown in **Figures 13-b-c** and according to the specification shown in **Appendix 1 SD 6-8**. Drainage from the crossing will be directed towards the southwest and into the sediment fencing.
    b. Construct sediment fencing - downslope of all areas where rehabilitation will result in areas of upslope disturbance as shown in **Figures 13-b-c** and **SD 6-8**. Sediment fence should be maintained until revegetation on the filled and rehabilitated excavation exceeds >80% groundcover.
    c. Construct sediment detention capacity – the existing water storage in the base of the quarry will be progressively filled during the rehabilitation of the quarry. Once this storage cannot be maintained for use as a suitable sediment detention basin, the new sediment basing will be constructed as shown in **Figures 13b-c** and **Appendix 1 – SD 6-4**. The sizing of the sediment detention basin will be designed to contain the first flush being the first four hours from a 1 in 10-year rainfall runoff event which equals approximately 500 cubic metres of storage per hectare of disturbed catchment. This capacity will be in addition to the residual storage capacity. A low flow trickle pipe will also be used to assist in managing discharge from the structure once capacity is reached. Flows which exceed the first flush storage capacity and capacity of the trickle pipe (if installed) will be discharged via an emergency overflow structure, refer **Figures 13b-c** and **Appendix 1 – SD 6-4**. The emergency overflow must terminate in a level spreader (sill) to spread flows and reduce erosion risk.

The sediment basin will be retained as a small water feature following the successful revegetation of the site. Active management of the basin will not be required at this stage as flows to the basin will be minimal due to the upslope topography created through filling and shaping of the excavation, and the establishment of groundcover in excess of 80% which will result in all flows entering the basin being clean water flows.

d. Construct diversion bank – diversion bank as shown in **Figures 13b-c** and **Appendix 1 – SD 5-6**, should be constructed to ensure all upslope run-on water is contained and redirected around the rehabilitation site prior to discharge. The channel of the bank will need to be lined with geotextile (or similar material) to ensure clean water captured remains uncontaminated and the grade and volume of flows does not create an erosion risk. Alternatively, these diversion banks can be constructed as a 'back – push bank' where the flows are conveyed on natural ground level and the borrow pit for the bank is located on the opposite side.

STAGE 2 – QUARRY FILLING

1. Prepare the quarry excavation for filling – The site base and batters of the existing excavation should be stripped of any useable topsoil/subsoil material. This material should be stockpiled adjacent to the site for use in final rehabilitation and revegetation phase, refer **Appendix 1** and **SD 4-1**. The base and batters of the excavation should be ripped to ensure that imported VENM/ENM fill material integrates properly with the underlying material to reduce the risk of downslope movement and slippage.
2. Commence filling operation using imported certified VENM/ENM material - Filling should maintain a slightly convex (mounded) landform to reduce infiltration into the fill material during filling process. Filling should progress from the back batter of the quarry towards the front and progressively raise the base and progress the back batter forward to maintain and suitable working face that enables dumped material to be spread in even layers on the base and batters and compacted by track rolling with a bulldozer and/or using a sheep's foot or vibrating drum roller to achieve levels close to field compaction. As soon as sections of the filled quarry reach finished levels progressive topsoiling and revegetating should commence, refer STAGE 3 – TOPSOILING AND REVEGETATION.

STAGE 3 – TOPSOILING AND REVEGETATION

1. Topsoil and revegetate - The finished area of fill material should be topsoiled with 150mm of suitable loam topsoil overlaying 100mm of clay loam material. The finished fill material should be lightly ripped on the contour prior to the spreading of subsoil and topsoil material. The topsoiled are should then be seeded with a suitable pasture seed mix and fertilised with a Starter type fertiliser. Whilst the vegetation is establishing stock access will need to be restricted from the area with temporary stock fencing.

2. Strategic revegetation – Locally endemic native tree and shrub species may be planted into the site whilst stock access is restricted and groundcover on the site is establishing. Species should be selected which will match the intended passive recreational land use and add to the overall biodiversity value of the existing remnant native vegetation.
3. Natural regeneration - Continuing to restrict stock access to the site will also encourage natural regeneration of endemic native tree and shrub species which will ensure species ideally suited to the site colonise the area.

STAGE 4 – REMOVE SEDIMENT AND EROSION CONTROL MEASURES

1. Remove sediment fencing – Following the successful revegetation of the rehabilitated quarry site (groundcover levels across the entire area >80%) the sediment fencing may be removed.

STAGE 5 – MONITORING AND MAINTENANCE

1. During rehabilitation:
    a. While rehabilitation activities are progressing the sediment and erosion measures should be inspected monthly and following any major rainfall runoff events. Particular attention should be paid to erosion along diversion bank channels, stabilised site access, access tracks and the emergency outlet of the sediment detention basin. Should erosion be identified appropriate remedial measures must be implemented such as lining of diversion bank channels with geotextile.
    b. The condition of the access track from Murrumbateman Road should be monitored to ensure a stable all-weather surface is maintained. Remedial maintenance should be implemented as required.
    c. Dust should be monitored during rehabilitation and dust suppression measures including use of water cart, should be implemented as required. During periods of excessive wind operations should be halted until such time as dust can be adequately managed using available dust suppression activities.
2. Post rehabilitation:
    a. Following the final topsoiling and revegetation activities, the success of revegetation efforts should be monitored including control of stock access to revegetating areas, establishment of weeds and extent of groundcover.
    b. The establishment of planted trees and shrubs should be monitored to check for disease, rabbit/hare impact and general health and vigour.
    c. The success of natural regeneration should also be monitored to check the amount of natural regeneration occurring, what species are being naturally recruited and provide support for this regeneration through stock removal and/or guarding where rabbit/hare impacts are significant.

d. Long term pasture management and stocking rates should always retain groundcover at >80%.

e. Long term monitoring and maintenance should focus on weed and feral animal management to maximise the biodiversity values of the rehabilitated site.

Figure 13a: Murrumbateman Road Quarry (extent as at 3 April 2020)

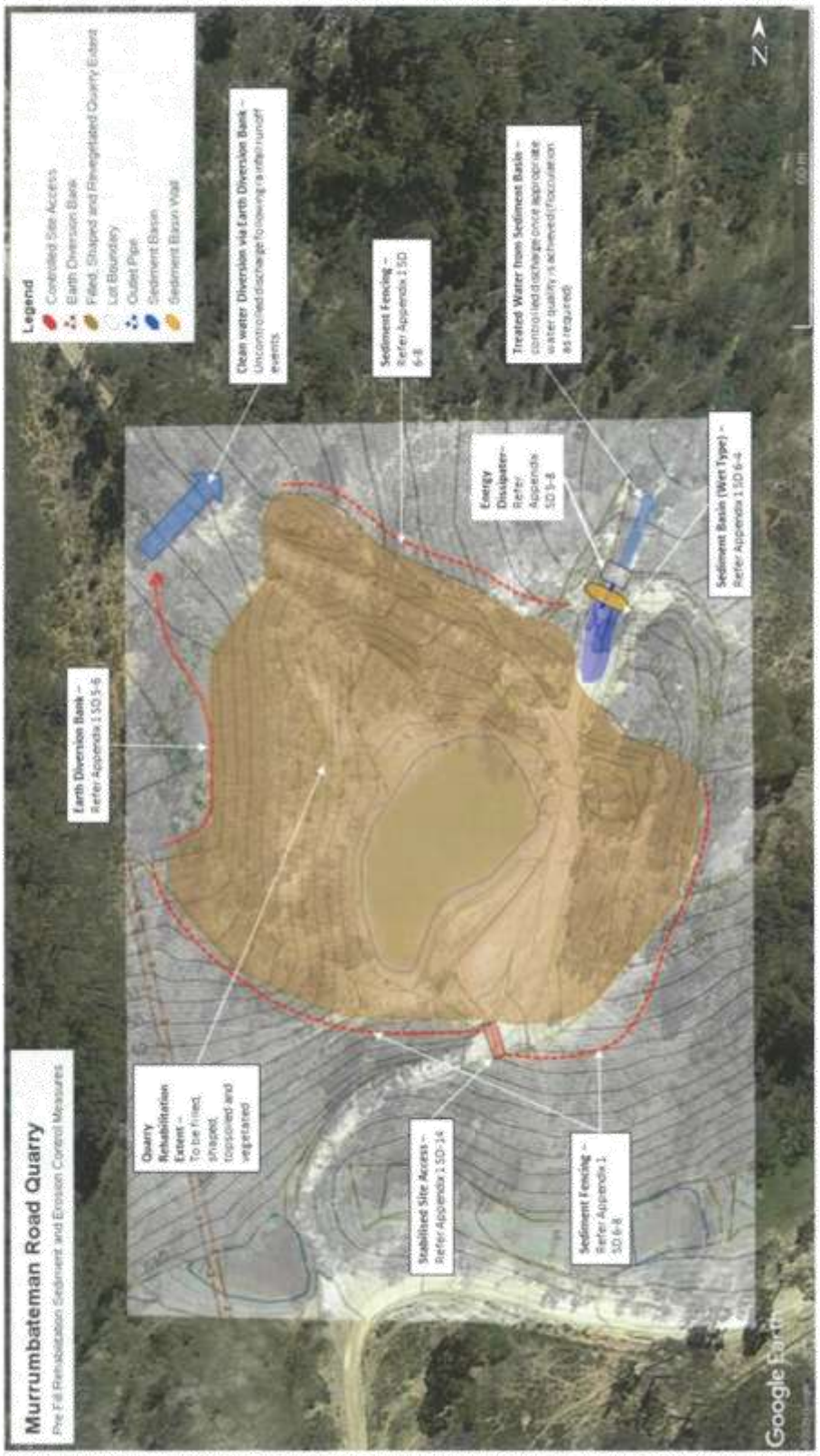


Figure 13b: Sediment and Erosion Control Measures – existing excavation contours

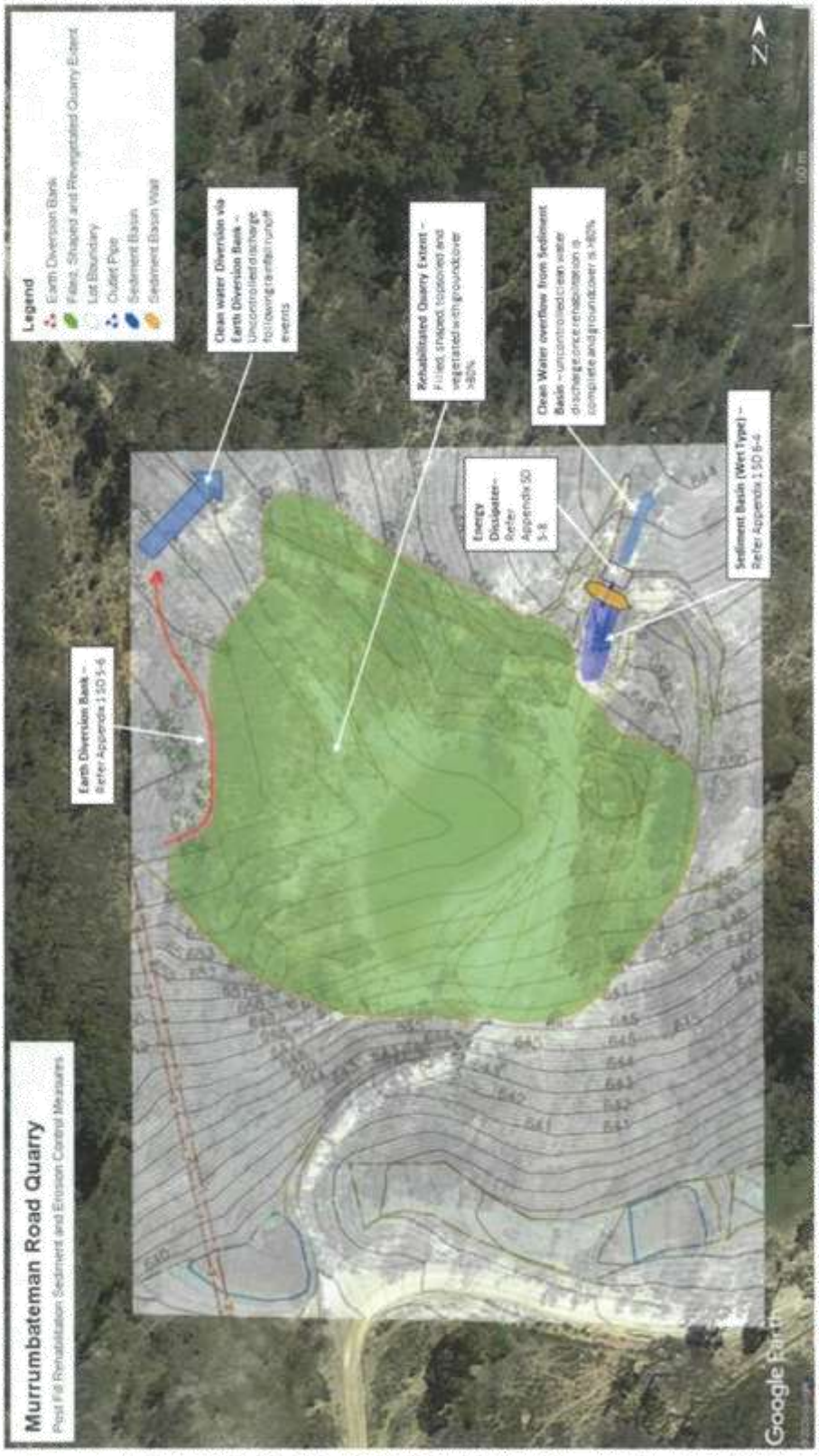


Figure 13c: Sediment and Erosion Control Measures – final contours

ALTERNATIVE REHABILITATION OPTIONS

The following evaluation compares rehabilitation options for the existing quarry to ensure the measures proposed are the most appropriate for the site.

1. Continue existing land management (do nothing)

The site in its current form has no agricultural productivity and is a blight on the landscape with limited options for future landuse. The continuation of the existing land management practices will not deliver improved agricultural productivity or biodiversity values. The aesthetic appeal of the site, and options for future landuse, will not be improved by the continuation of existing land management.

As a result, a continuation of existing land management will not deliver a net improvement to the environment, agricultural productivity, aesthetics or landuse options and is therefore not considered an attractive option.

2. Quarry Rehabilitation (without fill)

The quarry site could be rehabilitated in the traditional manner and without the use of imported fill material (VENM/ENM). This would generally involve the battering of the excavation to create lower batter grades which are stable (non-eroding), and opportunistic revegetation where adequate suitable soil material exists.

This approach presents limited benefit over the do-nothing options as the batter grades are generally already stable and the limited amount of available topsoil significantly restricts the amount revegetation that can be achieved on the site.

This type of rehabilitation will result in only a marginally improved agricultural productivity and aesthetic appeal with slightly improved landuse options. The cost of undertaking rehabilitation for the limited benefit derived, results in this option having a low cost-benefit.

3. Quarry Rehabilitation (with imported VENM/ENM fill material)

The quarry rehabilitation program proposed in this report utilises imported VENM/ENM to fill the existing excavation and reinstate a natural undulating landscape. As the VENM/ENM material provides the flexibility to create whatever landform best suits the landscape, through filling and shaping, the final rehabilitated site has a vastly improved aesthetic appeal Land use options available for the rehabilitated site are greatly increased as the final topography can be manipulated to best support agricultural and environmental/biodiversity outcomes.

The VENM/ENM material also provides a source of suitable subsoil and topsoil material for final revegetation activities enabling the entire site to be revegetated. This greatly increases the agricultural productivity of the site and reduces long term erosion risk. The use of VENM/ENM material which is a waste stream from the ACT, also cross subsidises the cost of rehabilitation

and enables a more comprehensive rehabilitation effort including strategic revegetation to supplement the natural regeneration. This cost benefit of this approach is therefore high.

The other benefit of using VENM/ENM material to rehabilitate a decommissioned quarry is that it represents a "whole of life" approach to waste management, with the Excavated Natural Material (quarry product) being extracted from the site as a resource, and similar material (VENM/ENM) from the waste stream, being returned to the site for use in rehabilitation.

JUSTIFICATION FOR REHABILITATION APPROACH

The rehabilitation of the quarry will improve the agricultural productivity and biodiversity benefits derived from the site and improve the land use options available to the site. The use of VENM/ENM material for rehabilitation also presents a good model of 'whole of life' or closed loop recycling with excess excavated material being used to rehabilitate an excavated quarry site. Other benefits include:

- Returns the quarry area to a land capability similar to the remainder of the paddock (following the successful rehabilitation and revegetation);
- Increases the area available for agriculture through recovery and rehabilitation of the previously unproductive area;
- Increases the number of land use options available to the site including for passive recreational uses and grazing;
- Reduced potential for livestock and/or land managers injury through eliminating the risk of falls by filling the quarry;
- Improved visual amenity and biodiversity values by removing the bare excavation area whilst maintaining existing remnant native vegetation, promoting natural regeneration and supplementing with strategic plantings.

Activities which deliver improved environmental outcomes and improved farm productivity are generally considered as effective and efficient land management measures for rural lands.

TYPE AND AMOUNT OF FILL MATERIAL TO BE USED IN REHABILITATION

The fill material to be used in the rehabilitation of the quarry will be restricted to certified VENM/ENM. This material will be sourced from selected Canberra construction sites through negotiation with site managers and excavation contractors by the proponent. Records of the VENM/ENM certification of all material to be used on site will be maintained by the proponent and provided to Council as required. The material will be conveyed to the site in rigid truck and dog trailer and/or semi-trailer combinations and managed onsite by the proponent's plant and equipment.

Topsoil to be used in the final rehabilitation of the quarry will be selectively sourced from the VENM/ENM stream and stockpiled onsite to be combined with insitu soil material. Should there be insufficient suitable material available from the VENM/ENM stream, then suitable topsoil material may be sourced from recognised suppliers.

The volume of VENM/ENM material required to fully rehabilitate the site has been estimated by pre and post rehabilitation survey of the site as presented in **Table 1** below.

Table 1: Imported Fill Volumes

Quarry Area	Excavation Volume to be Filled (m3)	Compaction Factor (40%)	Transported Volume Required (m3)	
Deep Excavation	25,878	10,351	36,230	
			[Tonnes	**54,344]**
Subsoil/Topsoil Volume (m3)– [8000m² X 0.2m] X 1.2 (topsoil compaction)				**1,920**
Subsoil/Topsoil Volume (tonnes)				**2,880**
			Total Volume of Fill Material Required	**38,150**
			Total Tonnes of Fill Material Required	**57,225**

The total volume of imported VENM/ENM (including topsoil) has been estimated at:

- 38,150 m³ of imported VENM/ENM material, or
- 57,225 tonnes of imported VENM/ENM material

TRUCK AND PLANT OPERATIONS

Truck and plant movements have been estimated based on the fill volumes detailed in the previous section, the rate at which the source material (VENM/ENM) is being generated and the capacity of the onsite works crew to assimilate material as part of the rehabilitation program.

The maximum number of truck movements per day is based on a team of 8 trucks each making 8 deliveries per day. This equates to maximum of 64 truck movements daily.

The results are presented in **Table 2** below.

Table 2: Truck Movements

Total Volume of VENM/ENM Required	**36,230m³** (25,878 m³ – compacted)	
Total Weight of VENM/ENM Required	**54,344 tonnes** (@1.5 tonnes per m³)	
Average Truckload	**18 - 22.5 tonnes** (@12-15m³)	
VENM/ENM Generated / Truck Movements	**Delivered (tonnes)**	**Truck Movements**
Daily (peak operating)	**1280**	**8 X 8 = 64**
Total Truck Movements Required – whole project	**2720**	**42.5 days @ peak operating (64 /day)**
Project Lifespan	**42.5 peak days**	**1 Year**

Based on the profile of truck movements provided, and total volume required for rehabilitation, the project has a lifecycle of approximately one year from commencement (based on approximately 42.5 days of peak operating being achievable in a single year). This provides adequate allowance for the intermittent supply of suitable VENM/ENM material, weather delays, time required for the construction of associated soil and water management works time required for topsoiling and revegetation activities.

Plant and equipment operating on the site at various times will include a bulldozer, roller and excavator, in addition to the trucks delivering the VENM/ENM material for quarry filling. The site will be controlled by the proponent's site foreman who be responsible for ensuring a safe working environment. Security of the site will also be maintained by the proponent who will ensure that all material delivered to site is in accordance with Council and other regulatory requirements and that no illegal dumping activities occur.

Access to the site will be controlled by the proponent and the site will be locked when not in operation and a Closed Circuit Television (CCTV) will be installed to monitor vehicle movements and potential unauthorised site access.

The proposed hours of operation of the site (including truck movements) will be between 8am and 5pm on weekdays. This will minimise noise impacts on neighbours and limit traffic during peak vehicle movement times associated with school buses and commuter traffic.

PROJECT MANAGEMENT

The project, operation and site will be strictly managed to ensure desired outcomes are delivered with no perverse impacts on the environment or neighbouring properties. The management mechanisms to be used are detailed in the following sections.

MATERIAL QUALITY

All material to be transported to the site will be certified VENM/ENM. Certification will be checked by the full-time site manager. All staff including drivers and earth moving operators will be inducted onsite which will include specifying that all material to be delivered onsite is to be certified VENM/ENM.

MATERIAL VOLUME

Truck movements and volumes of material received will be managed through daily truck run sheets. These will specify the number and timing of truck movements as required in Council consent and detailed in this report. The truck run sheets will be managed by the onsite manager.

SITE ACCESS AND SECURITY

The site will be secured by a locked access gate and a CCTV will be installed at the gate to ensure no unauthorised access to the site. During the hours of operation, a site manager will be present at all times to check deliveries against the truck run sheet, the certification and quality of material entering the site and driver behaviour.

DRIVER BEHAVIOUR

All drivers delivering material to the site will be inducted into the project which will include the behaviour of all operators. An incident reporting number will be provided to Council so that incidents of poor behaviour reported to Council can be forwarded to the project manager. A disciplinary process will be established which includes a single warning and counselling followed by dismissal from the site and the project should there be a second report of poor behaviour. NSW road rules will apply to all public roads and any breaches reported to the project manager will be forwarded to the relevant authorities for action.

MONITORING AND DUST MITIGATION

A protocol for managing dust will be developed prior to the commencement of the project which will include monitoring weather forecasts for periods of strong winds and wet weather and adjusting onsite operations to mitigate impacts from dust. Water may also be sourced from the temporary sediment and erosion control structures on the property when suitable. The reporting process developed for driver behaviour will also apply to other areas of the operation

including the reporting of dust or other impacts on neighbouring properties. Any reports will be forwarded to the site manager who will be responsible for addressing any issues related to the operation.

RECORD KEEPING

Records will be maintained by the site manager.

Records will include:

- VENM/ENM Certification
- Truck Run Sheets
- Safe Work Method Statements
- Induction Processes
- Incident Reporting
- Progress Reporting to Council and Regulators (as required)
- Complaints Management

Council and other regulatory authorities will be provided with contact details for the project site manager to which all complaints can be referred. The project manager will be available to respond to all complaints or enquiries and will instruct the site manager to shut down or modify operations in accordance with any direction received by Council and or regulatory authorities. All complaints or enquiries received will be logged in a complaint register which will be kept at the project managers office. All actions taken in response to complaints will be recorded in this register.

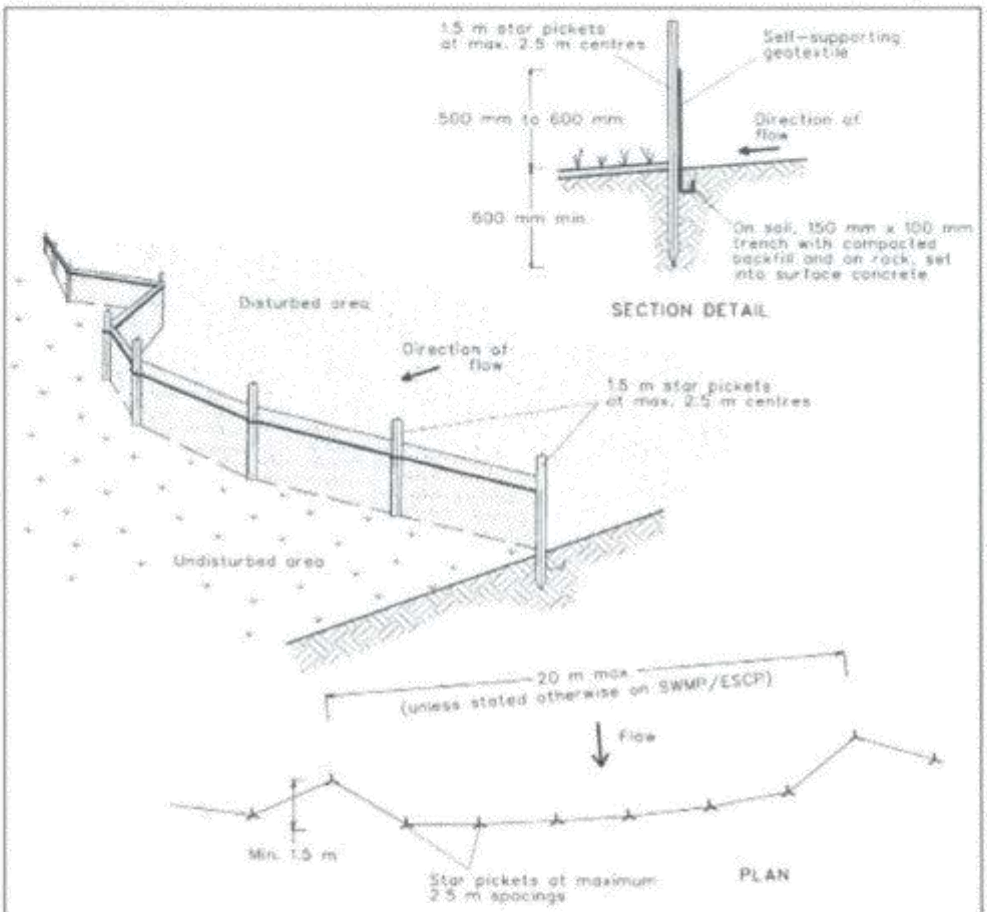
NEIGHBOUR RELATIONS

A register of neighbouring property holders will be established including contact details. The project site manager will inform all neighbours on any issues which may impact their properties and are outside the normal operating procedures as approved by Council. The project site manager will contact neighbouring properties at the inception of the project and provide a direct contact number for them to report any issues impacting their properties to the project site manager.

APPENDIX 1

STANDARD DRAWINGS

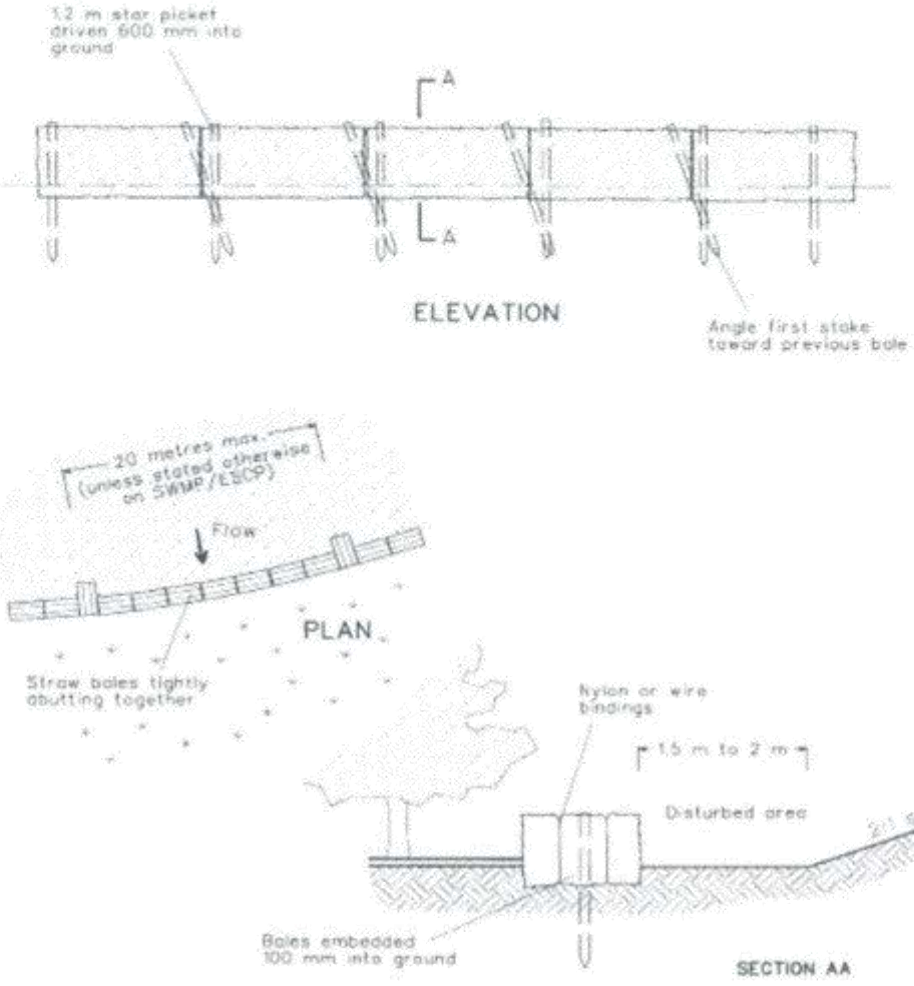
Erosion and sediment control works will be designed and constructed in accordance with *Managing Urban Stormwater: Soils and Construction, Volume 1 (Landcom, 2004)* as detailed in the following standard drawings:



Construction Notes

1. Construct sediment fences as close as possible to being parallel to the contours of the site, but with small returns as shown in the drawing to limit the catchment area of any one section. The catchment area should be small enough to limit water flow if concentrated at one point to 50 litres per second in the design storm event, usually the 10-year event.
2. Cut a 150-mm deep trench along the upslope line of the fence for the bottom of the fabric to be entrenched.
3. Drive 1.5 metre long star pickets into ground at 2.5 metre intervals (max) at the downslope edge of the trench. Ensure any star pickets are fitted with safety caps.
4. Fix self-supporting geotextile to the upslope side of the posts ensuring it goes to the base of the trench. Fix the geotextile with wire ties or as recommended by the manufacturer. Only use geotextile specifically produced for sediment fencing. The use of shade cloth for this purpose is not satisfactory.
5. Join sections of fabric at a support post with a 150-mm overlap.
6. Backfill the trench over the base of the fabric and compact it thoroughly over the geotextile.

SEDIMENT FENCE **SD 6-8**

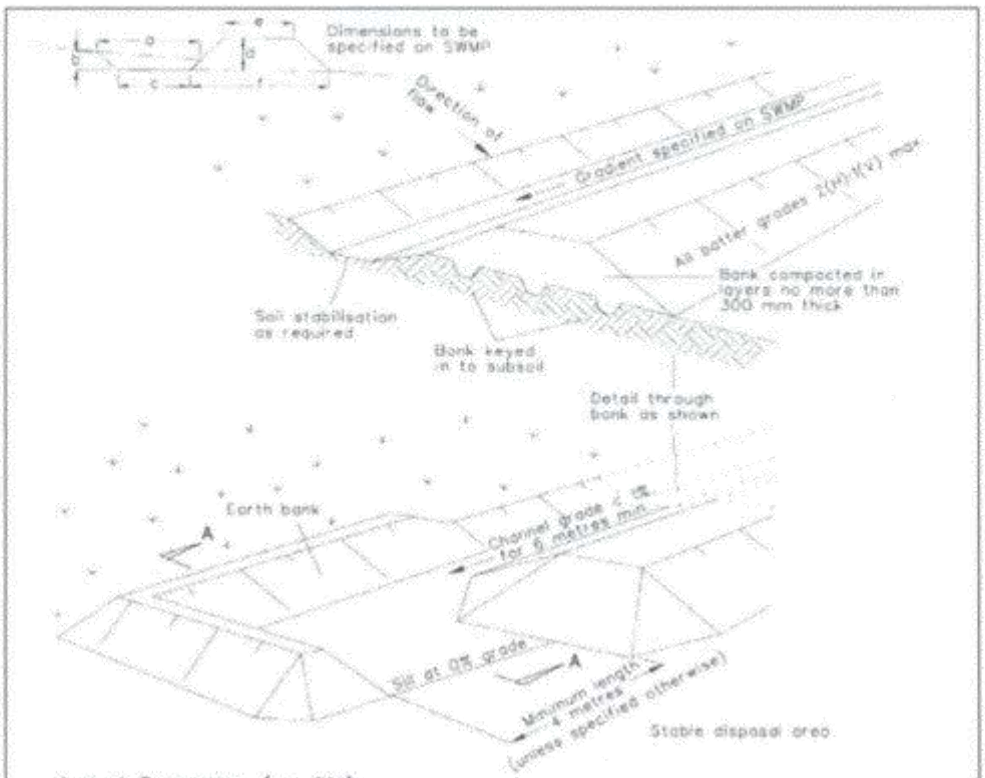


Construction Notes

1. Construct the straw bale filter as close as possible to being parallel to the contours of the site.
2. Place bales lengthwise in a row with ends tightly abutting. Use straw to fill any gaps between bales. Straws are to be placed parallel to ground.
3. Ensure that the maximum height of the filter is one bale.
4. Embed each bale in the ground 75 mm to 100 mm and anchor with two 1.2 metre star pickets or stakes. Angle the first star picket or stake in each bale towards the previously laid bale. Drive them 600 mm into the ground and, if possible, flush with the top of the bales. Where star pickets are used and they protrude above the bales, ensure they are fitted with safety caps.
5. Where a straw bale filter is constructed downslope from a disturbed batter, ensure the bales are placed 1 to 2 metres downslope from the toe.
6. Establish a maintenance program that ensures the integrity of the bales is retained - they could require replacement each two to four months.

STRAW BALE FILTER **SD 6-7**

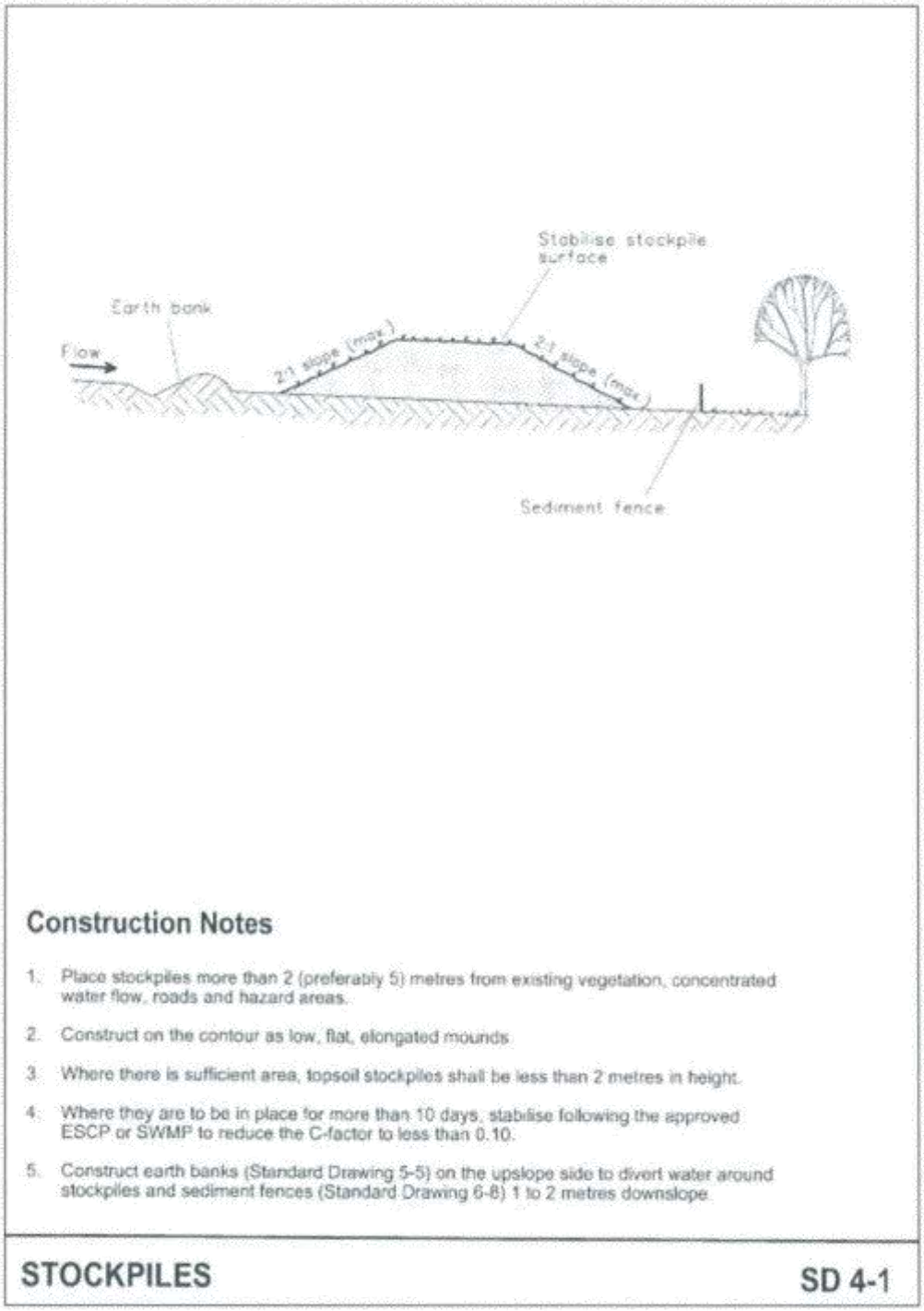
NB: These structures can be used in place of Sediment Fencing (SD 6-8)



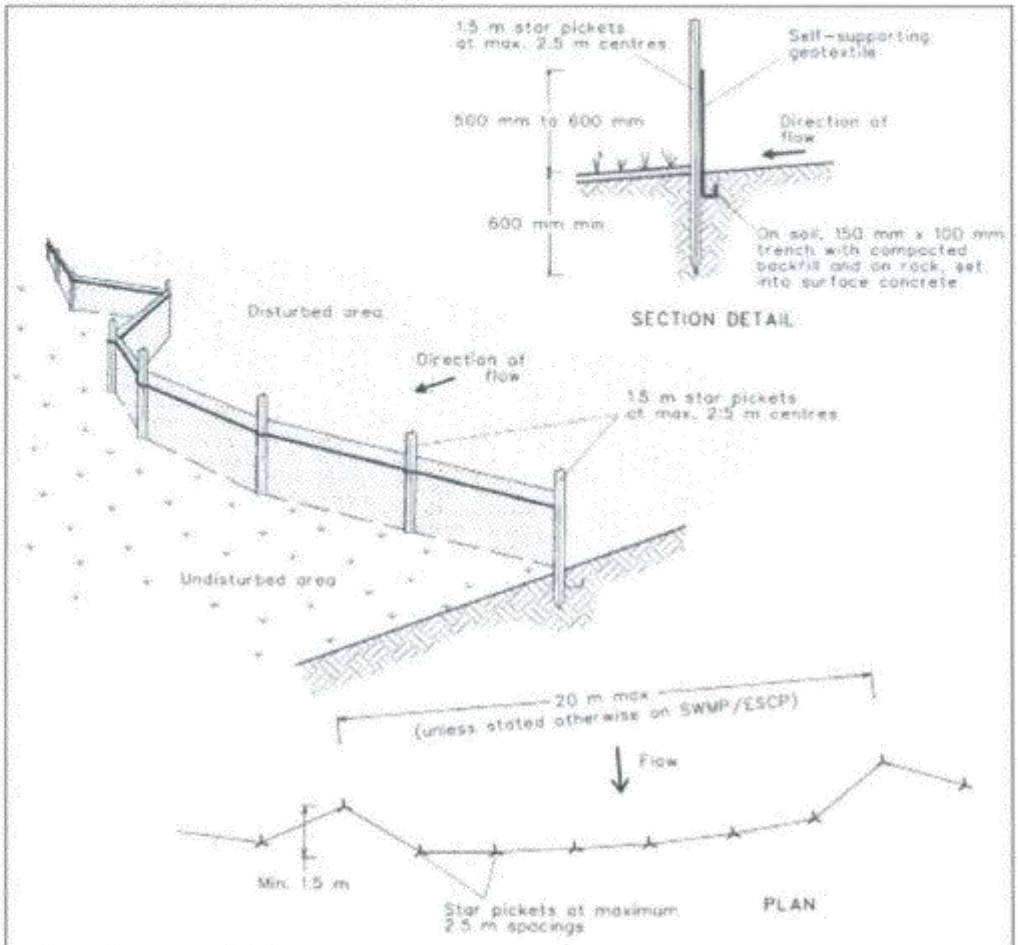
Construction Notes

1. Construct at the gradient specified on the ESCP or SWMP, normally between 1 and 5 percent
2. Avoid removing trees and shrubs if possible - work around them.
3. Ensure the structures are free of projections or other irregularities that could impede water flow.
4. Build the drains with circular, parabolic or trapezoidal cross sections, not V-shaped, at the dimensions shown on the SWMP.
5. Ensure the banks are properly compacted to prevent failure.
6. Complete permanent or temporary stabilisation within 10 days of construction following Table 5.2 in Landcom (2004).
7. Where discharging to erodible lands, ensure they outlet through a properly constructed level spreader.
8. Construct the level spreader at the gradient specified on the ESCP or SWMP normally less than 1 percent or level.
9. Where possible, ensure they discharge waters onto either stabilised or undisturbed disposal sites within the same subcatchment area from which the water originated. Approval might be required to discharge into other subcatchments.

EARTH BANK (HIGH FLOWS) **SD 5-6**



Stockpiles will be restricted to topsoil material and will be located outside drainage depressions, watercourses and the flood zone. Stockpiles will be managed according to Standard Drawing SD 4-1.

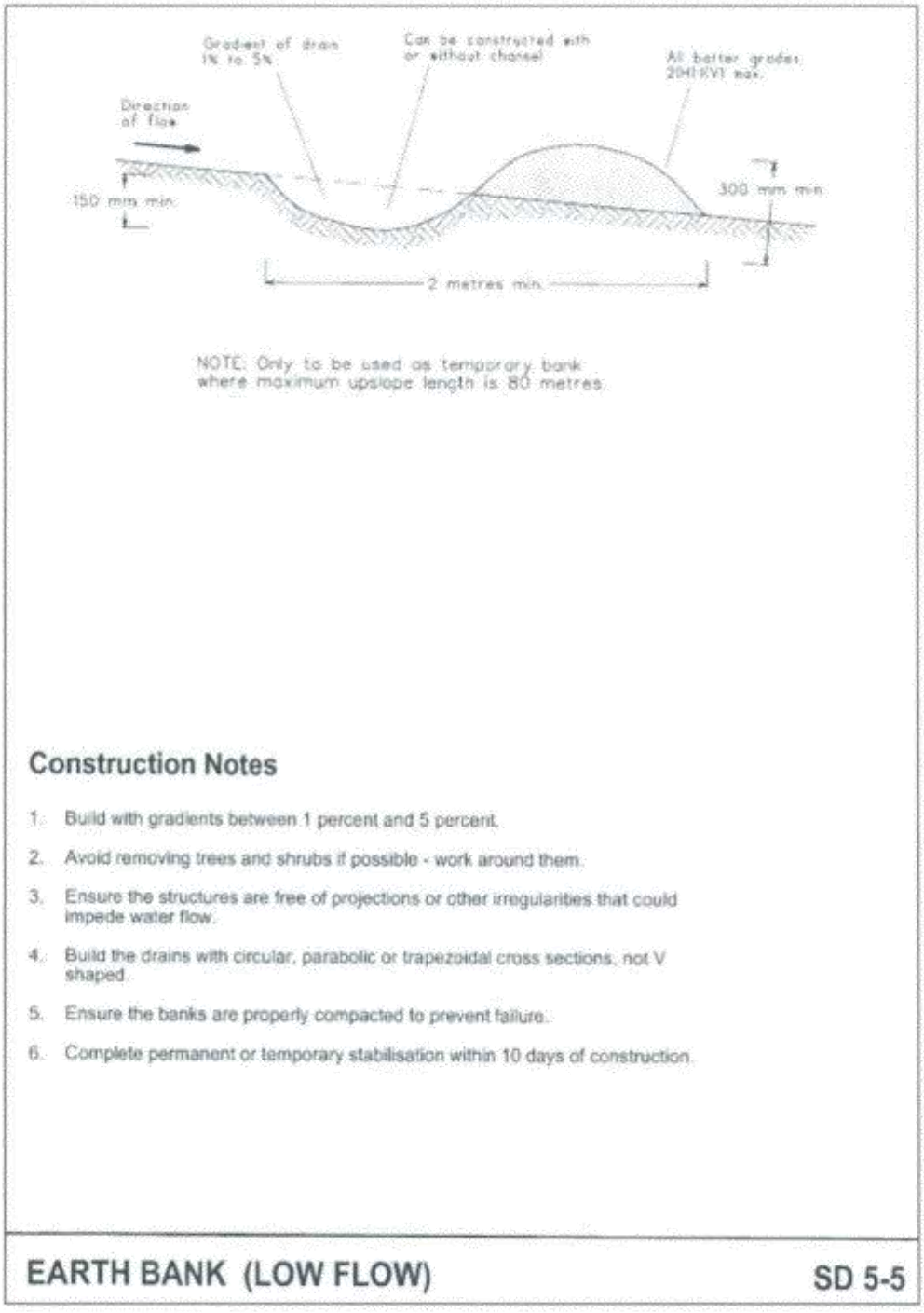


Construction Notes

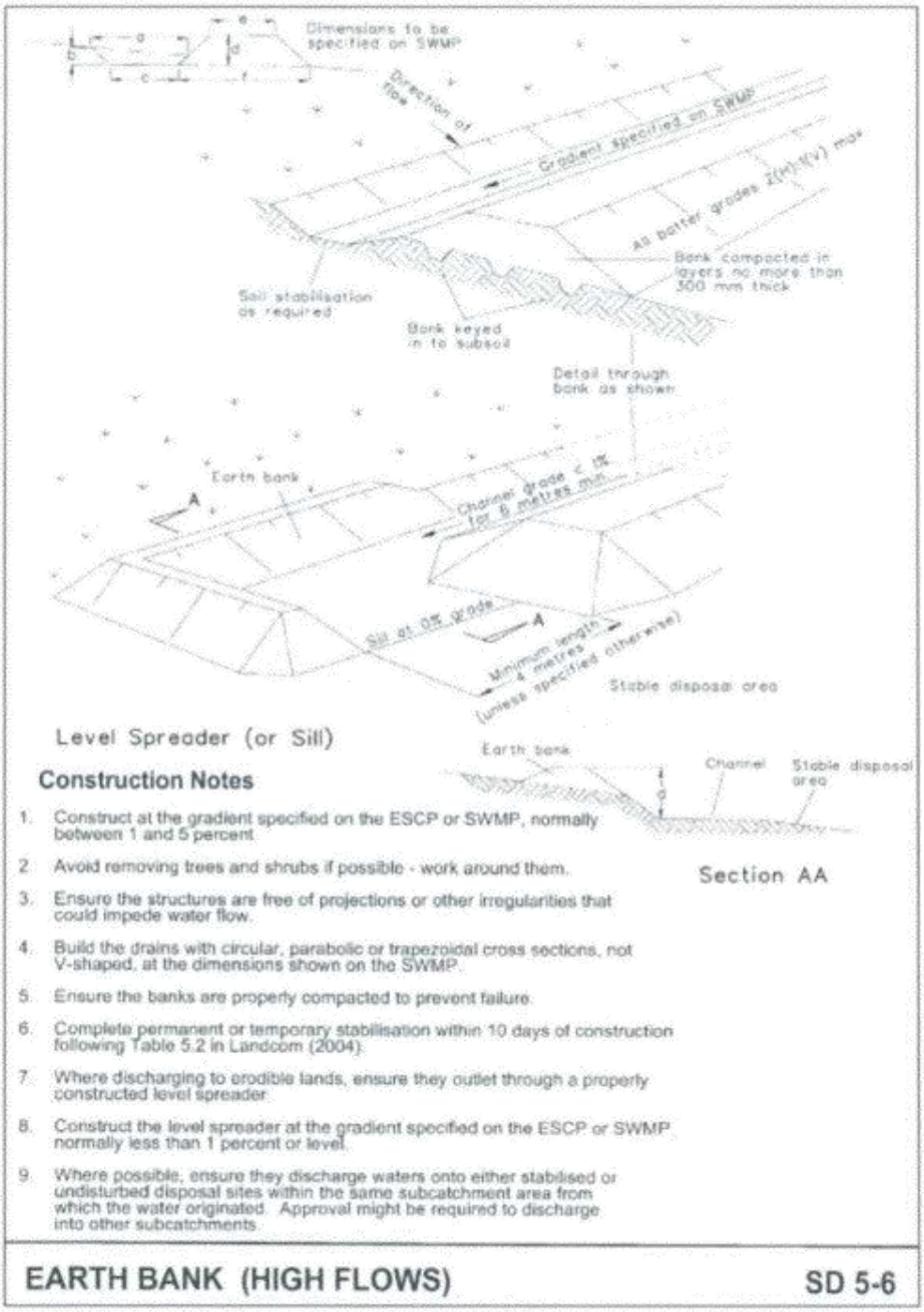
1. Construct sediment fences as close as possible to being parallel to the contours of the site, but with small returns as shown in the drawing to limit the catchment area of any one section. The catchment area should be small enough to limit water flow if concentrated at one point to 50 litres per second in the design storm event, usually the 10-year event.
2. Cut a 150-mm deep trench along the upslope line of the fence for the bottom of the fabric to be entrenched.
3. Drive 1.5 metre long star pickets into ground at 2.5 metre intervals (max) at the downslope edge of the trench. Ensure any star pickets are fitted with safety caps.
4. Fix self-supporting geotextile to the upslope side of the posts ensuring it goes to the base of the trench. Fix the geotextile with wire ties or as recommended by the manufacturer. Only use geotextile specifically produced for sediment fencing. The use of shade cloth for this purpose is not satisfactory.
5. Join sections of fabric at a support post with a 150-mm overlap.
6. Backfill the trench over the base of the fabric and compact it thoroughly over the geotextile.

SEDIMENT FENCE **SD 6-8**

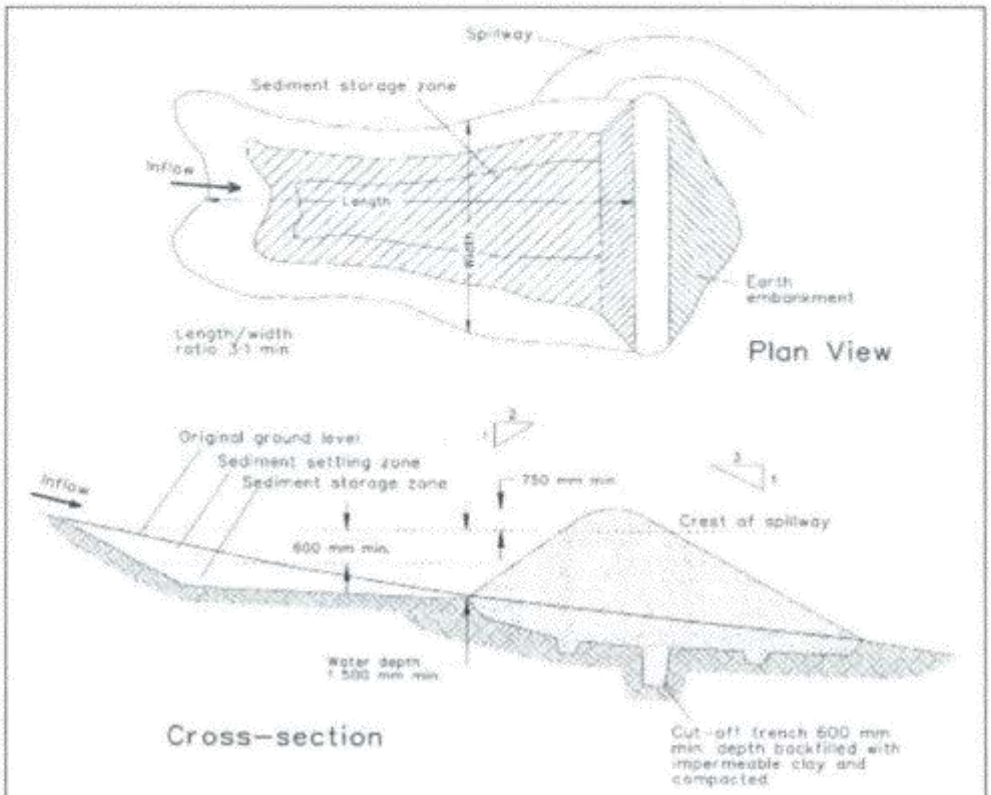
Sediment fencing below topsoil sites will be constructed according to Standard Drawing 6-8.



Diversion banks above topsoil stockpile sites will be constructed according to Standard Drawing SD 5-5.



Diversion Banks 1 and 2 (refer Figure Aa2) will be constructed according to Standard Drawing SD 5-6.



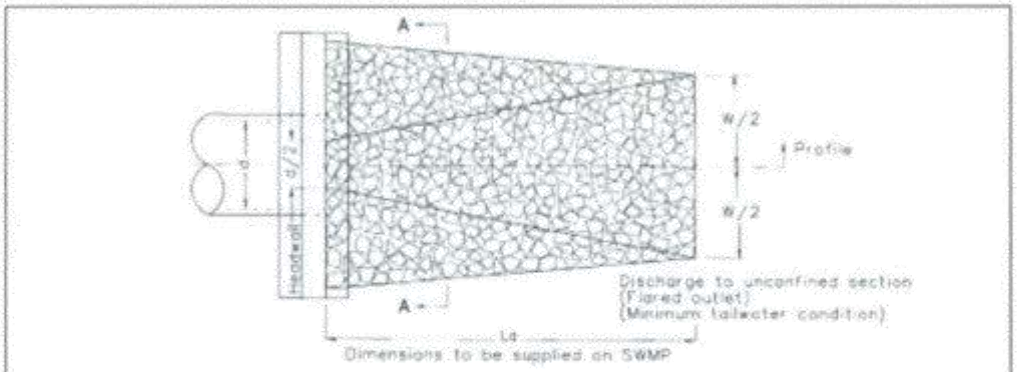
Construction Notes

1. Remove all vegetation and topsoil from under the dam wall and from within the storage area.
2. Construct a cut-off trench 500 mm deep and 1,200 mm wide along the centreline of the embankment extending to a point on the gully wall level with the riser crest.
3. Maintain the trench free of water and recompact the materials with equipment as specified in the SWMP to 95 per cent Standard Proctor Density.
4. Select fill following the SWMP that is free of roots, wood, rock, large stone or foreign material.
5. Prepare the site under the embankment by ripping to at least 100 mm to help bond compacted fill to the existing substrate.
6. Spread the fill in 100 mm to 150 mm layers and compact it at optimum moisture content following the SWMP.
7. Construct the emergency spillway.
8. Rehabilitate the structure following the SWMP.

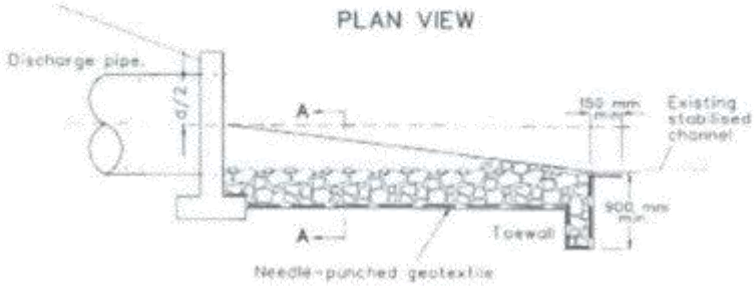
EARTH BASIN - WET
(APPLIES TO 'TYPE D' AND 'TYPE F' SOILS ONLY)

SD 6-4

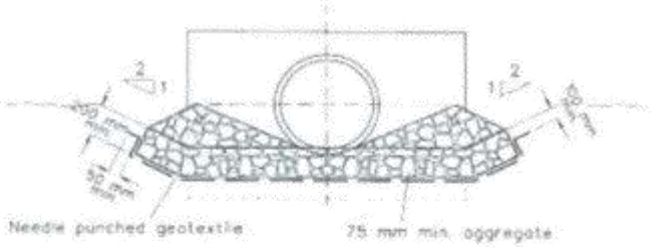
Sediment Basins 1 and 2 will be designed and constructed according to Standard Drawing SD 6-4.



PLAN VIEW



PLAN VIEW



CROSS SECTION AA

Construction Notes

1. Compact the subgrade fill to the density of the surrounding undisturbed material.
2. Prepare a smooth, even foundation for the structure that will ensure that the needle-punched geotextile does not sustain serious damage when covered with rock.
3. Should any minor damage to the geotextile occur, repair it before spreading any aggregate. For repairs, patch one piece of fabric over the damage, making sure that all joints and patches overlap more than 300 mm.
4. Lay rock following the drawing, according to Table 5.2 of Landcom (2004) and with a minimum diameter of 75 mm.
5. Ensure that any concrete or riprap used for the energy dissipator or the outlet protection conforms to the grading limits specified on the SWMP.

ENERGY DISSIPATER **SD 5-8**

SUBMISSION 1

SUBMISSION QUARRY REHABILITATION 1170 MURRUMBATEMAN ROAD , NANIMA. DA200151-PAN-23620-.

SUMMARY

I object to this development application for the following reasons.
1) Represents a further "industrialisation" of a rural residential zone.
2) Will have very significant impact to the amenity of residents along the Murrumbateman Road with the proposed 64 truck movements per day.

I note that for this development the risk of sediment contamination of waterways is low but given the Council poor record on monitoring compliance with amounts of fill taken to the site there is a definite risk that dumping will continue beyond the proposed 54,344 tonnes of fill

Detail

Truck movement and safety controls

Truck movements have long been an extremely controversial activity in the Spring Range, Nanima, Wallaroo and Jeir areas of the Yass Valley LGA. An important point is that while the documents on public display indicate that numerous conditions will be in place to limit impact on local residents , these conditions are **indicative only**. The **final actual conditions** that will apply are decided after the exhibition period when the proposal comes before Council for approval/rejection. The **final actual conditions** should form part of the exhibited documents.

It is noteworthy that Appendix B of the exhibited documents contains statements like

*"The finished area of fill material **should** be 150mm of suitable loam topsoil overlaying 100mm of clay loam material "*

*"Locally endemic native trees and shrub species **may** be planted into the site "*

Should and may are only indicative and do not constrain in any way what final conditions will apply. Binding conditions in the final documents put before Council must include

- Full details of truck movements and the hours/days of such movements should be clearly specified in the DA.
- An appropriate Section 94 Heavy Haulage fee should be levied to fully cover the cost of rural road restoration needed as a result of multiple truck movements.

• DAs which inject excessive heavy vehicle traffic on particular roads need limits placed on movements per day and/or hours of operation.

Compliance and audit trail

Again a very impressive list of conditions applying to the operation of the site are included in the documents on exhibition. However these conditions must be included in document which comes before Council for approval. Even in that case Council's very poor record of enforcing conditions on these types of operation means that they are purely cosmetic and the proponent has essentially a free hand to operate as they please.

Regards

SUBMISSION 2

Muzaffar Rubbani

From: Yass Valley Council <no-reply@wufoo.com>

To: YVC Customer Service Team
Subject: Public Consultation online submission [#189]

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Name *

Address *

Email *

Phone Number *

What item are you making a submission on? * DA 200151 1170 Murrumbateman Road, Namina

Submission *

Background:

This Development Application, as with so many that have come before it, raises unresolved concerns many of which have already been raised with Council.

Roads

The continued failure of the Yass Valley Council to develop, deliver and enforce a 'heavy haulage' or similar mechanism for recouping the costs of road use associated dumping and similar works, a significant tangible cost is being ignored and, simultaneously, the opportunity for the Yass Valley Shire ratepayers to benefit by way of the imposition of fees and charges on commercial works such as these is being foregone.

Equally, there is an apparent failure of YVC to develop an integrated whole-of-issue approach to DAs such as this

which carry a complex and competing range of benefits and costs to the proponents and the Shire's ratepayers and other citizens. Road safety, noise, catchment degradation, road maintenance funding, etc, are not drawn into and analysed in a complete policy setting and practical application.

Acceptance of Waste Material and Unknown Contaminants in the Yass Valley Shire

Despite YVC having endorsed the "ACT & Regional Catchment Strategy 2016 – 46", which included at Action 19: "Consider regional approaches to dealing with contaminated land, illegal dumping of contaminated waste and dumping of sub-soil construction waste", a fundamental anomaly persists: the ACT rids itself of waste building material in the form of excavated natural material (ENM); it being transported to an adjacent jurisdiction which seemingly either does not understand, or fails to acknowledge the problem that the ACT wants gone. The ACT doesn't want ENM but the Yass Valley Council does!
Alternatively, if there is a benefit to the Yass Valley which is not apparent to the ACT, it would be useful to have the benefit made known to the Yass Valley Shire ratep

Hours of Operation

NSW and ACT Public Holidays should also be excluded from allowable days of operation, so as not to conflict with the winery and tourist traffic that is being encouraged into this region.

The Real Costs and Risks of 2% Contaminants

The Protection of the Environment Operations (Waste) Regulation 2014's definition of Excavated Natural Material (ENM) is "naturally occurring rock and soil (including but not limited to materials such as sandstone, shale, clay and soil) that has:
a) been excavated from the ground, and
b) contains at least 98% (by weight) natural material, and
c) does not meet the definition of Virgin Excavated Natural Material in the Act.
Excavated natural material does not include material located in a hotspot; that has been processed; or that contains asbestos, Acid Sulfate Soils (ASS), Potential Acid Sulfate soils (PASS) or sulfidic ores."

Assuming that the provided calculations are correct at 54,344 tonnes of ENM potentially going into the site, 1,086 tonnes of unknown waste material will be included in the site (being the 2% of allowed contaminants (other than the proscribed ones).

SUBMISSION 3

Muzaffar Rubbani

From:

To: YVC Customer Service Team
Subject: Consultation on DA200151 quarry rehabilitation 1170 Murrumbateman Road

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Hi YVC,

Please find in this email feedback on DA200151. I'd like to bring to council's attention some immediate economic, social and environmental concerns that stood out from this application. These issues need to be carefully managed to ensure a good long term outcome for council, residents and rate-payers (and ideally the impacts are managed so that they are only in the short term and have no long term repercussions for our region - I recognise that the fill still needs to go somewhere!).

I appreciate your time and would be happy to discuss,

1. It is unclear which roads will be taken by the trucks - will Nanima Rd, Sutton Rd, Tallagandra Ln, Barton Hwy, other roads be affected by the significant increase in large truck traffic? If so, wider consultation and a careful review is needed on the overall impacts of this substantial traffic across these multiple roads, including:

a) **Economic cost** - In the recent years we've had much more large truck traffic on the roads which are likely linked to the higher number of potholes and degradation on our road conditions of late. This DA is proposing to increase this impact further. Would the additional road costs be compensated sufficiently by the DA? (The deep potholes being a serious safety issue also).

Council needs to ensure that road maintenance costs are accounted for by the proponent and are not ultimately borne by ratepayers.

Council should also ensure that the quantity of fill is indeed reasonable for the location, and ensure compliance in not using contaminated fill, not excessively dumping above the appropriate limit, and truck traffic keeping to the allocated time and speed restrictions. Does council have a clear understanding on truck movements in the region and their collective impacts? For example, there is currently regular movement of large loaded dump trucks along Tallangandra Lane even on weekends, which I am assuming is on different DA conditions hence they're allowed to do this.

b) **Social impact** - Murrumbateman road and the other above-mentioned roads are busy thoroughfares for tourist and commuting traffic, even during weekdays. These roads are also experiencing increased cyclist traffic. There are several narrow bends on the road with double lines (for Murrumbateman Road: at least near Tallagandra Winery, and near Dicks Creek Road - should the trucks be coming from Sutton Road) shared with residential driveways. These spots have already been observed to be quite dangerous due to peak-hour rush or unfamiliar tourist drivers using these roads at speed. There are blind spots at these bends and trucks certainly need to be way below 80km/hr with adequate signage, and ideally over much more restricted periods (i.e. non-peak traffic) to reduce collision risk.

The cumulative impacts of significant truck traffic in the region from this and other DAs need to be considered (traffic safety, noise, aesthetic appeal of the YVC region to tourists, etc).

2. **Environmental, economic and social impacts -** There is no reference to biosecurity and weeds management, which contradicts the applicant's statement of the development having negligible environmental effects. Pathways of new weed introductions include the very high likelihood of hitchhiking weeds on significant movement of trucks as they either pass through Canberra, as well as from far interstate should the trucks come from areas where weeds are not yet in NSW/Yass region (noting that Murrumbateman, Nanima and Tallangandra roads are still relatively weed free).

While it is reported that the material will be certified, this requires enforcement to ensure there is no contamination of weeds within the material itself.

There is a significant weed issue with importing typically contaminated soil from Canberra (though previous unregulated construction activity!), including African lovegrass, Chilean needle grass, sometimes Madagascan fireweed, etc, which will inevitably hitch a ride and result in much angst to land managers already managing the agricultural and environmental impacts of existing weeds.

The Biosecurity Officer should be involved in enforcing the Biosecurity Act to minimise the cost of new weeds incursion and further spread of existing weeds through such a known pathway for weeds to the region.

SUBMISSION 4

Objections re DA200151 Quarry fill
1170 Murrumbateman Rd Nanima.

My concerns are twofold: contamination of waterways and heavy haulage on load-limited roads.

Waterways

The proponent will be using ENM if he is permitted. It will save him millions. For the amount of fill required for this quarry, there can be up to 1,144 tonnes of any kind of building rubble along with the VENM. NSW calls this 'ENM'. Canberra calls it 'contaminated soil' and will not allow it into landfill.

ENM has greater potential for leaching chemicals into soil, pastures, and waterways. Chemicals can move between and interact with soil, plants, rock, sediment, air and water. "Builders rubble has potential ecosystem risks to water quality and aquatic life."
https://www.murrang.com.au/environmental-assessment

Why did Council change from its strict policy of only VENM for gullies and quarries?

It would take the expertise of a hydrologist and civil engineer to apply in a safe and effective way, the eight engineering solutions detailed in John Franklin's Report. No such expertise has been planned in. There will be nothing but a single sediment fence to protect the nearest waterway.

This waterway is a second-order stream immediately to the south (not the east, as in the Report). The distance from the scraped top of the quarry to the water of this stream is less than 40 metres. The slope from quarry to stream is 1 in 4.

A sediment fence, even perfectly placed, does nothing to prevent chemical contamination. This second order stream flows directly into Murrumbateman Creek 450 metres away, (not 741m as in the Report), then into the Yass River (and Yass drinking water?)

What monitoring will there be?

It is not practical to expect Council to carry out the monitoring this development needs. Information supplied by Council indicates there are no Council records on file of VENM certification or sediment control for five gully filling sites in our border country going back to 2014. (As of May this year)

Would Council consider the LEC Planning Principle:

> "Council can institute a Council-appointed qualified person who will, at the applicant's expense, carry out monitoring functions as directed by Council."

[*Responsibility for monitoring compliance with a condition Dayho v Rockdale City Council [2004] NSWLEC 184 at 7-8]*

Load-limited Roads

The logical route for the 128 truck movements per day is Nanima Rd. (The Report indicates 64 movements a day, but a trip or a delivery that returns via the same route is 2 movements, as detailed in the Applicant's Truck Depot DA). But there is a 10-tonne limit on Nanima Rd and through traffic carrying 20-tonne loads would be prohibited.

There are businesses on Nanima Rd that further Yass Valley Council's Vision for the Valley. They attract visitors and tourists to their various country offerings. But they absolutely rely on the rural ambient, and a truck every 4 minutes for 8 hours of the day, on a road never designed for heavy haulage and in sad need of repair because of it, would be an absolute blight for visitors and residents.

I ask Councillors to honour this load limit.
And I ask that any decision to accept ENM in this DA be furnished with a reason? Thank you for your consideration.

SUBMISSION 5

Muzaffar Rubbani

From: Yass Valley Council <no-reply@wufoo.com>
Sent:
To: YVC Customer Service Team
Subject: Public Consultation online submission [#188]

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Name *

Address *

Email *

Phone Number *

What item are you making a submission on? * DA 200151

Submission *

DA 200151, 1170 Murrumbateman Road, Nanima

Unresolved Concerns

Environmental Outcomes

Touted environmental outcomes, including revegetation and biodiversity, are key justifications offered for this site remediation option/approach. However, there are no plans for actually achieving sustainable, long-term revegetation and biodiversity. For example, without an initial, then periodic, watering program for the seeding and "strategic revegetation" of locally endemic native trees and shrubs, these benefits will be mere consultant puff. Encouraging revegetation is as much a plan as expecting hope to prevail – they are mere words and sentiment.

Acceptance of Waste Material and Unknown Contaminants in the Yass Valley Shire

Despite YVC having endorsed the "ACT & Regional Catchment Strategy 2016 - 46", which included at Action 19: "Consider regional approaches to dealing with contaminated land, illegal dumping of contaminated waste and dumping of sub-soil construction waste", a fundamental anomaly persists: the ACT rids itself of waste building material in the form of excavated natural material (ENM); it being transported to an adjacent jurisdiction which seemingly either does not understand, or fails to acknowledge the problem that the ACT wants gone. The ACT doesn't want ENM but the Yass Valley Council does!
Alternatively, if there is a benefit to the Yass Valley which is not apparent to the ACT, it would be useful to have the benefit made known to the Yass Valley Shire ratepayers.

Heavy Haulage Fees

The continued failure of the Yass Valley Council to develop, deliver and enforce a 'heavy haulage' or similar mechanism for recouping the costs of road use associated dumping and similar works, a significant tangible cost is being ignored and, simultaneously, the opportunity for the Yass Valley Shire ratepayers to benefit by way of the imposition of fees and charges on commercial works such as these is being foregone.

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Hours of Operation

NSW and ACT Public Holidays should also be excluded from allowable days of operation, so as not to conflict with the winery and tourist traffic that is being encouraged into this region.

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a) been excavated from the ground, and
b) contains at least 98% (by weight) natural material, and

c) does not meet the definition of Virgin Excavated Natural Material in the Act.

Excavated natural material does not include material located in a hotspot; that has been processed; or that contains asbestos, Acid Sulfate Soils (ASS), Potential Acid Sulfate soils (PASS) or sulfidic ores."

Assuming that the provided calculations are correct at 54,344 tonnes of ENM potentially going into the site, 1,086 tonnes of unknown waste material will be included in the site (being the 2% of allowed contaminants (other than the proscribed ones – and who actually does the testing and certification – the ACT building industry has a track record in WHS and similar issues/breaches, so it seem aspirational at best to expect these certifications to be meaningful – but let's assume that they are)). Have the risks to the catchment associated with this been properly considered? It is not sufficient to claim certification as 'ENM' as somehow bestowing acceptability on the material including the 2% of unknowns. How is this risk being analysed and managed? The notion of a 'whole of life' approach to the quarry's existence is appealing but not logically sound if the allowed 2% of contaminants (and it is faithfully no more than that), is something that the Shire needs and can manage.

SUBMISSION 6

Yass Valley Council

PO Box 6

YASS NSW 2582

To whom it may concern,

Development Application – DA200151 – 1170 Murrumbateman Road, Nanima – Quarry Rehabilitation

We wish to make a submission in relation to the above-mentioned Development Application (DA) to Yass Valley Council (YVC) in our capacity as residents and neighbours to the property of the proposed development.

We have serious concerns with the DA submitted by Mr Geoff Hewatt.

The submission will bring attention to:

- The unsuitability of access to the property to sustain the projected volume of heavy vehicle movements,
- Assessment of the existing environmental values of the quarry,
- The non-compliance of the Development Application, and
- The commercial gain of the proponent compared to the financial loss to the Yass Valley Council.

The current DA is deficient, and we provide the following issues and concerns for your attention and resolution.

1. **PROPOSED ACCESS FOR TRUCK MOVEMENTS** - The DA submission provides only cursery comments in relation to the existing access to the property and does not adequately assess the suitability for the significant number of heavy vehicle movements that are proposed under this development. At section 2.2 of the Statement of Environmental Effect (SEE) it is suggested that the only treatment proposed is to install 'Truck Entering' signs.
   It is further noted that Murrumbateman Rd is designated as a Regional Road (7069[1]) which is the highest category of road that is managed and maintained by YVC. This infers

[1] https://www.rms.nsw.gov.au/business-industry/partners-suppliers/lgr/documents/classified-roads-schedule.pdf

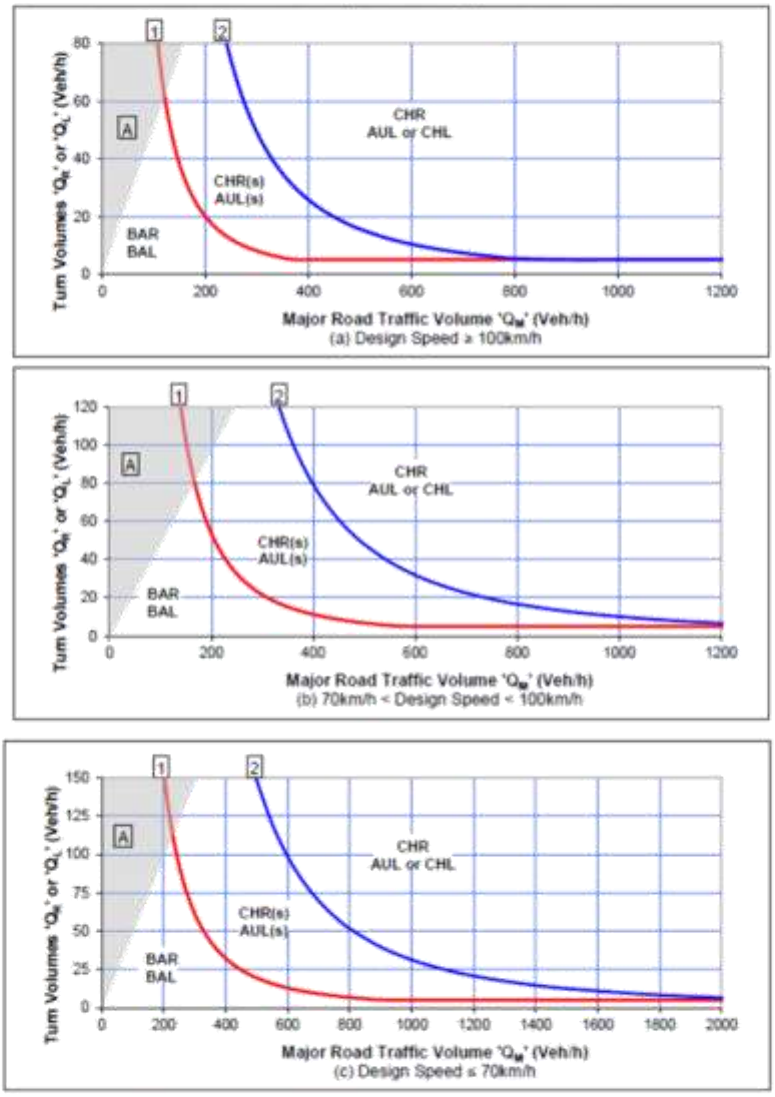
that it carries considerable traffic which should justify a more appropriate turn treatment.

As such, the following design considerations should be considered:

1.1 Warrants for Turn Treatments

The below is extracted from Austroads Guide to Traffic Management Part 6: Intersections, Interchanges and Crossings.

Figure 2.25: Warrants for turn treatments on major roads at unsignalised intersections



Note: the minimum right-turn treatment for multilane roads is a CHR(s).

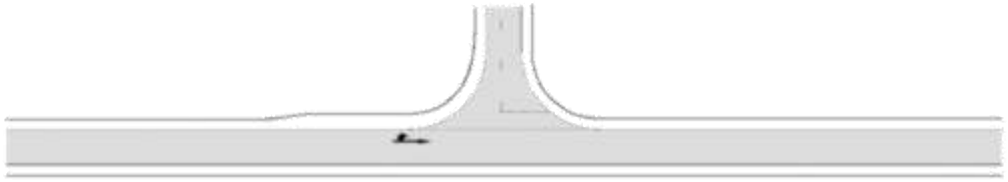
Source: TMR (2016a).

Figure 1- Austroads Guide to Traffic Management

Minimum of BAR/BAL arrangement required based on turn volumes of 13 trucks per hour (8 trucks with 8 deliveries per day = 64*2 = 128 vehicles per day / 10 = 13 veh/h).
An arrangement such as that illustrated below would be expected as a minimum to allow through movement traffic to pass freely while the trucks turn into the property.

Figure 2.1: Rural basic (BA) turn treatments

Basic Right Turn (BAR)
on the Major Road (Two-Lane, Two-Way Road)



Basic Left Turn (BAL)
on the Major Road

Figure 2- Rural basic (BA) turn treatments

If the traffic movements on Murrumbateman Rd exceed 200 veh/h then a CHR arrangement would be the minimum requirement. Therefore, the proposed 'Trucks Entering' signs are an insufficient treatment for the development.

1.2 Truck Turning Paths

In determining the geometry of the intersection, an analysis to determine clearances to Swept Paths of Turning Vehicles should be undertaken. This should allow a minimum offset of 0.5 m from the extremities of the vehicle path to the pavement edge and centreline. This is not reflected in the DA.

1.3 SISD Requirements

Safe Intersection Sight Distance (SISD) is to be demonstrated in the horizontal and vertical alignments to provide sufficient distance for a driver of a vehicle on Murrumbateman Road to observe a vehicle on the access driveway moving into a collision situation. This is

also to be demonstrated with the driver on the access driveway to the approach vehicle on Murrumbateman Road.

The minimum gap sight distance (MGSD) to be verified based on an acceptable critical acceptance gap time and the 85th percentile speed of Murrumbateman Road.
The current location of the driveway entrance to the property is represented by the red dot in the picture below, with view in the east bound direction. Due to both a vertical and horizontal change in geometry of Murrumbateman Rd just east of the driveway it is critical that SISD for the intersection is verified.

Figure 3- Nearmap image upon approach to 1170 Murrumbateman Road

1.4 On Road (Murrumbateman Road) Sediment and Erosion Control Plan

From the documentation provided, measures to control sediment tracked onto Murrumbateman Road has not been provided. Due to the high-speed nature of Murrumbateman Road (100km/h posted speed limit), this could pose a safety issue if not addressed. The developer is obligated to ensure that road user safety is suitably addressed in this DA.

2. **TRUCK MOVEMENTS INCORRECTLY STATED** – This development proposes up to 128 truck movements per day, five days per week for up to one year. The DA only refers to the movement of trucks coming onto the site (eight (8) trucks running per day, doing eight (8) loads per vehicle and a load an hour[2]) but does not consider the movement of those trucks off site and returning to the load location. Whilst the truck's movements

[2] DA 200151 – Franklin Consulting Table 2

leaving the site will not be loaded, they will contribute to the overall damage to the existing road surface and safety to other road users.

It is highly likely that there will be significantly more truck movements per day to keep with the demand of the development from which the fill will be removed. Council should note how such fill removal projects operate:

a. A Property Developer in Braddon, for example, needs to undertake a deep cut excavation in order to commence the construction of his/her development. Their ultimate commercial goal is to minimise the amount of time between the purchase of the block to receipt of income from that block via a completed development.

   They want the excavation to be completed as quickly as possible and will pay a sub- contractor to do that.

b. A sub-contractor, for example Geoff Hewatt from Hewatt Earthworks, will price for the removal of the fill on a cost per cubic metre. The more quickly he can remove that fill, the more quickly he will receive payment for it.

c. At the same time, the sub-contractor needs somewhere to dump the fill. Currently, the ACT does not have sufficient space to take fill, and as such there has been an increased demand within NSW to accept these loads via numerous DA's.

d. The sub-contractor will calculate the cost to remove the fill from the ACT location which will include the price to dump that fill – either to a commercial operation such as Holcim in Queanbeyan, Pialligo Stone Quarry in Pialligo or to a private location.

e. If the sub-contractor is able, it is in their commercial interests to remove the fill from the ACT as quickly as possible, by using as many trucks as they can access. In most cases, the property developer will pressure the sub-contractor to increases the truck movements. In reality, it is more common to have between 10 to 20 trucks to remove material to meet the program requirements of the job.

f. Most ACT blocks under commercial development have a requirement to remove at least 40,000 cubic metres of fill – based on common commercial block sizes.

Using the example above, it would be unrealistic for Yass Valley Council to expect that the proponent's estimate of eight (8) loads per truck per day is realistic. The DA does

not have any hard limits on how many movements will occur in a day, rather it offers some soft considerations by limiting the time of truck movements to between 8am and 5pm. It is quite possible that in order to achieve maximum financial gain, the proponent can have up to -320 truck movements per day – 20 trucks at eight (8) loads per day coming into site and returning to base. (20 trucks x 8 loads/day x2 trips/load = 320 truck movements).

YVC must be aware that in any decision they make about the proposed development the likelihood of 64 truck movements per day is underestimated, and as such the inherent risk and costs to the council increase. YVC should also note that these movements are in addition to the regular heavy vehicle on Murrumbateman Road.

3. **Commercial Gain versus Financial Loss** – it is important that YVC understands the commercial opportunity for the proponent through the proposed development whilst also understanding the potential risks and costs to Council if this proposal is approved.
The table below details the potential revenue to be raised by the proponent to rehabilitate the quarry. It compares market costs for disposing fill to known commercial operations within the ACT. It is based from movement from the Canberra CBD to the three locations at Queanbeyan, Pialligo and Nanima (using Google Maps). It calculates the total cost per load to dispose the fill based on the figures provided by the proponent. It finally determines total revenue (exclusive of GST) the proponent could make by having somewhere to dump the fill, as opposed to having to pay to dispose of it at a commercial location.

Table 1- Potential Revenue

Disposal Destination (minutes from CBD)	Disposal Fee $/t	Haulage[1] $140/hr/load	Total Disposal/ Load (22.5t/load)	Potential Revenue based on capacity at 1170 Murrumbateman Road
Holcim Quarry, Queanbeyan	$12	$140	$410	
Pialligo Quarry, Pialligo	$18	$95	$500	

Disposal Destination (minutes from CBD)	Disposal Fee $/t	Haulage[1] $140/hr/load	Total Disposal/ Load (22.5t/load)	Potential Revenue based on capacity at 1170 Murrumbateman Road
1170 Murrumbateman Rd, Nanima	$12[2]	$140	$410	54,344t / 22.5t/load = 2,415 loads Revenue[3] = 2,415 x $410/load = $990,150

a. Haulage cost is based on return trip of typical market rate in ACT for transport
b. Assumed disposal fee that the applicant could charge and remain competitive with current market rates from other commercial operations.
c. Revenue is Gross revenue excluding operating costs. The applicant is known to operate and/or subcontract the resources and equipment to undertake all transport and handling.
d. All rates are Exclusive of GST

This should be compared to the Draft Development Contribution- Heavy Haulage tariff applicable to this proposed development detailed in the Draft Operational Plan 2019 - 2020[3], where a charge of 4.5c per tonne payload per kilometre on sealed roads applies -

$0.045 x 54,344t x 11.7km (length of distance travelled on Murrumbateman Road) = **$28,612**

YVC must appreciate that this DA is driven by financial gain rather than environmental reward, and that gain will come at a cost to ratepayers. The revenue generated by YVC for the proponent to use the road for his desired purpose will not come close to covering costs to repair the damage caused by the truck movements.

It is yet to be proven that the quarry actually requires rehabilitation, rather it has the potential to cause more environmental damage if the work is approved to proceed.

4. **Integrated development** - At Section 16 of the DA, the proponent has stated the

[3] https://www.yassvalley.nsw.gov.au/assets/2019/Executive/Draft-Operational-Plan-2019-2020.pdf

development does not require concurrence. We believe that this DA should be classified as an Integrated Development[4] due to the consent required by the following NSW Government agencies:

a. **Roads and Maritime Service (RMS) –** as Murrumbateman Road intersects with the Barton Highway, the endorsement of the RMS is required[5]. The impact truck movements will have on the disruption of the traffic flow and safety demands their involvement in the approval process.

NSW Environmental Protection Agency (EPA) – The titled owner of the land is Winjarra Pty Ltd. Whilst this application is in the name of an individual (Geoff Hewatt) the activity proposed in this DA must be considered as a commercial activity on behalf of Winjarra Pty Ltd. As this proposal is a commercial activity, there is a requirement for the DA to be referred to the EPA[6] for an Environmental Authorisation and potentially an Operator's License for this commercial operation.

To that end, the DA is non-compliant and YVC cannot approve the DA190083 until this consent and/or approvals are provided.

5. **Existing Environmental Values -** While there is a focus within the SEE on the impact on vegetation there is effectively no assessment of fauna or reference to any fauna surveys. It is also not clear if the author of the SEE has consulted an accredited Ecologist in the preparation of the SEE.

The SEE report states that the quarry has been dormant for some time. A general review of available satellite images suggests that the quarry has not been used in at least the past 20yrs or more.

It is entirely reasonable to expect that a significant diversity of fauna would have developed within the rocky landscape within the disused quarry in that time and that the fauna may be classified as protected, threatened or endangered. The SEE is deficient in that a Biodiversity Development Assessment Report (BDAR) has not been provided. The outcome of the BDAR would then inform any offsets that may be

[4] https://www.legislation.nsw.gov.au/#/view/act/1979/203/part4/div4.8?TITLE=Environmental%20Planning%20and%20Assessment%20Act%201979%20No%20203&autoquery={Content%3D{(%22integrated%22)}}&display=Environmental%20Planning%20and%20Assessment%20Act%201979%20No%20203&dq=Within%20Title%3D%22Environmental%20Planning%20and%20Assessment%20Act%201979%20No%20203%22,%20Exact%20Phrase%3D%22integrated%22&fullquery={Content%3D{(%22integrated%22)}}&page=1&titleonly=&withintitle=yes

[5] Roads Act 1993, s 138

[6] Protection of the Environment Operations Act 1997, s 42 (a), (b), 47, 48 and 55

required due to the development.

6. **Exclusion of Local Roads –** The DA does not make any reference to the proposed route the trucks would take to travel to 1170 Murrumbateman Road. YVC must ensure that both personal and road safety is prioritised. Conditions must be applied to exclude the use of local roads and that only Murrumbateman Road, the Barton Highway or Sutton Roads are used to access the development site.

We request that the Yass Valley Council consider this DA with these concerns in mind and that, if approved, that it is done with specific reasonable conditions included in that approval. YVC must recognise that there is a commercial advantage for the developer, but this must not come at the detriment of local road users.

Based on the non-compliance of the application, together with serious considerations of the ongoing safety to road users, we propose that DA200151 be rejected by Yass Valley Council.

SUBMISSION 7

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Cc:
Subject: Re: DA200151 - Quarry Rehabilitation

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Re: DA200151

Dear YVC,

Although not against the proposal documented under DA200151 - Quarry Rehabilitation, I would like to request further information from both the applicant and YVC in relation to the detail.

This proposal is clearly a business/financial transaction and it should be assessed in that context.

- The quarry itself is relatively small and I would question whether 57,225 tonnes of fill (2,720 truck loads) is required for the site. **Has the YVC independently verified the requirements of the site?**
- Truck traffic, noise and damage to roads in the area will likely be the most significant impact and concern to neighbour's in the area. **Could the applicant clearly outline the YVC roads that will be accessed to transport the fill from Canberra (Barton Hwy, Nanima Rd, Tallagandra Ln, Sutton Rd etc)**. Nanima road is a significantly damaged road, most likely due to the trucks that have accessed the road despite the 10 tonne maximum weight restriction. Nanima road is scheduled for roadworks over coming months. **Could YVC confirm that Nanima road will retain the 10 tonne weight restriction into the future and therefore be off-limits to truck traffic.**
- Given this is effectively a business transaction, **could YVC confirm that it will receive sufficient fees from the project to properly compensate for the increased road wear.** That is, all projects of this nature will effectively subsidise required roadworks in the future, and therefore no additional costs to rate payers.

Kind regards,

SUBMISSION 8

Muzaffar Rubbani

From: Yass Valley Council <no-reply@wufoo.com>
Sent:
To: YVC Customer Service Team
Subject: Public Consultation online submission [#185]

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Name *

Address *

Email *

Phone Number *

What item are you making a submission on? * DA200151 rehabilitation of quarry

Submission *

The documentation provided with this DA is detailed. However:

1. the DA is silent on the matter of the route which trucks will take from the ACT to the quarry site. Nanima Road, with its 10t weight limit is an obvious route. Council is about to undertake extensive remedial work because the road is inadequate for the volume of traffic which it already carries;

2. the estimate of 8x8 = 64 truck movements per day is misleading. Allowing for return journeys there would be 128 movements or one every 4.2 minutes between 0800h and 1700h every week day. This is an extraordinary level of traffic even by the current standards for ACT fill movement by truck, for example, on the Barton Highway;

3. the hours of operation are also misleading in that they do not take into account journeys from and to truck depots at the beginning and end of the day. On present indications (from the two existing 'truck depots' on Nanima Road) 0600h to 1800h is more realistic.

Submission. If the DA is approved Council is requested (i) to specify that the truck movements concerned shall not

1

use Nanima Road; (ii) that truck movements be a TOTAL of 64 per day, that is, 32 return trips (iii) the entire 'working day' be within the hours of 0800h to 1700h.

SUBMISSION 9

31 August 2020

Yass Valley Council
PO Box 6
Yass NSW 2582

Dear Sir/Madam,

Development Application DA200151 – 1170 Murrumbateman Road, Nanima

We wish to make a submission in relation to the above development application, in our capacity as neighbours to the property where the development is proposed.

We are owners of the property located and have a number of specific concerns associated with the proposed development.

We wish to strongly object to the proposed development. Set out below are our specific concerns relating to the proposed development.

Type and Amount of Fill

Page 29 of the Quarry Rehabilitation Proposal document identifies that: "the fill material to be used ... will be restricted to certified VENM/ENM". Further, it states: "records of the VENM/ENM certification of all material to used on the site will be maintained by the proponent and provided to Council as required".

In relation to the above, we query:

- How often will the Council check to confirm that the applicant is complying with the requirement to only use certified VENM/ENM fill material, as well as checking that appropriate records are being maintained by the applicant?
- Since when has it been acceptable to use the Yass Valley as a dumping ground for Canberra's construction-site waste material?
- How is this proposal consistent with the recent concerns raised publicly by the Council about the dumping of Canberra fill in the Yass Valley Council? Reference is made to the following Canberra Times articles:
    - 14 January 2019 – "Developers using Yass farms to dump material, avoiding Canberra fees"; and
    - 28 January 2019 – "Yass council warned on risks of dumping Canberra fill" – this article specifically mentions: "the Yass Valley Council has been trying for years to tackle the problem of clean fill from Canberra's building sites being dumped over the border in NSW, and warned it could hit the region's water supply, roads and environment"; and "the 2016 report said the amount of trucks from Canberra laden with clean fill was having a detrimental impact on the council's roads".

We query how the Council could consider approving the development proposal taking into account its previous public comments and concerns?

Truck and Plant Operations

Page 29 (and following) of the Quarry Rehabilitation Proposal document identifies that:

- "the maximum number of truck movements per day ... equates to maximum of 64 truck movements daily".
- "the proposed hours of operation of the site (including truck movements) will be between 8am and 5pm on weekdays".
- "the material will be conveyed to the site in rigid truck and dog trailer and/or semi-trailer combinations".

It should be noted that no mention is made of the route planned to be taken by the trucks in delivery of the fill to 1170 Murrumbateman Road in either the Quarry Rehabilitation Proposal document or the Statement of Environmental Effects document.

It should be made very clear in the DA that Nanima Road is not to be used by the trucks in delivery of the fill.

Nanima Road is not an appropriate route for 64 daily trips of fully loaden "rigid truck and dog trailer and/or semi-trailer combinations".

We contend that Nanima Road is already struggling under existing traffic use and allowing any access to the proposed heavy vehicle traffic in the DA will make an already high-risk road even more dangerous for local, regular traffic users.

In addition to the risk to local traffic, Nanima Road is also a popular tourist road for the Yass Valley region. A number of significant local tourism businesses are located on Namima Road, including: Poachers Pantry; Robyn Rowe Chocolates; and Redbrow Garden. Allowing the proposed heavy vehicle traffic (64 daily trips of "rigid truck and dog trailer and/or semi-trailer combinations") will endanger the lives of visitors to the region using Nanima Road who are unaware of the local road conditions. This will impact not only the safety of the road users, but also have an adverse impact on the businesses being conducted on Namima Road.

We note that the Council has identified that rehabilitation works will be undertaken on Nanima Road in late 2020 to early 2021.

If the proposed heavy vehicle traffic identified in the DA is allowed to use Nanima Road during the period of rehabilitation works being undertaken, we argue this is inappropriate and will only add to the expected delays during stages of the rehabilitation work.

If the proposed heavy vehicle traffic identified in the DA is allowed to use Nanima Road after the rehabilitation is completed we would argue that Nanima Road would still be unsuitable for such proposed heavy vehicle traffic, based on all of the reasons identified above.

In addition to the above the intersection of Nanima Road and the Barton Highway is already a dangerous intersection of two busy roads. Should the DA be approved and the associated heavy vehicle traffic be allowed to use Nanima Road then the resulting increase in heavy traffic movement will only make this intersection even more dangerous to users of both the Barton Highway and Nanima Road.

In summary, Nanima Road could not sustain the increase in heavy vehicle traffic that the DA is proposing. The condition of the road is already struggling under current traffic use, including heavy vehicle traffic from the applicant's existing operations. The Council must send a clear message that Nanima Road is a rural residential road, supporting a rural residential community and local tourism businesses. It is not a road suitable for heavy vehicle traffic use. Therefore, the Council must ensure that the applicant is not be allowed to use Nanima Road for any transport of fill in the proposed DA.

Yours faithfully,

SUBMISSION 10

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Subject: DA200151 Applicant Name: Mr Geoff Hewatt,

Dear Planning Department

Re: DA200151

- Applicant Name: Mr Geoff Hewatt
- Property Description: LOT:10, DP:878725, 1170 Murrumbateman Road, Nanima
- Description of Proposal: Filling/Rehabilitation of Quarry

I wish to make a brief submission in the above regard.

My particular concern is the lack of clarity as to the route the dump trucks will take to and from the site. I understand that the applicant has stated that the routes will be " *via Murrumbateman Road only and from either the Barton Hwy or Gundaroo Road.*"

This statement isn't clear enough and appears to infer, through omission, that Nanima Road could be used as the route via the Barton Highway.

I request that Council make it a specific condition of this DA that **no trucks will use Nanima Road for either entry or exit** - I understand that the 10 Tonne Load Limit applies to Nanima Road and would be contravened if used by the applicant for the purpose of this DA.

Kind regards,

SUBMISSION 11

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Cc:
Subject: Submission on DA number DA200151

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

I have been alerted to the above DA and am concerned about the large volume of fill to be transported to the site (around 54,000 tonnes) and the number of truck trips required to deliver the fill to the site (about 5,400 trips each way).

Trucks will be operating between 8am and 5pm, weekdays, posing a risk to the large number of road users (including cyclists) using the roads that access the site between those hours.

I can see no reference in the proposal to routes the trucks might take to reach the site and the likely road impacts. This should be clarified with the applicant. The particular concerns on road damage and risks to road users raised about the applicant's similar 2019 proposal on the Nanima Road should be noted if truck traffic is expected on the Nanima Road.

--

SUBMISSION 12

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Subject: Objection to DA200151

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Dear Yass Shire Officials
We have read the content of DA200151. This proposal involves the transfer of an enormous volume of material for disposal in a quarry on a property in Murrumbateman Rd Nanima. The proposal does not set out which roads will be used to transport this material to the quarry site. If the proposal were to contain a specification of the route to the site which involved only main roads of a suitable engineering standard and load capability to cope safely with the transfer and if the council was prepared to police this requirement then we would have no objection to this proposal.
Our attitude is, however,shaped by our experiences with the large scale and ongoing dumping of excavated material by several developers who use our access road , , to their dumping sites. This road is patently unsuitable for heavy truck movements yet dumping via this road is a daily occurrence which we have to contend with. Most of this road is unsealed from Rd through to Murrumbateman Rd and it has 3 narrow creek crossings. At present, the pot holes in the road are so severe that at one crossing we have to come to a halt before proceeding over it. We are frequently confronted by trucks with trailers coming both towards us and up behind us necessitating that we pull over to avoid collisions and during dry periods until the dust has settled enough to have enough visibility to proceed. Yet this situation has been allowed by Yass Valley Council to persist now for a number of years. Should the proponent be allowed to use Tallagandra Rd to access the quarry site then we would like to register our strong objection to the proposal.
Thank you for allowing us to comment on this DA.
Yours sincerely

SUBMISSION 13

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Subject: DA200151 - 1170 Murrumbateman Road, Nanima

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Re: DA200151 - 1170 Murrumbateman Road, Nanima

Dear Yass Valley Council,

I live in and I am writing to comment on above application.
To reach 1170 Murrumbateman Road from Canberra, the shortest route will be via Nanima road. It is obvious that the current condition of the Nanima road is not suitable for 20-ish ton truck 128 trips per day for prolonged period of one year. I would like to see some concrete measures in place to make sure that the Nanima road is not used for that purpose, particularly, I would like to know what will be the penalty if the truck is caught of using Nanima road for this DA purpose.

Regards

SUBMISSION 14

Muzaffar Rubbani

From:
Sent:
To: YVC Customer Service Team
Subject: Re DA200151 by Mr. Geoff Hewatt

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

The Quarry Filling/Rehabilitation proposal by Mr Hewatt on Murrumbateman road understates the proposed number of truck movements. Eight trucks, each doing eight trips per day is 128 movements, not 64 as stated.
I am a resident on and am concerned that Nanima Road even with its 10 tonne limit, will experience increased trucking activity.
What checks and compliance procedures will be in place to ensure Nanima Road is not used as an alternative entry or exit route to Murrumbateman Road?

SUBMISSION 15

Muzaffar Rubbani

From: Yass Valley Council <no-reply@wufoo.com>
Sent:
To: YVC Customer Service Team
Subject: Public Consultation online submission [#186]

[EXTERNAL] Please exercise caution when clicking on links or attachments from external sources.

Name *

Address *

Email *

Phone Number *

What item are you making a submission on? * DA 200151

Submission *

Further to my submission on this matter I have revisited the Draft Conditions for approval of DA- 5.2015.303.1 – Hewatt's 'truck depot'

"(YVC meeting 25/05/16)

PART A – GENERAL CONDITIONS

(8) The number of truck (with a Gross Vehicle Mass (GVM) of more than 4.5 tonnes) movements associated with the 'truck depot' shall be limited to no more than 160 per calendar month (unless otherwise approved by Council)."

THIS WOULD APPEAR TO PRECLUDE HEWATT'S DEPOT BEING USED TO STABLE THE FLEET OF TRUCKS REQUIRED TO SERVICE DA 200151

"YVC meeting 27/07/16

RESOLVED that -

1. Conditional Development Consent be issued under delegation for Development Application No 5.2015.303.1 for a truck depot at 881 Nanima Road, Spring Range with a section 94 contribution of $71,100;

2. Council commences the application process to have 'bus route' advisory signage installed along Nanima Road;

3. The operator of the truck depot be required to keep a log of all heavy vehicle movements and this log be made available to council staff on request;

4. A condition of consent be added: That no heavy vehicles using the facility traverse Nanima Road between the hours of 7.15am to 8.00am and 4.00pm to 4.45pm".

CONDITION 4 REINFORCES THE CASE THAT VEHICLES INVOLVED UNDER DA 200151 SHOULD NOT USE NANIMA ROAD, PARTICULARLY BETWEEN THE TIMES SPECIFIED. THIS WOULD INCLUDE VEHICLES MOVING BETWEEN HEWATT'S DEPOT AND THE QUARRY SITE.

HEWATT CIVIL
ABN: 45 602 361 739
A SUBSIDIARY OF HEWATT GROUP

P.O. Box 94
HALL ACT 2618
Phone: 02 6227 5694
E-Mail: info@hewatt.com.au
www.hewatt.com.au

9 October 2020

Muzaffar Rubbani
Development Planner
Yass Valley Council
PO Box 6
YASS NSW 2630

Dear Muzaffar,

DA 200151 – Additional Information Request

Thank you for supplying us with copies of submissions.

We refer to your email dated 6/10/2020 in relation to the above Development Application and would like to supply the following information as requested.

Truck Movements

Please refer to Soil and Water Quarry Rehabilitation Plan – Truck and Plant Operations and Project Management

Please refer to the SEE 2.2 Signage, Operating Procedures and Hours of Operation

All trucks are regularly inspected by RMS, ACT Roads, Vic Roads etc to enable them to safely operate. To be able to have their licences Truck drivers must follow all road rules including limits on roads for loads and weights, which excludes those roads with only a 10tonne limit therefore automatically excluding Nanima Road for conveyance of material to the 1170 Nanima Road.

Safety to other road users

Please refer to Soil and Water Quarry Rehabilitation Plan – Staged Rehabilitation Plan – Stage 1.1 Entrance Upgrade

Please refer to the SEE 2.2 Signage, Murrumbateman Road Driveway and Project Management

HEWATT CIVIL
P.O. Box 94
HALL ACT 2618
Phone: 02 6227 5694
E-Mail: info@hewatt.com.au
www.hewatt.com.au

Dust Impacts

Please refer to Soil and Water Quarry Rehabilitation Plan – Truck and Plant Operations and Project Management

Please refer to the SEE 2.2 Dust, Noise and other Emissions, Murrumbateman Road Driveway and Project Management

Noise Impacts

Please refer to Soil and Water Quarry Rehabilitation Plan – Truck and Plant Operations and Project Management

Please refer to the SEE 2.2 Dust, Noise and other Emissions

Sediment and Erosion Impacts

Please refer to Soil and Water Quarry Rehabilitation Plan – Staged Rehabilitation Plan – Stage 1.3 Construct Sediment and Erosion Control Measures
Stage 5. 1 During Rehabilitation and 2 Post Rehabilitation

Would you kindly direct all future correspondence to myself at Geoff@hewatt.com.au with a cc to DPS.

Please do not hesitate to contact me to arrange a meeting to discuss the application.

Yours sincerely,

Geoff Hewatt

Section 4.15 Evaluation

Summary of Application

Development Application No.	DA200151
Type of Development	Local Development
Development Site	Lot 10 DP 878725 (Currently Lot 2 DP 1277698) 1170 Murrumbateman Road, Nanima
Description of Development	Quarry Rehabilitation including importation of up to 38,150m^3 of material (VENM/ENM)

Integrated Development

The application has been referred to the relevant government agency for concurrence and General Terms of Approval have been included in the development consent

Legislation	*Yes*	*N/A*
Coal Mine Subsidence Compensation Act 2017 s 22	☐	✓
Fisheries Management Act 1994 s 144, S201 S205. S219,	☐	✓
Heritage Act 1977 s 58	☐	✓
Mining Act 1992 ss 63, 64	☐	✓
National Parks and Wildlife Act 1974 s 90	☐	✓
Petroleum (Onshore) Act 1991 s 16	☐	✓
Protection of the Environment Operations Act 1997 ss 43(a), 47 and 55, ss 43(b), 48 and 55, ss 43(d), 55 and 122	✓	☐
Roads Act 1993 s 138	✓	☐
Rural Fires Act 1997 s 100B	☐	✓
Water Management Act 2000 ss 89, 90, 91	☐	✓

Comments

Murrumbateman Road is an unclassified regional road. Due to potential safety and traffic issues associated with the vehicles entering the site via Murrumbateman Road, the application was referred to TfNSW for comments. TfNSW has recommended conditions that will be included in any Consent that maybe issue.

The application was also referred to NSW Environment Protection Authority (EPA) for comments. After reviewing the submitted information, the EPA has indicated that an Environment Protection Licence under the *Protection of the Environment Operations Act 1997* is not required.

Section 4.15 – Matters for Consideration

Provisions of any environmental planning instrument

State Environmental Planning Policy (SEPP)	Where a SEPP is applicable to the proposed development, is the development: • Consistent with the aims and objectives of the instrument • Complies with development standards contained in the instrument • Satisfies the requirements of the instrument • Meets the relevant concurrence, consultation and/or referral requirements.

Comment

45 SEPPs and deemed SEPPs were consolidated into 11 new thematic SEPPs commencing on 1 March 2022. However, the subject application was lodged prior to the consolidation. Reference is made to the former SEPP and the new SEPP, in which the former SEPP is now located.

State Environmental Planning Policy (Koala Habitat Protection) 2020

Refer Chapter 3 of State Environmental Planning Policy (Biodiversity and Conservation) 2021

Clause 3.1 of the Koala Habitat Protection SEPP apply to development applications within a council area listed in Schedule 1. Yass Valley Council is listed in Schedule 1.

The Ecological Impact Assessment Report (EIA) assessed the development under the provisions of the SEPP and the following points were noted:

- There is no approved Koala Plan Management Plan which includes the subject land and the subject land has an area of greater than 1ha.
- The subject land supports a number of the tree species listed as suitable Koala use tree species in Schedule 2 of the SEPP and therefore the subject land supports 'potential koala habitat'.
- No Koalas have been recorded within 2.5Km of the subject land in the past 18 years and the species is not known to occur in the lowland agricultural land in the locality. Moreover the closest record was recorded in 2004 approximately 9km to the southeast of the subject land.

On this basis, it is concluded that the development site is considered unlikely to constitute important or occupied koala habitat.

Refer Chapter 4 of State Environmental Planning Policy (Biodiversity and Conservation) 2021

Pursuant to Clause 4.1 of Koala Habitat Protection SEPP 2021 apply to development applications relating to land within a council area listed in Schedule 2. Yass Valley Council is listed in Schedule 2.

However, there is no Koala Plan of Management for the Yass Valley Local Government Area. The EIA outlines the subject land does not support Koala habitat and is unlikely to constitute important or occupied Koala habitat.

State Environmental Planning Policy (Infrastructure) 2007

Refer Chapter 2 of SEPP (Transport and Infrastructure) 2021

The development site has frontage to the Murrumbateman Road which is a not a classified 'Regional Road'.

Schedule 3 of the SEPP identifies 'traffic-generating' development that require referral to Transport for NSW (TfNSW). The development does not meet the referral requirements however the application was referred to TfNSW for comment.

The recommendations of TfNSW can be included in any consent.

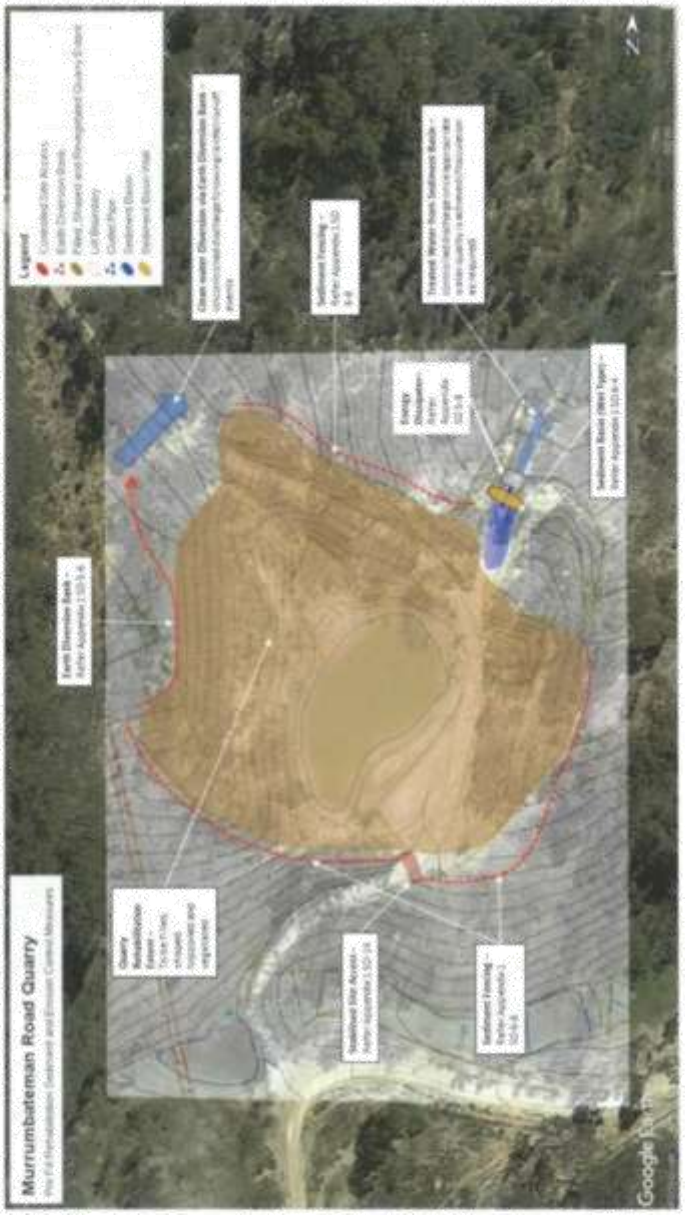
Local Environmental Plan (LEP)	In considering the provisions of the Yass Valley Local Environmental Plan 2013 (YVLEP), is the proposed development: • Consistent with the aims and objectives of the plan • Consistent with the aims and objectives of the land use zone • Permissible in the land use zone

	• Consistent with all relevant clauses within the LEP • Complies with development standards in the LEP.
Comment Below is an assessment of the application pursuant to the relevant clauses of the YVLEP.	
Clause 2.3 Zone and zone objectives	The proposed development is generally consistent with the objectives of the RU1 Primary Production zone as it will potentially result in an enhanced or improved natural resource base through the rehabilitation of the quarry footprint area. The following is also noted: • The proposed development is not considered to result in a significant fragmentation of resource lands. • The proposed development is not considered to result in a conflict between land uses zones or within the land use zone, subject to management through conditions of Development Consent (e.g. restrictions on heavy vehicle movements). • The proposed development is considered to have been designed in such a manner protects the biodiversity values of the site. • The proposed development does not have any long-term adverse impact on the rural character of the Yass Valley. Any impacts can be managed any consent. • The intensity of the development is appropriate having regard to the characteristics of the land, the rural environment and the need to protect significant natural resources. • The subject land is not situated on a fringe of the urban area.
Clause 2.3 Land Use Table	The proposed development is for 'environmental protection works' which is permitted without consent in the RU1 Primary Production zone. However, consent is required for the importation of the fill material and the earthworks pursuant to clause 6.1 of the LEP.
Clause 4.1 Minimum subdivision lot size	N/A
Clause 4.1B Subdivision using average lot sizes	N/A
Clause 4.1C Additional requirements for subdivision in certain rural zones	N/A
Clause 4.1D Minimum site areas for dual occupancies and multi dwelling housing in Zones R1, R2, R3 and RU5	N/A
Clause 4.2B Erection of dwelling houses and dual occupancies on land in certain rural and environment protection zones	N/A

Clause 4.3 Height of buildings	N/A
Clause 4.4 Floor space ratio	N/A
Clause 4.6 Exceptions to development standards	N/A
Clause 5.4 Controls relating to miscellaneous permissible uses	N/A
Clause 5.10 Heritage conservation	N/A
Clause 5.16 Subdivision of, or dwellings on, land in certain rural, residential or conservation zones	N/A
Clause 6.1 Earthworks	The objectives of this clause are to ensure earthworks for which development consent is required will not have a detrimental impact on environmental functions and processes, neighbouring uses, cultural or heritage items or features of the surrounding land. Before granting development consent for earthworks (or for development involving ancillary earthworks), the consent authority must consider the following matters: *(a) the likely disruption of, or any detrimental effect on, drainage patterns and soil stability in the locality of the development,* The proposal is not considered to have significant impact on drainage patterns and soil stability of land within the subject site and locality. The proposal is not being undertaken in a water course/erosion gully. The compliance with the conditions of any consent will ensure no significant impact on drainage patterns, soil stability, neighbouring properties and waterways. *(b) the effect of the development on the likely future use or redevelopment of the land,* The proposed development, and the earthworks required to facilitate it, are generally in accordance with the desired future character and use of the site. It will not significantly impact upon the neighbouring properties. Erosion and soil movement can be managed through sediment control measures being implemented. The proposal is likely to result in an improved state of the land and therefore increasing its potential *(c) the quality of the fill or the soil to be excavated, or both,* The quality of the fill is proposed to be VENM or ENM and can be managed through conditions of consent and in accordance the

	requirements of the *Protection of the Environment Operations Act 1997*. *(d) the effect of the development on the existing and likely amenity of adjoining properties,* The proposed development, and the earthworks required to facilitate it should not adversely affect the existing amenity of adjoining properties. Drainage patterns of adjoining properties will remain largely unaltered. Access to adjoining properties will be maintained during the proposed works. The effect of the development on nearby development and the amenity of the area has been considered and detailed elsewhere in this assessment. The primary amenity impact relates to the heavy vehicle movements delivering material, including by way of traffic generation, dust and noise. *(e) the source of any fill material and the destination of any excavated material,* The fill source will be developments primarily in the ACT. It must be certified as VENM or ENM before being transported and used on the site and in accordance with the NSW legislation. *(f) the likelihood of disturbing relics,* There are no known relics within the subject site. If relics are found, the relevant cultural heritage legislation still applies therefore protection will be ensured. A condition can be included in any consent requiring Heritage NSW to be contacted should any relic be unearthed. *(g) the proximity to, and potential for adverse impacts on, any waterway, drinking water catchment or environmentally sensitive area,* The compliance with the conditions of consent will ensure the proposed development, and the earthworks required to facilitate it will have no potential adverse impact on any waterway, drinking water catchment or environmentally sensitive areas. *(h) any appropriate measures proposed to avoid, minimise or mitigate the impacts of the development.* Soil and water management measures implemented during the rehabilitation will limit the potential impacts. Appropriate measures can be included in any consent.
Clause 6.2 Flood planning	N/A
Clause 6.3 Terrestrial biodiversity	The EIA documents the ecological value of the site and determines the likely impacts of the proposed development upon habitat for terrestrial flora and fauna species and ecological communities listed under the Commonwealth *Environment Protection and Biodiversity Conservation Act 1999* and the NSW *Biodiversity Conservation Act 2016*.

	The EIA concludes that the proposed development is unlikely to have an adverse impact on the condition, ecological value and significance of the fauna and flora on the land. The proposed development is not considered to have any potential to fragment, disturb or diminish the biodiversity structure, function and composition of the land.
Clause 6.4 Groundwater vulnerability	It is unlikely that the proposed development will have a significant impact on groundwater. The potential for on or off-site groundwater contamination is proposed to be managed by: • diverting surface water flows away from the filling areas via earth diversion bank and • managing sediment detention basin to treat water from the sediment basin The location of various structures and controls nominated including the relevant design features for surface water management are shown below:

	
Clause 6.5 Riparian land and watercourses	The site is not identified as being affected by a watercourses or riparian environments identified in the *YV LEP 2013*.
Clause 6.6 Salinity	The site is not identified as being affected by salinity.
Clause 6.7 Highly erodible soils	The site is not identified as being subject to erodibility for the purposes of clause 6.7.
Clause 6.8 Essential services	It is considered that all essential services are available to service the proposal. The subject land has legal and physical access from Murrumbateman Road across the crown road. This part of crown road is required to be transferred to Council. The property vehicular access is required to be upgraded to facilitate the heavy vehicle

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	movements. Any approval that may issue will contain this requirement.
Clause 6.9 Development within a designated buffer area	N/A
Clause 6.10 Development on land intended to be acquired for Barton Highway duplication	N/A
Other relevant clause	N/A

Proposed environmental planning instrument that is or has been subject of public consultation and has been notified to the consent authority

Primary Matters	Specific Consideration
Draft Environmental Planning Instrument	Where a draft environmental planning instrument is applicable to the proposed development, is the development: • Consistent with the aims and objectives of the draft instrument • Complies with development standards contained in the draft instrument • Satisfies the requirements of the draft instrument • Meets the relevant concurrence, consultation or referral requirements to address the provisions of the draft instrument
Comment No draft environmental planning instrument exist that applies to the subject land.	

Any development control plan

Primary Matters	Specific Consideration
Development Control Plan (DCP)	Where a DCP is applicable to the proposed development, is the development: • Consistent with the aims and objectives of the plan • Satisfies the requirements of the DCP
Comment No development control plan exists that applies to the subject land.	
Contributions Plans	Are contributions under the Yass Valley Developer Contribution Plan 2018 and/or the Yass Valley Heavy Haulage Contribution Plan 2021 applicable to the proposed development?
Comment The subject application was lodged prior to the commencement of *Yass Valley Heavy Haulage Development Contributions Plan 2021* meaning that a haulage contribution is applied in accordance with the *Yass Valley Heavy Haulage Plan 2006*. Refer to further discussion in the Council report regarding contributions.	

Planning agreement entered into or a developer has offered to enter into under s7.4 of the Act

Primary Matters	Specific Consideration
Planning Agreement or Draft Planning Agreement	**Details of Agreement** Provide a monetary contribution to Council in lieu of contributions required under Yass Valley Council Heavy Haulage Contributions 2006 whilst recognising the recently adopted Yass Valley Heavy Haulage Contributions Plan 2021.
Comment The Applicant proposes a Voluntary Planning Agreement (VPA) for the proposed development. Refer to the Council report regarding details of the VPA.	

Prescribed Matters – Environmental Planning and Assessment Regulation

Primary Matters	Specific Consideration
Environmental Planning and Assessment Regulation 2000	The following matters under the *Environmental Planning and Assessment Regulation 2000* have been considered: • AS 2601 when demolition is involved • The Low Rise Housing Diversity Design Guide for Development Application (July 2020) for a manor house or multi dwelling housing (terraces) • Fire safety provisions for a change of building use for an existing building • Provisions for temporary structures • Compliance with the Building Code of Australia if a building upgrade required
Comment N/A	

Likely impacts of the development including environmental impacts on both the natural and built environments, and social and economic impacts in the locality

Primary Matters	Specific Consideration
Context and setting	**Context** Compatibility of the development with: • scenic qualities and features of the landscape • character and amenity of the locality and streetscape • scale (bulk, height, mass) form, character, density and design of development in the locality • previous existing land uses and activities in the locality **Setting** Impact of the development on adjacent properties in terms of: • the relationship and compatibility of adjacent land uses • sunlight access (overshadowing)

	• visual and acoustic privacy • views and vistas • edge conditions such as boundary treatments and fencing
Comment The rural context and setting is appropriate for the development. Refer to the Council report regarding visual impacts.	
Access, transport and traffic	Consideration of access, transport and traffic and the proposed development: • The proposed development and Council's Roads Standards Policy • The volume of traffic generated from the proposed development and capacity of the local and arterial road network • Availability of public transport • Any traffic management study submitted • Provision of vehicle parking spaces • Compliance with relevant standards for on site car parking provisions for compliance with relevant standards • The proposed or existing location of vehicular access to the site
Comment The application was referred to TfNSW as well as Council's Infrastructure and Assets Directorate. TfNSW raised no objections to the proposal subject to the inclusion of conditions in any consent. Any conditions will ensure upgrading of the existing vehicular access and construction of BAL/BAR treatment to improve safety around the quarry site entrance and enabling safe vehicle movements on/off Murrumbateman Road.	
Utilities	Consideration of utilities and the proposed development: • Utilities are either existing and capable of supporting the proposed development or capable of being extended to service the site • Where onsite sewage management is proposed it has been accompanied by a report prepared by an appropriate consultant demonstrating the suitability of the site for on-site effluent disposal
Comment The demands of the development are unlikely to have an adverse impact on the utility supply.	
Heritage	Impact of the proposed development on heritage significance of the site, adjacent properties and/or a heritage conservation area: • Consideration of impact on items, landscapes, areas, places, relics and practices • Consideration of the historic, scientific, social, aesthetic, cultural, archaeological (both Aboriginal and non-Aboriginal) values of the site
Comment The subject land is not identified as being or containing a heritage item or in a heritage conservation area under the provisions of the YVLEP. Refer to previous comments regarding Aboriginal cultural heritage.	

Water	Impact of the proposed development on conservation of water: • water supply sources • treatment, reuse and disposal of waste water and runoff • drainage, flow regimes, flooding on-site, up and downstream and in the catchment flood plain • groundwater tables
Comment The development is unlikely to have an adverse impact on the conservation of water resources As discussed earlier in this report, the potential for on or off-site groundwater contamination is proposed to be managed by: • diverting surface water flows away from the filling areas via earth diversion bank, and • managing sediment detention basin to treat water from the sediment basin It is considered that the proposed works, through minimising movement of sediment will assist in improving the water quality downstream.	
Soils	Impact of the development on soils: • soil qualities - erodibility, permeability, expansion/contraction, fertility/productivity, salinity, sodicity, acidity, contaminants • instability - subsidence, slip, mass movement • the movement, formation, use and management of soils • soil erosion and degradation • remediation of contaminated soils
Comment The site is not identified as being subject to "dry land salinity" in accordance clause 6.6 of the YVLEP 2013 or as being affected by "high soil erodibility" in accordance with clause 6.7. The works must be undertaken in accordance with the Rehabilitation Plan and any conditions of consent which covers aspects of the development including quality of fill material and erosion and sediment control (short term and longer term, to allow re-vegetation). The site has not been identified as an area of contamination.	
Air and Microclimate	Impact of the development on air quality and microclimatic conditions in terms of emissions of dust, particulates, odours, fumes, gases and pollutants.
Comment Air impacts associated with the development are considered to primarily to be by way of dust. It is considered that appropriate dust suppression measures can be put in place to manage this impact in accordance with the Quarry Rehabilitation Plan and any conditions of consent, including the requirement for the applicant to submit a dust management protocol to Council, prior to works commencing.	
Flora and Fauna	Impact of the proposed development on: • wilderness areas and national parks • wildlife corridors and remnant vegetation • the relationship of vegetation to soil erosion/stability and the water cycle • weeds, feral animal activity, vermin and disease Outcomes of an assessment under the *Biodiversity Conservation Act 2016* considers: • whether the development will result in serious and irreversible impacts

	• whether a BDAR is required • where a BDAR is required, whether it is considered satisfactory
Comment Negligible impact is anticipated as a result of the proposed development. The application does not propose the removal of any trees. The proposed development does not trigger entry into the Biodiversity Offset Scheme (BOS) under the *Biodiversity Conservation Act 2016* as: • Proposal does not involve the clearing of 1ha or more of native vegetation. • The impact will not exceed the test of significance. • The land is not on the Biodiversity Values Map.	
Waste	Impact of the proposed development on waste: • solid, liquid and gaseous wastes and litter • the generation, collection, storage and disposal of waste
Comment The development is not considered to be a 'waste facility' due to the environmental outcomes of the proposed works. Refer to discussion in the Council report.	
Energy	Impact of the proposed development on energy: • the overall energy needs of the development • the measures employed to save energy - passive design, solar lighting and heating, natural ventilation, shading elements, insulation, high thermal mass building materials, energy efficient appliances and machinery • the use of renewable and non-polluting energy sources? • energy needs in producing building/structural materials? • energy use by-products and waste Where relevant the development also complies with the Building Sustainability Index (BASIX).
Comment There are no matters that require discussion given proposal does not involve erection of any building.	
Noise and Vibration	Whether the development has potential to generate noise pollution or vibration including during construction and potential impacts.
Comment Conditions of consent limit the movement of heavy vehicles which will assist is minimising impacts on the amenity of neighbouring and nearby properties. Refer to the discussion in the Council report.	
Natural Hazards - Geological	Risks to people, property and the physical environment as a result of geologic/soil instability - subsidence, slip, mass movement has been considered.
Comment A project design has been prepared by a person suitably experienced in soil conservation	

Natural Hazards - Flooding	Where the development is located on land identified as flood affected: • Compliance with the relevant Flood Risk Management Plan in accordance with the information submitted with the application or • The addition of conditions which require compliance with the relevant Flood Risk Management Plan or the Building Code of Australia.
Comment The subject land is not identified on Council's Floodplain Risk Management Study and Plan.	
Natural Hazards - Bushfire	Where the development is located on land identified as bushfire prone: • Compliance with Planning for Bushfire Protection 2019 (however in accordance with s.8.3.2 of *Planning for Bushfire Protection 2019* there are no bushfire protection requirements for class 10a buildings located more than 6 metres from a dwelling in bushfire prone areas); or • If it is integrated development it has been referred to the RFS in accordance with s100B Rural Fires Act 1997.
Comment The application was lodged prior to the current bushfire mapping coming into effect. The previous mapping does not identify the site as being bushfire prone land.	
Technological Hazards	Does the development present risks from: • industrial and technological hazards • land contamination and remediation Where potential land contamination has been identified an assessment must be provided determining whether the: • The contamination is likely to be low and does not warrant remediation as the proposed land use is not sensitive, or • The land is not contaminated, or • The land is contaminated and remediation is proposed prior to the proposed use
Comment The development is not considered to pose a risk to people or the natural environment from industrial and technological hazard. Refer to discussion in the Council report.	
Safety, Security and Crime Prevention	The assessment must determine whether adequate measures are included to address the potential for accident / injury and criminal activity.
Comment The proposed development is not considered to create an environment conducive to anti-social behaviour.	
Social impact in the locality	Whether the development is likely to have social benefits in the locality in terms of: • community facilities and links • the interaction between the new development and the community
Comment Not applicable.	

Economic impact in the locality	Whether the development is likely to have economic benefits in terms of: • employment generation • economic income • generating benefits for existing and future businesses
Comment The economic impact will be borne by the broader community through the impact that heavy vehicles have on the public road network. A contribution is required to be paid to Council towards road maintenance in accordance with the *Yass Valley Council Heavy Haulage Section 94 Contributions Plan 2006* as the application was lodged prior to the adoption of the 2021 Plan. However, in recognition of the difference in contributions between the 2006 and 2021 Plans the Applicant has offered a VPA to pay a contribution at a higher rate than required by the 2006 Plan. Refer to previous comments about the VPA.	
Site and internal design	The development is generally sensitive to environmental conditions and site attributes including: • the size, shape and design of allotments, easements and roads • the proportion of the site covered by buildings • the positioning of buildings • the size (bulk, height, mass), form, appearance and design of buildings • the amount, location, design, use and management of private and communal open space • landscaping The development is unlikely to affect the health and safety of the occupants in terms of: • inadequate lighting, ventilation and insulation • inadequate building fire risk prevention and suppression • inappropriate building materials and finishes • inappropriate common wall structure and design • lack of access and facilities for the disabled
Comment The site design, internal design and project design are considered to be suitable.	
Construction	• The proposed development has provision for compliance with the Building Code of Australia (as amended) and relevant Australian standards • The impacts of construction activities can be managed and suitable conditions have been included in the development consent.
Comment The proposal does not involve construction of any building/structure. The impacts of the proposed development can be managed by imposing appropriate conditions in the any approval.	

The suitability of the site for the development

Primary Matters	Specific Consideration

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Compatibility with existing development in the locality	The proposal is compatible with existing development in the locality as: • Utilities and services available to the site are adequate for the development • The development will not lead to unmanageable transport demands • Transport facilities are adequate in the area • The locality contains adequate recreational opportunities and public spaces to meet the needs of the development • The air quality and microclimate are appropriate for the development • No hazardous land uses or activities nearby • Ambient noise levels are suitable for the development • The site is not critical to the water cycle in the catchment • The proposal is compatible with the existing built environment
Comment The proposed development is compatible with the locality, subject to necessary conditions of consent relating to the movement of heavy vehicles etc to minimise any impacts on the local amenity.	
Site conduciveness to the development	The subject site is conducive with the proposed development as : • The site is suitable for the proposed development • The site is either not subject to natural hazards including flooding, tidal inundation, subsidence, slip, mass movement, and bushfires or where it is these risks have been adequately managed • The slope of the land is suitable for the proposed development • The proposal is compatible with conserving the heritage significance of the site • The soil characteristics on the site is appropriate for development (Saline / Sodic / Acidic) • The development is compatible with protecting any critical habitats or threatened species, populations, ecological communities on the site • The site is not prime agricultural land and the development will not unduly prejudice future agricultural production • The development will not unduly prejudice the future use of the site • Cut and fill is a suitable development option for the site
Comment The site is suitable for the proposed development, subject to the development being undertaken in accordance with the Rehabilitation Plan and any plans and documents approved as part of the s138 Approval under Roads Act.	

Any submissions made in accordance with this Act of the regulations

Primary Matters	Specific Consideration
Public Submissions	Community consultation was undertaken in accordance with Council's Community Engagement Strategy. Where submissions have been received, the issues raised have been considered and are summarised in the comments below.
Comment The application was notified to 36 land owners surrounding the subject land. Fifteen (15) submissions were received during the notification period.	

A response to the submissions was provided by applicant, indicating that issues raised in the submissions have been taken into consideration. The issues raised in the submissions are addressed in the Council report.	
Submissions from Public Authorities	Where relevant submissions received from Government or Public Authorities have been considered with any issues raised being resolved, addressed by conditions of consent/general terms of approval or are considered not relevant to the development

Comment

The proposal was referred to:

- Transport for NSW (TfNSW)
- NSW Environment Protection Authority (EPA)
- NSW Crown Lands

No objections have been raised by TfNSW and EPA subject to the inclusion of requirements in any approval that may be issued.

NSW Crown Lands has objected to the development on the basis that the entrance from Murrumbateman Road into the subject land is across a crown road. However, Crown Lands have indicated if an upgrade to provide safe access/exit of vehicles from Murrumbateman Road is required then they would not object providing the crown road is transferred to Council as Crown Lands cannot consent to any construction, upgrade or maintenance work on crown roads.

Council will only accept the transfer of triangular piece of the crown road (marked red in the Figure 1) but will not accept the transfer of the remainder of the crown road.

Figure 1 - Crown Road

The transfer of the triangular piece of the crown road to Council will enable the upgrading of existing access as well construction of a BAL and BAR treatment that will support safe vehicle movements on/off Murrumbateman Road.

The public interest

Primary Matters	Specific Consideration
Government (Federal, State and Local) and Community Interests	Government and community interests have been considered and are satisfied as: • The proposed development complies with the Council Policies identified as applicable in the schedule below. Where a variation to this policy has been supported details have been included in the comments. • The proposed development is generally consistent with any relevant planning studies and strategies

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	• Covenants not imposed by council have been set aside for the purpose of this assessment • The proposal generally complies with all other covenants, easements, restrictions and agreements that have an bearing on the proposal • Issues raised in public meetings and inquiries have been considered. Where relevant more detail has been provided under the heading public submissions. • It is unlikely that the development will have a detrimental effect on the health and safety of the public

Comment

Any environmental outcomes have been considered alongside potential adverse impacts on the amenity of neighbouring properties in the assessment presented.

The proposed development is in the public interest as it complies with the relevant planning framework and is unlikely to have adverse impacts on the natural or built environment.

	Policy	Code	Applicable
Council Policies	**Building Line – Rural and Residential Land**	DA-POL-8	
	Building Line – Urban	DA-POL-4	
	Building Over Sewer Mains	SEW-POL-1	
	Development Assessment and Decision Making	DA-POL-18	✓
	Filling Policy	DA-CP-22	✓
	Holiday Cabins – Micalong Creek Subdivision	DA-POL-3	
	Kerb and Gutter Construction	ENG-POL-4	
	Non-Urban Fencing	DA-POL-12	
	Off-Street Car Parking	ENG-POL-8	
	Provision of Electricity Supply and Telecommunications Service for Subdivisions	DA-POL-17	
	Road Naming	RD-POL-6	
	Road Standards	RD-POL-9	✓
	Temporary Accommodation	DA-POL-2	
	Truck and Transport Depots in Rural Areas	DA-POL-11	
	Water Supply in Rural Areas and Villages	WS-POL-2	

Comment

Council policies applicable to the proposed development are detailed below.

The application is presented to Council for determination in accordance with *Application Assessment and Decision Making DA-POL-18* due to the number of submissions received.

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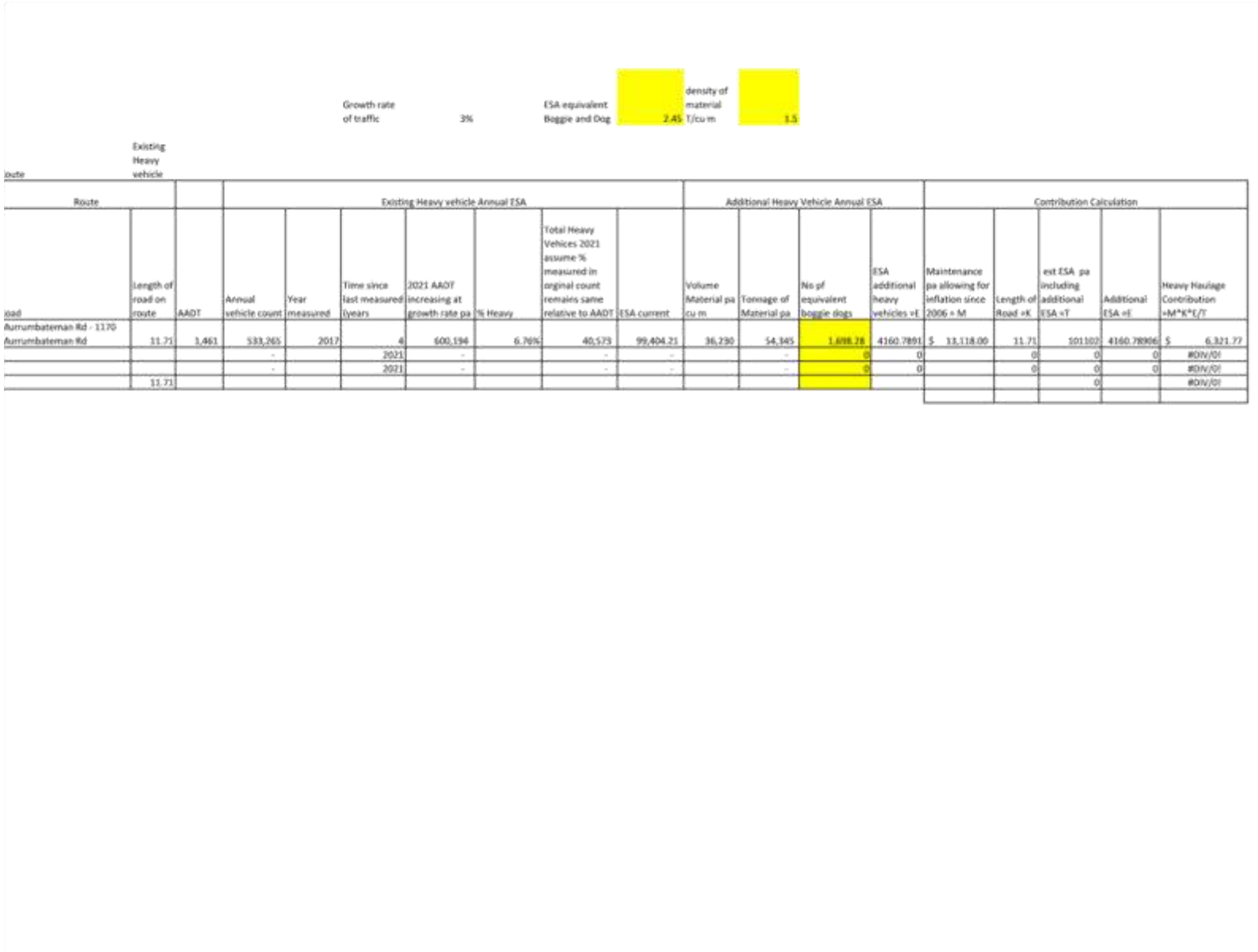
The application was lodged prior to the Filling Policy. The policy has draft weight consideration for this application. The proposal is however generally consistent with the requirements of the policy. The Applicant has sought professional advice on the erosion issue, the design of the works and the available options. Any environmental outcomes have been considered alongside potential adverse impacts on the amenity of neighbouring properties in the assessment presented Refer to the Council report and previous comments in this assessment regarding the requirements for road improvements in relation to RD-POL-9 Road Standards Policy.



Growth rate of traffic 3% | ESA equivalent Boggie and Dog 2.45 | density of material T/cu m 1.5

oute	Existing Heavy vehicle		Existing Heavy vehicle Annual ESA							Additional Heavy Vehicle Annual ESA				Contribution Calculation				
Route																		
oad	Length of road on route	AADT	Annual vehicle count	Year measured	Time since last measured (years	2021 AADT increasing at growth rate pa	% Heavy	Total Heavy Vehicles 2021 assume % measured in orginal count remains same relative to AADT	ESA current	Volume Material pa cu m	Tonnage of Material pa	No pf equivalent boggie dogs	ESA additional heavy vehicles =E	Maintenance pa allowing for inflation since 2006 = M	Length of Road =K	est ESA pa including additional ESA =T	Additional ESA =E	Heavy Haulage Contribution =M*K*E/T
Aurrumbateman Rd - 1170 Aurrumbateman Rd	11.71	1,461	533,265	2017	4	600,196	6.76%	40,579	99,404.21	36,230	54,345	1,698.28	4160.7891	$ 13,118.00	11.71	101102	4160.78906	$ 6,321.77
			-		2021	-		-	-		-	0	0		0	0	0	#DIV/0!
			-		2021	-		-	-		-	0	0		0	0	0	#DIV/0!
	11.71															0		#DIV/0!

Diverse Project Solutions
7 Adele Street
Yass NSW 2582
Postal PO Box 5 Yass NSW 2582

Telephone 02 6226 3322
Email info@dpsyass.com.au
www.dpsyass.com.au

VOLUNTARY PLANNING AGREEMENT

THIS PLANNING AGREEMENT is made on this ……day of……20….

BETWEEN

Parties:

Yass Valley Council (ABN 50 119 744 650) **('the Council')**

and

Winjarra Pty Limited (ABN 38 106 134 150) **('the Developer')**

Subject Land:

Lot 2 DP1277698
1170 Murrumbateman Road, NANIMA NSW 2582

CONTENTS

PLANNING AGREEMENT
Lot 2 DP1277698
1170 Murrumbateman Road, NANIMA NSW 2582

Parties:

Council	**Name**	**YASS VALLEY COUNCIL**
	Address	209 Comur Street YASS NSW 2582
	ABN	50 119 744 650
	Email	council@yassvalley.nsw.gov.au
	Phone	02 6226 1477
	Representative	Chris Berry
Developer/ Owner	**Name**	**WINJARRA PTY LIMITED**
	Address	888 Nanima Road SPRINGRANGE NSW 2582
	ABN	38 106 134 150
	Email	susi@hewatt.com.au
	Phone	0408 275 694
	Representative	Susi Bauer

Background:

A. The Developer is the registered proprietor of the Development Land.
B. Development Application DA200151 is lodged via the NSW Planning Portal to Council on 23 July 2020 for the approval of Quarry Rehabilitation.
C. Submissions received 08 October 2020.
D. Response submitted to Council 09 October 2020
E. Notice that the Council will be holding a Planning Forum 09 December 2020
F. Additional information requested 22 January 2021
G. Site inspection by Councillors scheduled for 15 February 2021
H. Additional information submitted 12 August 2021
I. Further Planning Forum for the new Council held 14 February 2022

J. Conditional Consent received from Yass Valley Council XXXXXXX

K. In recognition of the difference in Contributions plans from 2006 to 2021 we propose to pay an additional $1.09/m^3$ equating to $41,150.98 which is approximately 10 times the amount when calculated against the Yass Valley Heavy Haulage Section 94 Plan (2006).

Operative Provisions:

1. Agreement

The agreement of the parties is set out in the Operative Provisions of this document, in consideration of, among other things, the mutual promises contained in this document.

2. Definitions

2.1 Act

Means the *Environmental Planning and Assessment Act 1979* (NSW) (as amended).

2.2 Authority

Means (as appropriate) any:

a) Federal, state or local government;

b) Department of any federal, state or local government;

c) Any court or administrative tribunal; or

d) Statutory corporation or regulatory body.

2.3 Claim

Means any allegation, action, demand, cause of action, suit, proceeding, judgement, debt, damage, loss, cost, expense or liability howsoever arising and whether present of future, fixed or unascertained, actual or contingent whether at law, in equity, under statute or otherwise.

2.4 Completion of Works

Means as per Part E of the draft Conditions attached to Councils Conditional Consent dated XXXXX.

2.5 Council

Means Yass Valley Council of it's successors.

2.6 Dealing

In relation to the Land, means without limitation, selling, transferring, assigning, mortgaging, charging, encumbering or otherwise dealing with the Land.

2.7 Development

Means the development application for the approval of the rehabilitation via filling of an existing eroded quarry.

2.8 Development Application

Has the same meaning as in the Act.

2.9 Development Consent
Has the same meaning as in the Act.

2.10 Development Contribution
Means a monetary contribution, the dedication of land free of cost or the provision of a public material benefit.

2.11 GST
Has the same meaning as in the GST Law.

2.12 GST Law
Has the meaning given to that term in *A New Tax System (Goods and Services Tax) Act 1999 (Cth)* and any other Act or regulation relating to the imposition or administration of the GST.

2.13 Land
Means Lot 2 DP1277698 1170 Murrumbateman Road, NANIMA NSW 2582.

2.14 Party
Means a party to this agreement, including their successors and assigns.

2.15 Planning Legislation
Means the Act, the *Local Government Act 1993* (NSW) and the *Roads Act 1993* (NSW).

2.16 Regulation

Means the *Environmental Planning and Assessment Regulation 2000*.

2.17 S7.12

Means contributions in accordance with S7.12 of the *Environmental Planning and Assessment Act 1979 (as amended)*.

In the interpretation of this Planning Agreement, the following provisions apply unless the context otherwise requires:

a) Headings are inserted for convenience only and do not affect the interpretation of this Planning Agreement

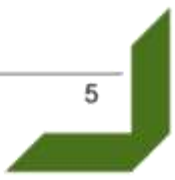
b) A reference in this Planning Agreement to a business day means a day other than a Saturday or Sunday on which banks are open for business.

c) If the day on which any act, matter or thing is to be done under this Planning Agreement is not a business day, the act, matter or thing must be done on the next business day.

d) A reference in this Planning Agreement to dollars or $ means Australian dollars and all amounts payable under this Planning Agreement are payable in Australian dollars.

e) A reference in this Planning Agreement to a $ value relating to a Development Contribution is a reference to the value exclusive of GST.

f) A reference in this Planning Agreement to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision.



g) A reference in this Planning Agreement to any agreement, deed or document is to that agreement deed or document as amended, novated, supplemented or replaced.

h) A reference to a clause, part, schedule or attachment is a reference to clause, part, schedule or attachment of or to this Planning Agreement.

i) An expression importing a natural person includes any company, trust, partnership, joint venture, association, body corporate or governmental agency.

j) Where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning.

k) A word which denotes the singular denotes the plural, a word which denotes the plural denotes the singular, and a reference to any gender denotes the other genders.

l) References to the word 'include' or 'including' are to be construed without limitation.

m) A reference to this Planning Agreement includes the agreement recorded in this Planning Agreement.

n) A reference to a Party to this Planning Agreement includes a reference to the servants, agents and contractors of the Party, the Party's successors and assigns.

o) Any schedules, appendices and attachments form part of this Planning Agreement.

p) Notes appearing in this Planning Agreement are operative provisions of this Planning Agreement.

3. Application and operation of this document

3.1. Planning Agreement

This document is a planning agreement:

1) Within the meaning set out in s7.4 of the Act; and
2) Governed by Subdivision 2 of Division 7 of the Act

3.2. Application

This document applies to the:

1) Land; and
2) Development

3.3. Operation

This Agreement commences when it has been executed by all of the Parties.

4. Application of S7.12 of the Act

4.1 Section 7.12

This document does not exclude the application of S7.12 of the Act to the Development.

5. Monetary Contributions

5.1 Payment

1) The Developer must pay:

   a) the Monetary Contribution; and

   to Council in accordance with this document, and in particular in accordance with **Schedule 3.**

2) **Schedule 3** has effect as an operative provision of this document.

3) The Developer must pay the full amount of the Monetary Contribution in cash, or by unendorsed bank cheque, or by deposit by means of electronic funds transfer of cleared funds, into a bank account nominated by Council.

5.2 Indexation

The amount of the Monetary Contribution will be indexed in accordance with Section 4.4 of Yass Valley Council Heavy Haulage Development Contributions Plan dated September 2021.

6. Developer Warranties

The Developer warrants to Council that:

1) It is legally and beneficially entitled to the Land;

2) It is able to fully comply with it's obligations under this document;

3) It has full capacity to enter into this document; and

4) There is no legal impediment to it entering into this document, or performing the obligations imposed under it.

7. Registration of this Document

7.1 Registration

This document must be registered on the title of the Land pursuant to s7.4 of the Act.

7.2 Obligations of the Developer

Promptly after the date of this document, the Developer must at its own expense, do all things necessary to procure:

a) The consent of each person that has an estate or interest in the Land.

b) The production of the Certificate of Title relating to the land; and

c) The lodgement and registration of this document by the Registrar-General in the relevant folio of the Register.

7.3 Evidence of Registration

The Developer must provide the Council with a copy of the registered dealing and a title search in respect of the land evidencing registration within 14 days of registration occurring.

7.4 Removal from Title of the Land

a) Council will do all things necessary to allow the Developer to remove the registration of this document from the title of the Land where the Developer has provided all Monetary Contributions.

b) The Developer must pay any reasonable costs incurred by Council in undertaking that discharge.

8. Determination of this Document

8.1 Determination

This document will determine upon the Developer satisfying all of its obligations under the document.

8.2 Effect of the Determination

Upon the determination of this document Council will do all things necessary to allow the Developer to remove this document from the title of the whole or any part of the Land as quickly as possible.

9. Security

9.1 Prohibition

Neither party may Assign their rights under this document without the prior written consent of the other party.

9.2 Assignment of Land

The Developer must not Assign its interest in the land, unless:

a) Council consents to the Assignment; and

b) On or before the Assignment occurring all Monetary Contributions (and any interest payable) have been repaid to the Council; or

c) The proposed assignee enters into an agreement to the satisfaction of Council under which the assignee agrees to be bound by the terms of this document with respect to the relevant part of the Land being Assigned and to make any further Contributions in relation to that Land which have not been made as at the date of the Assignment.

9.3 Enforcement of Agreement

a) Without limiting any other remedies available to the Parties, this Agreement may be enforced by the Parties in any court of competent jurisdiction.

b) For the avoidance of doubt, nothing in the Agreement prevents:

i. A Party from bringing proceedings in the Land and Environment Court to enforce any aspect of this Agreement or nay matter to which this Agreement relates; or

ii. The Council from exercising any function under the Act or any other Act or law relating to the enforcement of any aspect of this agreement or any matter to which this Agreement relates.

iii. If the Applicants are in breach of this Agreement, Council taking action to restrain the Applicants from operating otherwise than in accordance with the Development Consent.

9.4 Charge and Caveat

The Developer acknowledges and agrees that:

a) The Land is charged with the payment to Council of the Monetary Contributions until the Monetary Contributions are paid to Council in full;

b) Council has a caveatable interest in the Land from the date of this document until all of the Monetary Contributions have been paid to Council in full;

c) Council has the right to lodge and maintain a caveat against the title to the Land to notify of and protect its interest created by this document (including the charge referred to in clause 8.4(a)) until all of the Monetary Contributions have been paid in full to the Council.

10. Dispute Resolution

The parties agree that any dispute arising during the term of this document will be dealt with as follows:

a) First, the party claiming that there is a dispute will send to the other a notice setting out the nature of the dispute;

b) Secondly, the parties will try to resolve the dispute by direct negotiation, including by referring the matter to persons who have the authority to intervene and direct some form of resolution;

c) Thirdly, the parties have 10 business days from the receipt of the notice in clause 9(a) to reach a resolution or to agree that the dispute will be submitted to mediation or some other form of alternative dispute resolution procedure; and

d) Lastly, if:

i. There is no resolution or agreement; or

ii. There is a submission to mediation or some other form of alternative dispute resolution procedure, but there is no resolution within 15 business days of the submission, or such extended time as the parties may agree in writing before the expiration of the 15 business days,

then, either party may commence legal proceedings.

11. Position of Council

11.1 Consent Authority

The parties acknowledge that Council is a consent authority with statutory rights and obligations pursuant to the terms of the Planning Legislation.

11.2 Document does not Fetter Discretion

This document is not intended to operate to fetter:

(a) the power of Council to make any Law; or

(b) the exercise by Council of any statutory power or discretion

11.3 Severance of Provisions

(a) No provision of this document is intended to, or does, constitute any unlawful fetter on any Discretion. If, contrary to the operation of this clause, any provision of this documentis held by a court of competent jurisdiction to constitute an unlawful fetter on any Discretion, the parties agree:

(i) they will take all practical steps, including the execution of any further documents, to ensure the objective of this clause 10 is substantially satisfied;

(ii) in the event that paragraph (i) cannot be achieved without giving rise to an unlawful fetter on a Discretion, the relevant provision is to be severed and the remainder of this document has full force and effect; and

(iii) to endeavour to satisfy the common objectives of the parties on relation to the provision of this document which is held to be an unlawful fetter to the extent that it is possible having regard to the relevant court judgment.

(b) Where the Law permits Council to contract out of a provision of that Law or gives Council power to exercise a Discretion, then if Council has in this document contracted out of a provision or exercised a Discretion under this document, then to the extent of this document is not to be taken to be inconsistent with the Law.

11.4 No Obligations

Nothing in this document will be deemed to impose any obligation on Council to exercise any of its functions under the Act in relation to the Development Consent, the Land or the Development in a certain manner.

12. Confidentiality

12.1 Document not Confidential

The terms of this document are not confidential, and this document may be treated as a public document and exhibited or reported without restriction by any party.

13. GST

13.1 Definitions

In this clause 14 the terms 'Taxable Supply', 'GST', 'Tax Invoice' and 'Input Tax Credit' have the meaning given to them in the GST Law.

13.2 Supply Expressed in Terms of Money

If any party reasonably believes that it is liable to pay GST on a supply expressed in terms of money (or where the consideration for the supply is expressed in terms of money) and made to the other party under this document and the supply was not expressed to include GST, then:

a) The recipient of the supply must pay an amount equal to the GST on that supply to the other party;

b) The party making the supply will issue a Tax Invoice to the other party; and

c) The recipient of the supply will pay the amount of the GST to the supplier within fifteen (15) days of receiving the Tax Invoice.

13.3 Expenses and Costs Incurred

If any expenses or costs incurred by one party are required to be reimbursed by the other party under this document, then the amount of the reimbursement will be calculated as follows:

a) The amount of the cost or expense incurred by the party seeking reimbursement will be initially calculated excluding any Input Tax Credit to which that party is entitled to claim.

b) This amount initially calculated will be increased by the applicable rate of GST to equal a GST inclusive reimbursement amount and this amount will be paid by the party liable to make the reimbursement.

c) The party being reimbursed will issue a Tax Invoice to the other at the GST Inclusive reimbursement amount prior to being reimbursed.

13.4 Survival of Clause

This clause 12 continues to apply after the expiration or termination of this agreement.

14. Legal Costs

The Developer must pay Council's legal costs and disbursements with respect to the preparation, negotiation, formation and implementation of this document.

15. Administrative Provisions

15.1 Notices

(a) Any notice, consent or other communication under this document must be in writing and signed by or on behalf of the person giving it, addressed to the person to whom it is to begiven and:

(i) delivered to that person's address;

(ii) sent by pre-paid mail to that person's address; or

(iii) sent by email to that person's email address.

(b) A notice given to a person in accordance with this clause is treated as having been givenand received:

(i) if delivered to a person's address, on the day of delivery if a business day,otherwise on the next business day;

(ii) if sent by pre-paid mail, on the third business day after posting; and

(iii) if sent by email to a person's email address and a conformation of receipt can be retrieved, on the day it was sent if a business day, otherwise on the next business day.

(c) For the purpose of this clause the address of a person is the address set out in this document or another address of which that person may from time to time give notice toeach other person.

15.2 Entire Agreement

This document is the entire agreement of the parties on the subject matter. All representations, communications and prior agreements in relation to the subject matter are merged in and superseded by this document.

15.3 Variation

a) Any variation of this document shall be of no effect unless in writing signed on behalf of the Council and the Developer.

b) The parties agree to negotiate any variation that may become necessary to this document as a consequence of any modification to the Development Consent

15.4 Waiver

The non-exercise of or delay in exercising any power or right of party does not operate as a waiver of that power or right, nor does any single exercise or a power or right preclude any otheror further exercise of it or the exercise of any other power or right. A power or right may only bewaived in writing, signed by the parties to be bound by the waiver.

15.5 Counterparts

This document may be executed in any number of counterparts and all of those counterpartstaken together constitute one and the same instrument.

15.6 Unenforceability

Any provision of this document which is invalid or unenforceable in any jurisdiction is to be readdown for the purposes of that jurisdiction, if possible, so as to be valid or enforceable, and is otherwise capable of being severed to the extent of the invalidity or enforceability, without affecting the remaining provisions of this document or affecting the validity or enforceability of that provision in any other jurisdiction.

15.7 Power of Attorney

Each attorney who executes this document on behalf of a party declares that the attorney has no notice of:

(a) the revocation or suspension of the power of attorney by the granter; or

(b) the death of the grantor.

15.8 Governing Law

The law in force in the State of New South Wales governs this document. The parties:

a) submit to the exclusive jurisdiction of the courts of New South Wales and any courts that may hear appeal from those courts in respect of any proceedings in connection with this document; and

b) may not seek to have any proceedings removed from the jurisdiction of New South Wales on the grounds of forum non conveniens.

SCHEDULE 1

REQUIREMENTS UNDER SECTION S7.4 OF THE ACT

REQUIREMENT UNDER THE ACT	THIS PLANNING AGREEMENT
Planning Instrument and/ or Development Application – (Section 7.4(1)) The Developer has: a) sought a change to an environmental planning agreement; b) made, or proposes to make, a Development Application; and / or c) entered into an agreement with, or is otherwise associated with, a person to whom paragraph (a) or (b) applies.	 a) Not Applicable b) Yes c) Not Applicable
Description of land to which this agreement applies – (Section 7.4(3)(a))	See Clause 2.13 of this Planning Agreement
Description of change to the environmental planning instrument to which this agreement applies – (Section 7.4(3)(b))	Not Applicable
Application of Section 7.11 of the Act – (Section 7.4(d))	Not Applicable
Application of Section 7.12 of the Act – (Section 7.4(d))	Not Excluded
Consideration of benefits under this agreement if S7.11 applies – Section 7.4(3)(e))	Not Applicable
Mechanism for Dispute resolution – (Section 7.4(3)(f))	Refer to Clause 10 of the Planning Agreement
Enforcement of this Agreement – (Section 7.4(3)(g))	Refer to Clause 9 of the Planning Agreement
Registration of the Planning Agreement – (Section 7.6)	Refer to Clause 7 of the Planning Agreement
No obligation to grant consent or exercise functions – (Section 7.4(9))	Refer to Clause 11 of the Planning Agreement

SCHEDULE 2

YASS VALLEY COUNCIL & WINJARRA PTY LIMITED VOLUNTARY PLANNING AGREEMENT EXPLANATORY NOTES

These explanatory notes have been prepared in accordance with Clause 25E *Environmental Planning & Assessment Regulation 2000.*

1. Objective

The objective of the Voluntary Planning Agreement is to provide a contribution to Council in lieu of the Yass Valley Council Heavy Haulage Contributions Plan 2006 whilst recognising the recently adopted Yass Valley Heavy Haulage Contributions Plan 2021 in relation to the development application for quarry rehabilitation at Lot 2 DP1277698 1170 Murrumbateman Road, NANIMA NSW 2582.

It should be noted this development application was lodged prior to the adoption of Yass Valley Heavy Haulage Contributions Plan 2021 and therefore assessed under Yass Valley Council Heavy Haulage Contributions Plan 2006.

2. Nature of the Voluntary Planning Agreement

The Voluntary Planning Agreement sets the parameters for providing Council a contribution for the Yass Valley Council Heavy Haulage Contributions Plan 2006 whilst recognising the recently adopted Yass Valley Heavy Haulage Contributions Plan 2021.

3. Effect of the Voluntary Planning Agreement

The Voluntary Planning Agreement provides for the payment of Heavy Haulage Contributions.

4. Merits

The merits of the Voluntary Agreement are to:

- Give effect to the Council resolution to agree to the Heavy Haulage Contributions amount.

a) How the Voluntary Planning Agreement promotes the public interest

In accordance with Section 7.4 (2) *Environmental Planning & Assessment Act 1979* the Voluntary Planning Agreement promotes the public interest by providing a mechanism by which Council have the mechanism to share the provision of public amenities generated by the payment of Contributions.

b) How the Voluntary Planning Agreement promotes elements of the Council's Charter

In accordance with Section 8 *Local Government Act 1993* the Voluntary Planning Agreement promoted the Council's Charter by managing land and other assets so that the current and future local community needs can be met in an affordable way without being financially disadvantaged.

c) How the Voluntary Planning Agreement promotes the objects of the Act

The Voluntary Planning Agreement promotes the objects of the Act by ensuring that the quarry rehabilitation promotes the orderly and economic use and development of the land, promoting good design and amenity of the built environment.

The Voluntary Planning Agreement promoted the objects of the Act by ensuring that the development contributions *to offset the accelerated decline in service life of roads caused by additional traffic movement on Council roads associated with Heavy Haulage operations* are paid and appropriately indexed.

d) The impact of the Voluntary Planning Agreement on the public or any section of the public

The Voluntary Planning Agreement is not anticipated to have a negative impact on the public or any section of the public.

e) Whether the Voluntary Planning Agreement conforms with Council's capital works program

The Voluntary Planning Agreement will not affect Council's capital works program until such time as the contributions are received. Council allocates development contributions to capital works as part of its annual capital works program.

f) The planning purpose or purposes of the Voluntary Planning Agreement

The purpose of the Voluntary Planning Agreement is to provide an agreement between both parties for the payment of Heavy Haulage Contributions and ensure they are appropriately indexed for the provision offsetting the decline of public infrastructure caused by additional traffic movement on Council roads associated with Heavy Haulage operations.

g) Compliance of certain requirements prior to the issue

There are no requirements for the developer to pay contributions prior to the issue of any Part 4A Certificate as the Agreement will not become effective until such time as the Completion of Works and a *'Final Project Report'* submitted to Council.

SCHEDULE 3

MONETARY CONTRIBUTION

CONTRIBUTION	TIME FOR PAYMENT	PUBLIC PURPOSE
Monetary Contribution Forty-one thousand one hundred and fifty dollars and ninety-eight cents. ($41,150.98)	Payment of the Heavy Haulage Contribution is to occur upon *'Completion of Works'* and the submission of a *'Final Project Report'* to Council.	*The Heavy Haulage Contributions will offset the accelerated decline in service life of roads caused by additional traffic movement on Council roads associated with Heavy Haulage operations:* *The public amenities and services covered by the Yass Valley Council Heavy Haulage Plan include the following:* • *Pavement damage to Council managed roads caused by Heavy Haulage operations associated with developments throughout the LGA.* • *The upgrade and augmentation of Council managed roads to operate safely as Heavy Haulage routes.*

SCHEDULE 4

SIGNING PAGE

EXECUTED as a deed

EXECUTED by **CHRIS BERRY** on behalf of the **YASS VALLEY COUNCIL** pursuant to a resolution dated XXXXXXXX

In the presence of

SIGNATURE OF CHRIS BERRY
GENERAL MANAGER

SIGNATURE OF WITNESS

NAME OF WITNESS

EXECUTED by **WINJARRA PTY LIMITED (ABN 38 106 134 150)** in accordance with Section 127 of the Corporations Act 2001

SIGNATURE OF SUSANNE BAUER
SOLE DIRECTOR/ COMPANY SECRETARY

Draft Conditions DA200151

Definitions for the purposes of this Development Consent:

"Virgin excavated natural material" (VENM) is as defined in the Protection of the Environment Operations Act 1997:

"natural material (such as clay, gravel, sand, soil or rock fines):

- that has been excavated or quarried from areas that are not contaminated with manufactured chemicals or process residues, as a result of industrial, commercial, mining or agricultural activities, and
- that does not contain any sulfidic ores or soils or any other waste."

"Excavated natural material" (ENM) is as defined in the Protection of the Environment Operations (Waste) Regulation 2014 – Excavated Natural Material Resource Recovery Exemption 2014:

"naturally occurring rock and soil (including but not limited to materials such as sandstone, shale, clay and soil) that has:

(a) been excavated from the ground, and
(b) contains at least 98% (by weight) natural material, and
(c) does not meet the definition of Virgin Excavated Natural Material in the Act.

Excavated natural material does not include material located in a hotspot; that has been processed; or that contains asbestos, Acid Sulfate Soils (ASS), Potential Acid Sulfate soils (PASS) or sulfidic ores."

Part A General Conditions

(1) Consent is granted generally in accordance with the plan(s) and details submitted to Council with the Development Application. The plan and details have been stamped and attached to this consent. The development shall be carried out in accordance with the stamped plans or as modified by these conditions;

(2) This approval relates only to the development referred to in the development application and specifically does not amount to an approval or acceptance by the Council of any works or buildings already erected on the land, whether or not those works or buildings are the subject of a prior development or building approval;

(3) The Applicant shall limit the total volume of virgin excavated natural material (VENM) or excavated natural material (ENM) imported onto the site as fill to a maximum of 38,150m^3;

A modification of consent is required to be lodged with Council if the total volume of virgin excavated natural material (VENM) or excavated natural material (ENM) imported onto the site exceeds 38,150m^3.

(4) The capacity and effectiveness of runoff and erosion control measures shall be maintained at all times to the satisfaction of Council;

(5) Dust, noise and odour emissions from the proposed development must comply with the provisions of the Protection of the Environment Operations Act 1997;

(6) The applicant, at no cost to Council or Transport for NSW (TfNSW), will assume accountability for site cleanup and remediation measures in the event that material other than virgin excavated natural material (VENM) or excavated natural material (ENM) has been used;

(7) All engineering design and construction work must be undertaken in accordance with the following, current at the time of Development Consent being issued:

- Council's Road Standards Policy RD-POL-09
- Council's Design and Construction Specification – AUS-SPEC #1
- Australian Standards and;
- AustRoads

(8) All adjustments to existing utility services whether caused directly or indirectly by this proposed development are to be undertaken at the developer's expense.

(9) Should any Aboriginal sites or objects be unearthed during works associated with the subdivision, all work must cease and the Heritage NSW is to be contacted immediately.

(10) The haulage operations are to be restricted and shall not occur during school bus pick-up and drop off operating times.

(11) Haulage operations for all heavy haulage activities associated with the development shall be restricted to Barton Highway to Murrumbateman Road. No other road shall be used for the haulage of material associated with this development.

(12) Appropriate vehicle hygiene shall be maintained. Vehicles and machinery entering the site shall be clean of weed seed or propagules.

(13) Only sterile materials such as hessian/jute or rice straw shall be used for soil stabilisation or similar purposes.

(14) High threat weeds shall be prevented from establishing on newly revegetated areas and access tracks.

(15) The proponent shall maintain accurate records of imported fill quantities and traffic movement to and from the subject site. These records shall be kept on site and be available for inspection at the request of either of the Consent Authority or Transport for NSW.

Part B Prior to the issue of s138 Roads Act Approval

(16) Engineering drawings for upgrading access to the site and BAL/BAR treatment shall be submitted to Council's Infrastructure and Assets Division for approval in accordance with:

- Council's Roads Standards Policy RD-POL-09 and
- Council's Design and Construction Specification – AUS-SPEC #1.
- Australian Standards and;

- AustRoads

All accesses (entry and exit) shall be appropriately designed to suit the expected vehicles that will or expected to use the site.

Note: All costs associated with the property access and BAL/BAR treatment shall be the responsibility of the Applicant.

(17) A Design Certification Report relating to the detailed engineering design work shall be submitted to Council as per Council's Design Specification - AusSpec #1, Annexure DQS-A.

Note: This Design Report shall provide evidence that suitably qualified designers have designed each component of the engineering works for the development

(18) Any contractor undertaking works in an existing Council road reserve must submit the following details to Council:

- A current public liability certificate with a minimum cover of $20 million
- Current plant / vehicle insurances
- A certified traffic control plan for the proposed works

Note: No work within the road reserve of a classified road is to be undertaken until approval from TfNSW is received.

Part C Before the Commencement of Works

Prior to the Commencement of any Works

(19) The Applicant must nominate a suitably qualified and experienced person to the satisfaction of the Council (and with appropriate knowledge of soil conservation practices) who will be responsible for the day to day environmental management of the site and provide liaison between the Applicant and all relevant government agencies including Yass Valley Council;

(20) Appropriate soil erosion and sediment control measures must be installed.

(21) A sign shall be displayed in a prominent position on the boundary of the site and must be maintained while filling work is being carried out.

The sign must list the following details:

- The name of the person who will be responsible for the day to day management of the site and an afterhours telephone number;
- That unauthorised entry to the site is prohibited; and
- The Development Consent Number;

Prior to Importation of Any Material

(22) The Applicant must enter into a Voluntary Planning Agreement (VPA) with Council for the payment of heavy haulage development contributions in respect of road maintenance.

The terms of the Voluntary Planning Agreement must include:

- That the contribution amount is $41,150.98

- The applicable contribution rate is to be indexed in accordance with Section 4.4 of the *Yass Valley Heavy Haulage Development Contributions Plan 2021*.
- All contributions must be paid at the rate determined at the most recent review

(23) A transport management plan that outlines the measures to manage potential traffic related issues associated with the transport of bulk material shall be submitted to Council for approval. The transport management plan must address:

- The number of haulage vehicles used to transport fill to the site shall not exceed 8 vehicle trips per day.
- Measures for managing delivery of fill material to the site in order to minimise potential for disruption to local traffic including school bus movements.
- Measures to address restrictions on haulage during periods of low visibility e.g., heavy rain periods or fog etc., along the haulage route,
- Measures to ensure that dust and loose surface road material generated by traffic activities on and accessing the subject site do not cause nuisance or hazard to traffic on the public road network
- Measures to ensure that all loaded vehicles entering or leaving the site are covered, and are cleaned of materials that may fall onto public roads
- Expected driver behaviour and speed limits.
- Points of potential conflict, including concealed driveways on the transport route.
- Details of procedures for receiving and addressing complaints from the community
- Use of airbrakes.
- Measures to ensure that the provisions of the Traffic Management Plan are implemented and complied with.
- Movements must occur between 9:00am and 4:00pm Monday to Friday only, excluding NSW/ACT public holidays.
- Haulage operations shall not occur during school bus pick-up and drop off operating times
- Heavy vehicles associated with this development must have a clear marking indicating that they are transporting material associated with this Development Consent.

(24) A survey plan(s) showing the existing levels and the proposed levels for areas of filling shall be submitted. The survey plan must include a confirmation of the volume of material required to complete the work.

(25) A detailed revegetation plan prepared by a suitably qualified and experienced person shall be submitted to Council for approval. Local native species (recommended in the submitted Ecological Impact Assessment prepared by Capital Ecology Pty Ltd dated 19 July 2021) in all strata shall be used for landscaping.

Where practicable, a diversity in strata shall be established (i.e. groundcover grasses and forbs, midstorey shrubs, and canopy trees) to increase habitat complexity encouraging small woodland birds to visit the site.

The revegetation plan must include:

- Details of the species, health, life expectancy and structural stability of trees within the area proposed for rehabilitation and filling.
- The measures to protect these trees throughout the development, including in relation to impacts associated with fill, vehicles and earthmoving machinery, etc.

- Any recommendations for measures necessary to ensure the ongoing health of the trees/vegetation.

(26) Truck Entering' (W5-22C) signs must be installed, at all times whilst trucks are entering and exiting the site, on the approaches to the development site warning motorists along Murrumbateman Road of heavy vehicles;

(27) The vehicular access to the site and BAL/BAR treatment works must be carried out to improve the road safety in accordance with Council's Road Standards Policy RD-POL-09, Council's Design and Construction Specification – AUS-SPEC #1, Australian Standards and AustRoads requirements, and the approved engineering design drawings.

(28) 'Measures shall be applied, to the satisfaction of Council, to prevent site vehicles tracking sediment and other pollutants onto any sealed roads serving the development.

(29) A copy of the dust management protocol must be submitted to Council.

Part D While works are being carried out

Environmental Heritage

(30) If an Archaeology object is discovered during the course of work:

(a) All work must stop immediately and

(b) The *Department of Planning, Industry and Environment* must be advised of the discovery.

Depending on the significance of the object, an archaeological assessment and excavation permit issued under the *Heritage Act 1997*, may be required before work can continue

(31) If an Aboriginal object (including evidence of habitation or remains) is discovered during the course of work:

(a) All must stop immediately and

(b) The *Department of Planning, and Environment* must be advised of the discovery in accordance with s.89A *National Parks and Wildlife Act 1974*.

Depending on the nature of the discovery, an Aboriginal Heritage Impact Permit issued under the *National Parks and Wildlife Act 1974,* may be required before work can continue.

Earthworks & Importation of Material

(32) Material imported to the site for the construction of the proposed development must be suitable for the proposed application/fit for purposes and:

(a) Sourced from a suitably licenced facility (i.e. landscaping supplies or quarry operation); or

(b) Virgin Excavated Natural Material (VENM) as defined in the Protection of the Environment Operations Act 1997;

(c) Excavated Natural Material (ENM) as defined in the Protection of the Environment Operations (Waste) Regulation 2014 – Excavated Natural Material Resource Recovery Exemption 2014:

The document titled *Certification: Virgin excavated natural material* as published by the *Environmental Protection Authority* in September 2013 is considered a suitable form of certification to achieve compliance with this condition for VENM.

The use of ENM must be in accordance with the requirements of the Protection of the Environment Operations (Waste) Regulation 2014 – Excavated Natural Material Resource Recovery Exemption 2014 and Protection of the Environment Operations (Waste) Regulation 2014 – Excavated Natural Material Resource Recovery Order 2014 (as modified or superseded);

(33) Heavy vehicle movements associated with the delivery of material to the site on the local road network are restricted as follows:

(a) A maximum of eight (8) movements per day (1 movement = in and out of the site);
(b) No movements on Saturday and Sundays or NSW/ACT public holidays;
(c) Movements must occur between 9:00am and 4:00pm Monday to Friday;
(d) Haulage operations shall not occur during school bus pick-up and drop off operating times

(34) A ' Fill Delivery Record' shall be established and must record:

- The source address of the fill;
- Whether the fill has been certified as VENM or ENM;
- The volume of material delivered;
- The name, contact details, and organisation or affiliation of the person delivering the material;
- Vehicle registration;
- The date of delivery.

(35) A copy of the 'Fill Delivery Record' shall be submitted to Council upon request within seven (7) days, including a copy of all record sheets and a spreadsheet in a Microsft Excel (.xls) format with all record lines entered and tabulated.

(36) Heavy vehicles associated with this development shall have a clear marking indicating that they are transporting material associated with this Development Consent.

(37) The designated haulage route for the importation of fill must be:

- Canberra to Barton Highway
- Barton Highway to Murrumbateman Road

Progress Reports

(38) A project status report shall be submitted to Council every six (6) months from the date of commencement until the date of completion. The project status report must include as a minimum:

(a) The date on which the project status report relates.

(b) Evidence classifying the material used in the cell as being virgin excavated natural material (VNEM) or excavated natural material (ENM).

(c) A copy of the 'Fill Delivery Record', including a copy of all record sheets and a spreadsheet in a Microsft Excel (.xls) format with all record lines entered and tabulated.

(d) A copy of the 'Complaints Register'.

(e) A statement from the site's environmental manager confirming that the work has been undertaken in accordance with the Quarry Rehabilitation Plan Version 2 dated 3 June 2020.

(39) A survey plan(s) where filling has occurred shall be submitted to Council at six months from the commencement of work, or at importation of approximately 10,000m^3 of VENM/ENM, whichever occurs first. The survey plans must include a confirmation of the volume of material that has been imported, and the volume of material still required to complete the work.

Inspections

To arrange an inspection with Council please use the on-line booking system on Council's website: yassvalley.nsw.gov.au > Our Services > Planning and Building > Certification and Inspections > Inspections.

(40) A compliance certificate must be obtained from Council's Infrastructure and Assets Division at the following stages of construction:

(a) Completion of sub-grade pavement layer for BAL and BAR (proof roll);
(b) Completion of base course pavement layer for BAR and BAL (proof roll);
(c) Completion of two-coat bitumen seal;
(d) Completion of property accesses. This inspection is for access dimensions and to ensure there are no 'trip-fall' hazards. Compliance with change in longitudinal grade will only be undertaken where it can be confirmed via WAE drawings;

Part E Completion of works

(41) The development will not be considered completed until all conditions of this consent have been complied with in accordance with the provisions of the *Environmental Planning and Assessment Act 1979* and *Environmental Planning and Assessment Regulation 2000*.

(42) The developer must restore, replace or reconstruct any damage caused to road pavements, surfaces, street furniture, roadside drainage, street lighting or underground facilities as a result of the development.

(43) A final project report must be submitted to Council and must include as a minimum:

(a) The dates between which work was commenced and completed.

(b) Evidence classifying the material used in the cell as being virgin excavated natural material (VNEM) or excavated natural material (ENM).

(c) A copy of the 'Fill Delivery Record', including a copy of all record sheets and a spreadsheet in a Microsoft Excel (.xls) format with all record lines entered and tabulated.

(d) A copy of the 'Complaints Register'.

(e) A statement from someone with appropriate qualification and knowledge of soil conservation practices confirming that the work has been completed in accordance with the Quarry Rehabilitation Plan.

(f) A survey plan(s) where filling has occurred providing confirmation of the volume of material that has been imported.

(44) All terms of the Voluntary Planning Agreement associated with the payment of heavy haulage development contributions must be satisfied.

Advisory Notes Accompanying Development Consent DA200151

(Please read these notes carefully to ensure you are fully conversant with the conditions under which this consent is granted.)

(1) This consent has been granted under clause 6.1 of the *Yass Valley Local Environmental Plan 2013*.

(2) All fees and charges associated with this consent shall be adjusted annually from the date of this consent in accordance with seasonal movements in the CPI for the Canberra region.

(3) Any additional Council inspection, beyond the scope of any Compliance Certificate package and needed to verify the compliance of any work, shall be charged at the individual inspection rate nominated in Council's Fees and Charges Schedule.

(5) The applicant shall ensure all sub-contractors are licensed by the NSW Department of Fair Trading.

(6) The *Work Health and Safety Act 2011*, the *Work Health and Safety Regulation 2011* and various Australian Standards provide a comprehensive set of risk control measures and procedures for development sites which cover all types of risk. This legislation is administered by WorkCover New South Wales which has produced a variety of guidelines and other supporting documents for the information of developers.

All persons undertaking work in connection with this consent should ensure that all required risk control measures and procedures are complied with.

a) Council Investments as at 30 April, 2022

Investment Type	Market Value $	Credit rating	Date Lodged	Maturity date	Term (Days)	Rate
Cash Working Accounts						
NAB Working Account[1]	4,497,830.32	A1/AA	n/a	n/a	at call	0.25%
Tcorp Strategic Cash Facility[2]	4,838,696.72	unrated	n/a	n/a	at call	-0.55%
	9,336,527.04					
Term Deposits < 12 Months						
NAB	2,700,000.00	A1/AA	25/04/22	23/08/22	120	1.00%
NAB	2,000,000.00	A1/AA	28/04/22	27/07/22	90	1.05%
NAB	1,000,000.00	A1/AA	08/03/22	05/09/22	181	0.65%
BOQ	1,400,000.00	A2/BBB	31/03/22	24/02/23	330	1.25%
AMP	2,000,000.00	A2/BBB	05/08/21	05/07/22	334	0.75%
AMP	2,000,000.00	A2/BBB	01/12/21	31/10/22	334	1.00%
AMP	1,000,000.00	A2/BBB	11/01/22	12/12/22	335	1.10%
AMP	1,000,000.00	A2/BBB	28/01/22	29/07/22	182	1.00%
JUDO Bank	1,500,000.00	A3/BBB-	06/09/21	06/09/22	365	0.80%
Macquarie	1,000,000.00	A1/A+	03/11/21	03/11/22	365	0.50%
Macquarie	1,000,000.00	A1/A+	08/03/22	06/09/22	182	0.65%
CBA	2,100,000.00	A1/AA	26/04/22	27/01/23	276	2.12%
CBA	2,000,000.00	A1/AA	26/11/21	25/05/22	180	0.40%
CBA	2,000,000.00	A1/AA	07/02/22	07/02/23	365	0.76%
CBA	1,000,000.00	A1/AA	07/02/22	05/10/22	240	0.50%
MyState	1,500,000.00	A2/BBB	10/03/22	10/03/23	365	1.05%
	25,200,000.00					
Total Short Term	**34,536,527.04**					
Investment Property						
Hawthorn - Current Fair Value	4,350,000.00	Revalued March 2020				

1. The NAB account balance shown above includes deposits at month end not processed to Council's Financial system and excludes cheques that have not been presented.
2. Tcorp Strategic Cash Facility is an allowable investment under the Ministerial Order.

b) Investment Exposure by Credit Rating Type

S&P Rating (or equivalent)	Policy Maximum %	Current Exposure %	Current Investment $
A1+ / AAA	100%	0.00%	-
A1 / AA	100%	55.88%	19,297,830.32
A2 / BBB	60%	25.77%	8,900,000.00
A3 / BBB	30%	4.34%	1,500,000.00
Unrated / TCorp Facility	30%	14.01%	4,838,696.72

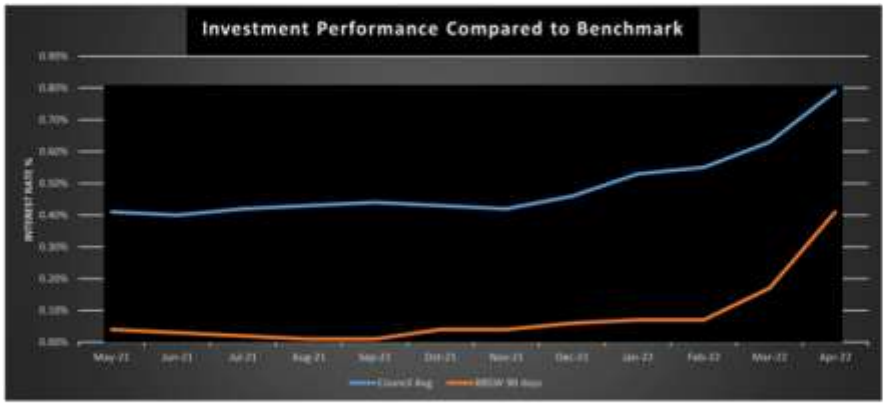
c) Exposure to a Single Institution

Institution	S&P Rating	Policy Maximum %	Current Exposure %	Current Investment $
NAB	A1/AA	50%	29.53%	10,197,830.32
AMP	A2/BBB	30%	17.37%	6,000,000.00
IMB	A3	30%	0.00%	-
CBA	A1/AA	50%	20.56%	7,100,000.00
BOQ	A2/BBB	30%	4.05%	1,400,000.00
Macquarie	A1/A+	50%	5.79%	2,000,000.00
Judo Bank	A3/BBB-	30%	4.34%	1,500,000.00
ME	BBB	30%	0.00%	-
Bendigo	BBB	30%	0.00%	-
Illawarra Credit Union	unrated	10%	0.00%	-
MyState	A2/BBB	30%	4.34%	1,500,000.00
TCorp	unrated	30%	14.01%	4,838,696.72

d) Investment Portfolio Performance UBS 90 day bank bill index

Investment Performance vs Benchmark

	Investment Portfolio return (%pa)	Benchmark: BBSW 90 day Bank Bill Index (source RBA)
1 month average	0.79%	0.41%
3 month average	0.66%	0.22%
6 month average	0.56%	0.14%
12 month average	0.49%	0.08%



Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Report by Responsible Accounting Officer

The following statement is made in accordance with Clause 203(2) of the Local Government (General) Regulations 2005:

31 March 2022

It is my opinion that the Quarterly Budget Review Statement for Yass Valley Council for the quarter ended 31/03/22 indicates that Council's projected financial position at 30/6/22 will be satisfactory at year end, having regard to the projected estimates of income and expenditure and the original budgeted income and expenditure.

Signed: _____ **Date:** 14/05/2022

Tracy Sligar
Responsible Accounting Officer

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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Income & Expenses Budget Review Statement

Budget review for the quarter ended 31 March 2022
Income & Expenses - Council Consolidated

($000's)	Original Budget 2021/22	Approved Changes: Carry Forwards	Approved Changes: Other than by QBRS	Approved Changes: Sep QBRS	Approved Changes: Dec QBRS	Approved Changes: Mar QBRS	Revised Budget 2021/22	Variations for this Mar Qtr	Notes	Projected Year End Result	Actual YTD figures
Income											
Rates and Annual Charges	18,472				222		18,694	18	1	18,712	18,736
User Charges and Fees	6,571				163		6,734	14	2	6,748	3,612
Interest and Investment Revenues	230				-		230			230	91
Other Revenues	456				(128)		328			328	265
Grants & Contributions - Operating	5,189			(203)	618		5,604	(4)	3	5,600	2,833
Grants & Contributions - Capital	11,670		5,487	700	1,330		19,187	(5,097)	4	14,090	10,356
Net gain from disposal of assets	458				-		458	(145)	5	313	175
Other income	383				-		383			383	289
Total Income from Continuing Operations	**43,429**	**-**	**5,487**	**497**	**2,205**	**-**	**51,618**	**(5,214)**		**46,404**	**36,357**
Expenses											
Employee Costs	13,118		50	55	(358)		12,865	(277)	6	12,588	8,989
Borrowing Costs	1,181				(1)		1,180	7	7	1,187	577
Materials & Services	10,437	285	(27)	(176)	603		11,122	320	8	11,442	6,326
Depreciation	6,006				-		6,006	76	9	6,082	-
Other Expenses	985	14			(165)		834			834	602
Total Expenses from Continuing Operations	**31,727**	**299**	**23**	**(121)**	**79**	**-**	**32,007**	**126**		**32,133**	**16,494**
Net Operating Result from Continuing Operation	**11,702**	**(299)**	**5,464**	**618**	**2,126**	**-**	**19,611**	**(5,340)**		**14,271**	**19,863**
Discontinued Operations - Surplus/(Deficit)							-			-	-
Net Operating Result from All Operations	**11,702**	**(299)**	**5,464**	**618**	**2,126**	**-**	**19,611**	**(5,340)**		**14,271**	**19,863**
Net Operating Result before Capital Items	**32**	**(299)**	**(23)**	**(82)**	**796**	**-**	**424**	**(243)**		**181**	**9,507**

This statement forms part of Council's Quarterly Budget Review Statement (QBRS) for the quarter ended 31/03/2022 and should be read in conjuction with the total QBRS report

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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Income & Expenses Budget Review Statement

Budget review for the quarter ended 31 March 2022
Income & Expenses - Council Consolidated

($000's)	Original Budget 2021/22	Approved Changes: Carry Forwards	Approved Changes: Other than by QBRS	Approved Changes: Sep QBRS	Approved Changes: Dec QBRS	Approved Changes: Mar QBRS	Revised Budget 2021/22	Variations for this Mar Qtr	Notes	Projected Year End Result	Actual YTD figures
Income											
Governance	-	-	-	-	-		-	-		-	-
Administration	15,714	-			50		15,764	(127)		15,637	13,467
Public Order & Safety	260	-			153		413			413	416
Health	144	-			164		308	16		324	227
Environment	3,910	-			82		3,992			3,992	3,788
Housing & Community Amenities	1,297	-		(3)	245		1,539	139		1,678	1,252
Water Supplies	4,844	-	2,543		73		7,460	(1,322)		6,138	3,233
Sewerage Services	2,491	-			75		2,566			2,566	2,491
Recreation & Culture	2,053	-			538		2,591	(1,645)		946	1,692
Transport & Communication	11,283	-	2,944	500	838		15,565	(2,255)		13,310	8,653
Economic Affairs	1,433	-			(13)		1,420	(20)		1,400	1,138
Total Income from Continuing Operations	**43,429**	**-**	**5,487**	**497**	**2,205**	**-**	**51,618**	**(5,214)**		**46,404**	**36,357**
Expenses											
Governance	370				-		370			370	107
Administration	5,586	194			(72)		5,708	78		5,786	2,792
Public Order & Safety	1,298				(50)		1,248			1,248	826
Health	913	10			96		1,019	(25)		994	639
Environment	3,541			55	11		3,607	5		3,612	2,042
Community Services & Education	-						-			-	-
Housing & Community Amenities	2,372	74		24	22		2,492	131		2,623	1,549
Water Supplies	4,216				2		4,218			4,218	1,836
Sewerage Services	1,931		24		19		1,974			1,974	792
Recreation & Culture	2,286				(15)		2,271	(26)		2,245	1,473
Transport & Communication	6,337			(200)	35		6,172	(22)		6,150	2,893
Economic Affairs	2,878	21			30		2,929	(16)		2,913	1,545
Total Expenses from Continuing Operations	**31,728**	**299**	**24**	**(121)**	**78**	**-**	**32,008**	**125**		**32,133**	**16,494**
Net Operating Result from Continuing Operation	**11,701**	**(299)**	**5,463**	**618**	**2,127**	**-**	**19,610**	**(5,339)**		**14,271**	**19,863**
Discontinued Operations - Surplus/(Deficit)	-	-	-	-	-	-	-	-		-	-
Net Operating Result from All Operations	**11,701**	**(299)**	**5,463**	**618**	**2,127**	**-**	**19,610**	**(5,339)**		**14,271**	**19,863**
Net Operating Result before Capital Items	**32**	**(299)**	**(23)**	**(82)**	**796**	**-**	424	**(243)**		181	**9,507**

This statement forms part of Council's Quarterly Budget Review Statement (QBRS) for the quarter ended 31/03/2022 and should be read in conjuction with the total QBRS report

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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Income & Expenses Budget Review Statement
Recommended changes to revised budget

Budget Variations being recommended include the following material items:

Notes	Details
1	Additional rates and charges income due to part year rating subdivisions.
2	Increased income has been received at the Library due to an increase in photocopying services being provided to the Community and book sales that have not occurred over the last few years. Additional income was received from dwelling entitlement searches on historic rates properties. These services are hard to predict.
3	This adjustment is a net effect of a number of changes to Operational Grant income. Council secured $20,000 from Local Land Services to provide roadside weed spraying. Unfortunately due to Council's inability to be able to deliver the nominated initiative under the Better Regulation Divison grant, Council will be required to repay these funds.
4	A budget reduction of $5.097m is a net result of a number of changes to Capital Grant income. Capital grant income and corresponding capital expenditure has been removed from the 21/22 budget and placed into the 22/23 budget. This has come about due to delays in completing or starting these projects due to COVID-19 and wet weather. The following grant income expected has been reduced and reallocated to next years budget: - $1,650,000 - NSW Public Spaces Legacy Program - $155,000 - Crown reserve Improvement Fund - $1,400,000 - Fixing Country Roads Round 4 - $800,000 - Bridge Renewal Program Round 5 - $200,000 - Building Better Regions Fund Round 3 - $200,000 - Fixing Local Roads Round 3 - $1,360,000 - Housing Acceleration Fund Council is bringing in additional grant funding to reflect funding received to comlete current projects: - $355,000 - School Zone Infrastructure grant - $144,560 - additional Regional Repair Program funding for projects started in 2020/21 and completed in 2021/22 - $38,000 funds from accessing a bank guarantee to finalise uncompleted works - $130,000 additional funding from Developer Contributions
5	This budget has been adjusted to reflect the timing of when plant will be sold. Items of plant have been identified as not being sold within this financual year so this budget has been adjusted to reflect that and a corresponding increase in this budget will be included in the 2022/23.
6	The budget for Employee costs has been reduced to reflect actual costs to date. The budget saved from vacant positions has been reallocated to Materials and Services to cover increased costs associated with contractors filling these roles.
7	Borrowing costs budget has been adjusted slightly to more accurately show the split between interest costs and a reduction to the debt liability.
8	The primary adjustment to Materials and Services is due to the additional costs associated with contractors filling vacant positions. These costs have been offset by savings in Employee costs budget line.
9	This budget was adjusted to more accurately reflect the depreciation associated with Right of Use assets.

Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Capital Budget Review Statement

Budget review for the quarter ended 31 March 2022
Capital Budget - Council Consolidated

($000's)	Original Budget 2021/22	Approved Changes: Carry Forwards	Approved Changes: Other than by QBRS	Approved Changes: Sep QBRS	Approved Changes: Dec QBRS	Approved Changes: Mar QBRS	Revised Budget 2021/22	Variations for this Mar Qtr	Notes	Projected Year End Result	Actual YTD figures
Capital Expenditure											
New Assets											
- Plant & Equipment	47	19	-	-	(20)		46	256	1	302	34
- Land & Buildings	198	1,637	55	-	465		2,355	(755)	2	1,600	1,381
- Roads, Bridges, Footpaths	1,000	942	1,847	(28)	1		3,762	348	3	4,110	1,557
- Stormwater	-	42	-	-			42	(33)	4	9	9
- Water Supply Network	1,112	128	2,593	-	68		3,901	(1,322)	5	2,579	642
- Sewerage Network	-	848	-	-	165		1,013	-		1,013	673
- Other Open Space / Recreational Assets	1,785	152	-	-	8		1,945	(1,650)	6	295	161
- Waste	60	19	-	-	8		87	-		87	85
Renewal Assets (Replacement)											
- Plant & Equipment	1,566	469	-	-	97		2,132	(821)	7	1,311	793
- Land & Buildings	15	290	-	-			305	(305)	8	-	-
- Roads, Bridges, Footpaths	9,755	5,383	1,921	693	(1)		17,751	(2,619)	9	15,132	8,637
- Stormwater	-	-	-	-			-	-		-	-
- Water Supply Network	760	903	-	-	(68)		1,595	-		1,595	252
- Sewerage Network	610	80	-	150	(165)		675	-		675	107
- Other Open Space / Recreational Assets	-	626	-	(6)	(12)		608	(209)	10	399	379
- Waste	-	480	-	-	(8)		472	-		472	-
Loan Repayments (Principal)	871						871	-		871	871
Total Capital Expenditure	**17,779**	**12,018**	**6,416**	**809**	**538**	**-**	**37,560**	**(7,110)**		**30,450**	**15,581**
Capital Funding											
Rates & Other Untied Funding	798	1,504					2,302	(108)		2,194	406
Capital Grants & Contributions	12,207		5,487	700	155		18,549	(6,357)		12,192	5,357
Reserves:											
- External Restrictions/Reserves	3,517	9,169	530	109			13,325	(1,133)		12,192	7,103
- Internal Restrictions/Reserves	799	1,345	399		383		2,926	633		3,559	2,540
New Loans							-			-	
Receipts from Sale of Assets											
- Plant & Equipment	458						458	(145)		313	175
Total Capital Funding	**17,779**	**12,018**	**6,416**	**809**	**538**	**-**	**37,560**	**(7,110)**		**30,450**	**15,581**
Net Capital Funding - Surplus/(Deficit)	-	-	-	-	-	-	-	-		-	-

This statement forms part of Council's Quarterly Budget Review Statement (QBRS) for the quarter ended 31/03/2022 and should be read in conjuction with the total QBRS report

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Capital Budget Review Statement
Recommended changes to revised budget

Budget Variations being recommended include the following material items:

Notes	Details
1	Additional funding has been required to cover the purchase of a Commercial Waste Truck. An adjustment has also been made to move costs into the 22/23 financial year due to delays in delivering projects because of COVID-19 and wet weather
2	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
3	The budget for new Roads, Bridges & Footpaths infrastructure is being increased to reflect work undertaken on the Safer Roads Program. This program is funded by a grant and as such the grant income budget associated with this will be increased.
4	This budget was reduced to reflect actual costs associated with Stormwater projects. Any remaining budget has been returned to the Stormwater reserve and general revenue as per the funding source for the original budget.
5	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
6	An adjustment has been made to this budget to reallocate the budget for the Adventure Playground at Riverbank Park to the 22/23 financial year, when the majority of this work will be undertaken.
7	An adjustment has been made to this budget due to delays in delivery of plant which will now occur in 22/23 Financial year.
8	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
9	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
10	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.

Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Cash & Investments Budget Review Statement

Budget review for the quarter ended 31 March 2022
Cash & Investments - Council Consolidated

($000's)	Opening Balance 2021/22	Approved Changes: Original Budget	Approved Changes: Carry Forward	Approved Changes: Other than by QBRS	Approved Changes: Sep QBRS	Approved Changes: Dec QBRS	Approved Changes: Mar QBRS	Revised Balance 2021/22	Variations for this Mar Qtr	Notes	Projected Year End Result	Actual YTD figures
Externally Restricted (1)												
Unexpended Grants	5,198	-	(5,054)		7	(25)		126	664	1	790	790
Water Supplies	3,726	(1,144)	(296)			14		2,300			2,300	2,300
Sewerage Services	4,056	345	(928)			43		3,516			3,516	3,516
Waste Management	2,711	474	(499)		(55)	41		2,672	(267)	2	2,405	2,405
Stormwater Management	231	58	(28)			27		288	19	3	307	307
S64 Water	3,002	-	(100)	(50)		56		2,908			2,908	2,908
S64 Sewer	1,082	-	-		(150)	14		946			946	946
Heavy Haulage	1,384	-	-					1,384	(15)	4	1,369	1,369
S7.11 Yass Valley Council Area	4,722	(33)	(2,293)	(480)		245		2,161	(20)	5	2,141	2,141
Total Externally Restricted	**26,112**	**(300)**	**(9,198)**	**(530)**	**(198)**	**415**	**-**	**16,301**	**381**		**16,682**	**16,682**
(1) Funds that must be spent for a specific purpose												
Internally Restricted (2)												
Plant & Vehicle Replacement	2,043	(381)	(410)			(77)		1,175	677	6	1,852	1,852
Employee Leave Entitlement	820	-	-					820			820	820
Binalong Pool	22	(10)	-					12			12	12
Comur Street Rehabilitation	20	-	-					20			20	20
Infrastructure	1,453	537	(701)	(344)		1,246		2,191	34	7	2,225	2,225
Local Government Elections	134	(130)						4			4	4
Murrumbateman S355	123	-	-					123			123	123
Quarry Rehabilitation	106	-	-					106			106	106
Roads	369	50	-					419			419	419
Victoria Park	621	(60)	(230)					331	245	8	576	576
Electricity Savings Reserve	97	-	-					97			97	97
General Revenue Carry Forward	1,777	-	(1,775)		6			8	521	9	529	529
Total Internally Restricted	**7,585**	**6**	**(3,116)**	**(344)**	**6**	**1,169**	**-**	**5,306**	**1,477**		**6,783**	**6,783**
(2) Funds that Council has earmarked for a specific purpose												
Unrestricted (ie. available after the above Restrictions)	57	294	12,314	874	192	(1,584)	-	12,147	(1,858)		10,289	10,091
Total Cash & Investments	**33,754**	**-**	**-**	**-**	**-**	**-**		**33,754**	**-**		**33,754**	**33,556**

This statement forms part of Council's Quarterly Budget Review Statement (QBRS) for the quarter ended 31/03/2022 and should be read in conjuction with the total QBRS report

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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Cash & Investments Budget Review Statement

Comment on Cash & Investments Position

Investments

Investments have been invested in accordance with Council's Investment Policy.

Cash

The Cash at Bank figure included in the Cash & Investment Statement totals $33,555,861

This Cash at Bank amount has been reconciled to Council's physical Bank Statements.
The date of completion of this bank reconciliation is 31/03/22

Reconciliation Status

The YTD Cash & Investment figure reconciles to the actual balances held as follows:	**$ 000's**
Cash at Bank (as per bank statements)	2,505
Investments on Hand	31,051
Reconciled Cash at Bank & Investments	33,556
Balance as per Review Statement:	33,556
Difference:	-

Recommended changes to revised budget

Budget Variations being recommended include the following material items:

Notes	Details
1	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
2	Additional funding from the Waste reserve is to be used to cover the purchase of a new Commercial Waste Truck
3	Unspent budget on Stormwater projects has been returned to the Stormwater reserve as per the original budget.
4	Funding has been sourced from the Developer Contributions Heavy Haulage reserve to cover costs associated with the renewal of the plan.
5	This budget adjustment is the net result of allocating additional Developer Contributions income received into the reserve and then utilising this reserve to fund additional works on Moreton Avenue.
6	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 plant will not be delivered until the next financial year.
7	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year. Some projects have been finalised and surplus funds are being returned to the reserve.

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Notes	Details
8	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.
9	An adjustment has been made to this budget to reallocate the budget to the 22/23 financial year. Due to delays associated with COVID-19 and wet weather, some projects will not be undertaken until the next financial year.

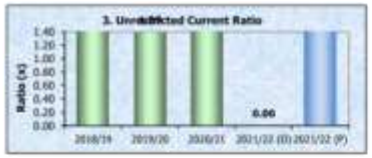
Yass Valley Council

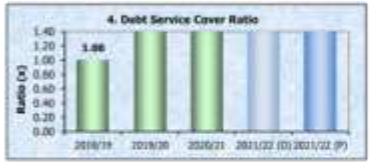
Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Key Performance Indicators Budget Review Statement - Industry KPI's (OLG)

Budget review for the quarter ended 31 March 2022

($000's)	Current Projection Amounts 21/22	Current Projection Indicator 21/22	Original Budget 21/22	Actuals Prior Periods 20/21	Actuals Prior Periods 19/20
NSW Local Government Industry Key Performance Indicators (OLG):					
1. Operating Performance					
Operating Revenue (excl. Capital) - Operating Expenses	- 132	-0.41 %	-1.36 %	-1.35 %	12.08 %
Operating Revenue (excl. Capital Grants & Contributions)	32,001				
This ratio benchmark is >0.0%. This result is currently projected at just under the benchmark, of -0.03%. This is a significant improvement from the original budget projection of -1.36% and shows council's commitment to improving this result.					
2. Own Source Operating Revenue					
Operating Revenue (excl. ALL Grants & Contributions)	26,401	57.3 %	60.77 %	51.50 %	60.23 %
Total Operating Revenue (incl. Capital Grants & Cont)	46,091				
This ratio is sitting below the bechmark primarily due to substantial grant income budgeted for.					
3. Unrestricted Current Ratio					
Current Assets less all External Restrictions	9,524	2.24	0.00	3.36	1.39
Current Liabilities less Specific Purpose Liabilities	4,260				
This ratio hasn't been calculated for the original budget. Council is sitting above the benchmark of >1.5 times. This is due to a reduction in our liabilities and external restrictions as work progresses through the year.					
NSW Local Government Industry Key Performance Indicators (OLG):					
4. Debt Service Cover Ratio					
Operating Result before Interest & Dep. exp (EBITDA)	7137	3.14	3.29	3.38	3.20
Principal Repayments + Borrowing Interest Costs	2275				
This ratio measures the availability of operating cash to service debt including interest, principal and lease payments. This result is sitting above the benchmark of 2.00x					





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Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Contracts Budget Review Statement

Budget review for the quarter ended 31 March 2022
Part A - Contracts Listing - contracts entered into during the quarter

Contractor	Contract detail & purpose	Contract Value	Start Date	Duration of Contract	Budgeted (Y/N)	Notes
Westrac Equipment Pty Ltd	Supply & Delivery 2x Backhoe loaders	411,385	28/01/22	one off supply	Y	
Ausroad Manufacturing Pty Ltd	Supply & Delivery of truck mounted road repair unit	521,957	25/03/22	one off supply	Y	
Electrical Design & Construction Pty Ltd	Yass WTP Stage 1 Upgrade Package 1 - Electrical & Mechanical Works	386,718	02/02/22	5 months	Y	
RCE Australia Pty Ltd	Yass WTP Stage 1 Upgrade Package 2 - Civil Works	664,340	02/02/22	5 months	Y	
Alliance Automation Group Pty Ltd	Yass WTP Stage 1 Upgrade Package 3 - Systems Integrator	78,688	02/02/22	5 months	Y	
Bucher Municipal Pty Ltd	Supply & Delivery of truck mounted road suction & broom sweeper	376,571	25/03/22	one off supply	Y	

Notes:

1. Minimum reporting level is 1% of estimated income from continuing operations of Council or $50,000 - whatever is the lesser.
2. Contracts listed are those entered into during the quarter being reported and exclude contractors on Council's Preferred Supplier list.
3. Contracts for employment are not required to be included.

Yass Valley Council

Quarterly Budget Review Statement
for the period 01/01/22 to 31/03/22

Consultancy & Legal Expenses Budget Review Statement

Consultancy & Legal Expenses Overview

Expense	YTD Expenditure (Actual Dollars)	Bugeted (Y/N)
Consultancies	61,448	Y
Legal Fees	65,375	Y

Definition of a consultant:

A consultant is a person or organisation engaged under contract on a temporary basis to provide recommendations or high level specialist or professional advice to assist decision making by management. Generally it is the advisory nature of the work that differentiates a consultant from other contractors.

Comments

Expenditure included in the above YTD figure but not budgeted includes:

Details

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Yass Valley Council Operational Projects 2021/22						
Project description	Total Budget	Mar 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Local Roads (Operational)	**120,000**	**97,976**	**22,024**			
Installation of minor matters identified via Traffic committee	20,000	138	19,862	1/07/2021	30/06/2022	Projects to be identified by RSO January to June 2022
Drainage - Hardwick Lane	50,000	97,002	- 47,002	1/11/2021	10/12/2022	Drainage work completed.
Gums Lane pavement repairs	50,000	836	49,164			
Recreational Assets (Operational)	**12,000**	**4,453**	**7,547**			
Key Replacement project Amenities buildings	5,000	4,453	547	1/11/2021	28/02/2022	To be installed by April 2022
Bookham Recreation Grounds toilet upgrade	7,000	-	7,000	1/12/2021	13/06/2022	Quotes received- works to be completed in March 2022
Swimming Pool	**15,000**	**12,555**	**2,445**			
Yass Pool Solar Blanket roller replacement	15,000	12,555	2,445	Oct-21	Oct-21	Complete
Property Management	**170,500**	**24,162**	**146,338**			
Goodradigbee Centre subdivision	38,500	-	38,500	1/12/2021	30/06/2022	jamie bush engaged to Survey and lodge Subdivision DA Start march 2022.
116 Laidlaw St subdivision & contamination report	72,000	24,149	47,851	1/10/2021	30/06/2022	subdivision plan lodged 9/11 /21 D&N Geotechnical under Contract YSS/ASS/03.2019 Starting March 2022to undertake contamination report
Yass Memorial Hall	43,071	13	43,058	1/07/2021	30/06/2022	Cultural Capital Grant EOI unsuccessful- ongoing searching for other grants
Yass memorial Hall - Grant funded	16,929	-	16,929			Not commenced
Water Supply Network	**88,000**	**19,122**	**68,878**			
Yass River Catchment Improvement	20,000	15,664	4,336			Will be completed by end Feb – two invoices expected
Yass Dam Riparian Vegetation Improvement	20,000	-	20,000			Not expected to be invoiced until late May when landholder reports are received.
New water connections	48,000	3,458	44,542			Depend on the customer applications for new water services. GL number for invoices to be verfied
Media & Communications	**5,000**	**2,273**	**2,727**			
Social Media Software	5,000	2,273	2,727		Jun-22	Website upgrade is in progress
Service, Information, Technology	**296,070**	**39,280**	**256,790**			
Magiq Enterprise into the Cloud	78,539	-	78,539			PO raised for commencement of this project
HRMS - ELMO	37,531	33,610	3,921			To be finalised in June
Network Switches	-	-	-			Part of this project was completed in 2021 using ICT Budget funds instead of project funds. This funding will be used to finish the FortiGate Firewalls for the Fibre to the Premises Project

Yass Valley Council Operational Projects 2021/22						
Project description	Total Budget	Mar 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Penetration test of YVC Network	-	-	-			Quotes being received from various vendors. Cyber Security NSW also has complimentary services on offer which are being investigated
Network Monitoring System	-	-	-			Options currently being evaluated
Modernise IT Systems	80,000	5,670	74,330			Upgrade to O365 and hardware purchases are underway
Yass Business Fibre Zone	100,000	-	100,000			In progress, following resolution to proceed at February Council Meeting
Customer Service	**50,000**	**20,205**	**29,795**			
Property File Digitisation	50,000	20,205	29,795			Purchase underway for new scanner to assist with this project
Governance	**30,000**	**1,880**	**28,120**			
Probity plan	30,000	1,880	28,120	1/07/2021	30/06/2022	MoU signed December 2021. Further probity work may be required as planning commences.
Planning & Administration	**12,000**	**8,880**	**3,120**			
Village Masterplan	12,000	8,880	3,120			Consultant appointed
Strategic Planning	**323,735**	**42,750**	**280,985**			
Crown Land Plan of Management	24,000	24,000	-			Vic Park Masterplan completed.
North Murrumbateman Masterplan	50,000	-	50,000			Brief being developed
Engineering Design Standards	50,000	-	50,000			Brief being developed
Yass Mainstreet Street Space Plan	80,000	-	80,000			Consultants appointed & background research underway
Yass Valley Open Space Strategy	65,000	18,750	46,250			Consultants appointed and first visit completed.
Settlement Strategy - Murrumbateman Land Investigation	54,735	-	54,735			Project management resource being considered.
	63,868	**39,157**	**24,711**			
Strategic Planning - Donations	63,868	39,157	24,711			$24,000 of this funding has been placed towards the AWW tourism promotion
Development Services	**39,686**	**29,332**	**10,354**			
Crago Mill Precinct Independent assessment	10,000	-	10,000			DA exhibition commenced
Planning Portal Projects	29,686	29,332	354			Testing underway
Public Health & Environment	**220,500**	**87,158**	**133,342**			
Monitor Gasworks site	30,000	-	30,000			Matter has been returned to I&A (Tony) for follow up - budget can be transferred back to I&A Asset Manager
Roadside Reserve Priority Weed Control	120,000	87,158	32,842			Weed spraying commenced - invoices for received to date (approx $82 K work done to date - invoice for approx $12K coming in during February)
Control of Weeds at Gundaroo Common	-	-	-			Not a grant to YVC - community grant
Control of Weeds at Lake George	30,000	-	30,000			work to be undertaken - to carry over to next FY - most likley in November - due to season
Serrated Tussock at Lake George	28,500	-	28,500			work to be undertaken - seasonal dependant

Yass Valley Council Operational Projects 2021/22						
Project description	Total Budget	Mar 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Control of St Johns Wort opposite Gilbert Grave	3,000	-	3,000			work to be undertaken - to carry over to next FY - most likley in November - due to season
Control of Blackberry at Yass Cemetery	3,000	-	3,000			work to be undertaken - to carry over to next FY - most likley in November - due to season
Control of Blackberry at Joe O'Connor Park	1,500	-	1,500			work to be undertaken - to carry over to next FY - most likley in November - due to season
Control of Weeds at Kangiara Cemetery	2,250	-	2,250			work to be undertaken - to carry over to next FY - most likley in November - due to season
Control of Weeds at Old Yass Tip	2,250	-	2,250			work to be undertaken - to carry over to next FY - most likley in November - due to season
	125,731	**84,918**	**40,813**			
Public Health & Environment - Contractors	125,731	84,918	40,813			Deed for funding signed off - payment from LLS for $ $117 988
Ranger Services	**15,000**	**1,667**	**13,333**			
Desexing Program - Companion Animals	5,000	1,667	3,333			Currently being advertised on Facebook - focussed on cats - 6 offers taken up to date (invoice for $100 to be received in February)
Plans for new Companion Animal Facility	10,000	-	10,000			RFQ on Tenderpanel - for reponse by 25 Feb 22 - 2 responses received and currently being assessed
Economic Development & Tourism	**32,712**	**8,176**	**24,536**			
Small Business Month	2,000	999	1,001	Mar-22	Mar-22	In progress: being used, with grant funds received for Small Buisness Month, for small business month
Mainstreet Lighting	21,084	862	20,222	Feb-22	Jun-22	This will be reviewed by Director Corporate & Community once the Maint Street Strategy is completed
Christmas Street Parade 2021	6,315	6,315	0		Dec-21	There was no 2021/22FY budget for this event. This project will have a budget allocation from 2022/23 onwards
Better Regulation Division Project - TBA	-	-	-			
Youth Week Grant	3,313		3,313			
Organisational Development	**53,104**	**8,218**	**44,886**			
Work Health and Safety Framework	53,104	8,218	44,886		Jun-22	Being used for EAP, Drug & Alcohol testing (commencing 1 April 2022), and calibration of breath alysers. Funding will be used for WHS consultants - Helpful solutions
Total	**1,672,906**	**532,160**	**1,140,746**			

Yass Valley Council Operational Projects 2021/22						
Project description	Total Budget	Mar 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Funding Source:						
General Revenue	730,964	171,539	559,425			
Grant	358,579	129,586	228,993			
Unexp Grants	80,645	69,606	11,039			
Water	88,000	19,122	68,878			
GR carry forward	264,218	54,010	210,208			
Infrastructure	135,500	28,740	106,760			
Victoria Park	15,000	12,555	2,445			
over budget unfunded		47,002	- 47,002			
	1,672,906	**532,160**	**1,140,746**			

Yass Valley Council Capital Works Program 2021/22						
Project description	Total Budget	March 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Local Roads	**17,139,991**	**9,694,960**	**7,445,031**			
Shingle Hill Way Bridge Replacement	1,918,378	763,216	1,155,162	Jul-21	Jun-22	Earthworks continuing on site and precast components commenced off site
Bango Bridge	177,748	440	177,308	Jul-21	Jun-22	Draft design approved, detailed design to commenced
Local Roads Resealing (including heavy patching)	-	14,335	(14,335)	Jul-21	Jun-22	As part of the 2nd Qtr review the actuals in this to be transferred and the income and expenditure budgets reduced to $0. As there is no availble funds from R2R to fund these works.
Winery Trail	1,891,694	1,287,325	604,369	Jul-21	Dec-21	Finalising last section of Murumbateman Road as well as clean up at other locations
Nanima Rd Rehabilitation	1,622,638	1,336,302	286,336	Jul-21	Dec-21	Stage 1 completed, Stage 2 underway and progressing well, currently requesting an EOT due to the wet weather and covid conditions - hope to be completed by March 22.
Construction of Shared Paths	992	992	0	Jul-21	Sep-21	Completed.
Illalong Road Seg 7	375,583	424,173	(48,590)	Jul-21	Dec-21	Completed.
Yass River Road Seg 5B & 6	1,092,921	819,072	273,849	Jul-21	Jun-22	Completed.
Moreton Avenue	566,990	631,108	(64,118)	Jul-21	Dec-21	Issue identified during Stabilising - additonal works underway
Walls Junction Road Seg 3	378,375	59,420	318,955	Jul-21	Jun-22	Works commenced on site
Cusack Place Seg 1	333,115	500,425	(167,310)	Jul-21	Dec-21	Completed.
Faulder Avenue Seg 2	669,931	15,049	654,882	Jul-21	Jun-22	Works to commence April 22
Good Hope Road Seg 9	363,658	345,941	17,718	Jul-21	Jun-22	Completed.
FLR Grant Resealing program	1,386,785	948,091	438,694	Jul-21	Jun-22	Heay Patching and Resealing underway
Dog Trap Seg 8	400,000	329,950	70,050			Works completed
Traffic facilities - Yass Public School	15,950	15,950	-			Completed.
Detailed Design for 21/22 Transport Asset - Local Roads	40,504	38,990	1,514	Jul-21	Sep-21	Completed
Concept Designs for Bridge renewal Rd 5 - Greenwood Rd	1,575	-	1,575	Jul-21	Dec-21	completed
Concept Designs for Fixing Country Roads Rd 2021	10,280	9,470	810	Jul-21	Dec-21	Works underway - grant not yet open
Detailed Design for 21/22 sealing an unsealed road	32,250	29,642	2,608	Jul-21	Sep-21	Detailed design almost competed, finalising REF.
Resheeting - Back Creek Road, Seg 4 & 8	20,695	107,022	(86,327)			Completed.
Resheeting - Bango Lane, Seg 1,3,4 & 5	50,800	680	50,170			Omitted. Will get work done during next maintenance run.
Resheeting - Casey Close, Seg 1	19,994	23,025	(3,031)			Completed.
Resheeting - Connell's Lane, Seg 1 & 2	48,910	35,435	13,475			Completed.
Resheeting - Coolalie Road, Seg 7,8 & 9	96,600	89,272	7,328			Completed
Resheeting - Dicks Creek Road, Seg 3 & 4	51,450	58,569	(7,119)			Completed.
Resheeting - Dog Trap Road, Seg 14-19	142,823	141,420	1,403			Completed.
Resheeting - Gum's Lane, Seg 4-8	107,008	133,125	(26,117)			Completed.
Resheeting - Longrail Cully Road, Seg 7	17,500	75,444	(57,944)			Completed.
Resheeting - Lucernvale Road, Seg 1	35,000	26,693	8,307			Completed.
Resheeting - Old Gap Road - Seg 2	38,500	39,432	(932)			Completed.
Resheeting - Springrange Road, Seg 7-8	80,500	100,660	(20,160)			Completed.
Resheeting - Tallagandra Lane, Seg 2,3 & 5	64,680	80,503	(15,823)			Completed.
Resheeting - Yass River Road, Seg 35	42,398	78,982	(36,584)			Completed.
Resheeting - Black Range, Seg 7-9	-	3,248	(3,248)			Completed.
Hillview Road Seg 1 Rehab	460,000	1,740	458,260	Jul-21	Jun-22	Contract awarded, works to commence April 2022 - noting due to late notice this may not be delivered by June 22. As part of the 2nd Qtr review the income and expenditure budgets are to be reduced to $460k and $40k of R2R income redistributed to other projects
Resealing (Capital)	-	-	-	Jul-21	Jun-22	As part of the 2 Qtr review th income and expenditure budgets for this are to be requced to $0. The R2R grant income is then to be redistrubuted to other projects
FLR Grant Rd 2 Resealing program	1,300,000	834,146	465,854	Jul-21	Jun-22	Heay Patching and Resealing underway
Gravel resheeting of unsealed roads	-	-	-	Jul-21	Jun-22	Roads Delivery to manage delivery
Lot St, Gundaroo - Pedestrian Refuge	129,000	528	128,473	Jul-21	Jun-22	Additional funded provided by TfNSW - works to commence April 2022
Safer Roads Program	455,000	6,250	448,750	Jul-21	Jun-22	Report to March Council meeting, works to commence early April 2022
Rossi St, Mt Carmel - Upgrade existing childrens crossing	129,000	258	128,743	Jul-21	Jun-22	Additional funded provided by TfNSW - works to commence May 2022
Laidlaw St, Yass - Bus Stop & Car park safety upgrades	874,000	49,994	824,006	Jul-21	Jun-22	Works underway, should be completd by end of May 2022
Grand Junction Rd, Berinba - Shared Path & pedestrian fa	213,306	75,191	138,115	Jul-21	Jun-22	Works commenced on site - progressing well
Mulligans Flat Road - Safety Improvements	745,000	35,406	709,594			Report to March 2022 Council meeting, works to commence early April
Back Creek Road, Gundaroo	300,000	107,977	192,024			Detailed design underway - Vegetation removal tender to March 2022 Council meeting- Road Contstruction tender to be called June 2022
Berinba St Footpath Stage 2	188,460	20,120	168,340			Works commenced on site - progressing well
Resheeting - Bobbara Road, Seg 1-5	169,000		169,000			
Resheeting - Glengarry Road, Seg 1-3	81,000		81,000			

Yass Valley Council Capital Works Program 2021/22						
Project description	Total Budget	March 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Regional Roads	**2,104,104**	**498,889**	**1,605,215**			
Annual Resealing - Regional Roads Network	572,773	128,348	444,425	Jul-21	Jun-22	Heay Patching and Resealing underway
Wee Jasper Rd Rehabilitation Seg 68	158,962	176,626	(17,664)	Jul-21	Sep-21	Final seal completed - lines to be done then completed
Wee Jasper Rd Rehabilitation Seg 70 & 71	661,269	11,189	650,080			Contract awarded, works to commence end of March 2022 - noting due to late notice this may not be delivered by June 22
Murrumbateman Road - Safety Improvements	660,000	135,701	524,299			Works underway after environmental delays
Regional Roads - Sutton Refuge	51,100	47,024	4,076			Completed
Recreational Assets	**715,052**	**547,230**	**167,822**			
Murrumbateman sand arena stabilisation	-	-	-			Awaiting outcome of grant applications by user groups.
Murrumbateman Rec Grounds dog park	20,000	-	20,000		30/06/2022	Contractor commenced clearing location.
Bowning Rec Ground new septic system	1,627	1,627	(0)	1/09/2021	28/02/2022	System purchased. Awaiting quotes for installation and Council approval.
Murrumbateman Rec Ground Amenities	59,920	7,555	52,365	1/09/2021	20/03/2023	Architect engaged for design. Tender to be released May 2022
Gundaroo Amenities Building	478,805	480,317	(1,512)		16/12/2021	Construction completed - awaiting occupation certificate
Playground Equipment Replacement - Binalong	-	-	-			COMPLETED
Adventure Playground - Riverbank Park	134,700	39,158	95,542	1/09/2021	22/12/2022	Detailed design 90% complete. Tender to be released April 2022.
Retaining wall Binalong Amenities building	20,000	18,573	1,427		28/02/2022	Retaining wall complete - plantings to be installed
Bowning Rec Ground Amenities	-	-	-			RFQ to be released April 2022
Parks, Gardens & Recreation	**538,680**	**500,710**	**37,970**			
Village Ovals Bore Water Investigations	37,828	-	37,828			Contractor completing reports by June 2022
Murrumbateman Equestrian Ground/Oval Upgrade	-	-	-			To be completed in conjunction with amenities building- works commencing June 2023
Murrumbateman Rec Grounds Club House	-	-	-			To be completed in conjunction with amenities building- works commencing June 2023
Sutton Rec Grounds Stage 1	-	-	-		30/11/2021	Sutton community have received significant additional government funding Rd4 SCCF- project to be revised
Walker park Sporting complex Improvements	378,722	378,722	(0)		30/06/2022	COMPLETED
Murrumbateman Rec Ground Storage & Horse Yards Upg	130	130	-	1/09/2021	30/11/2021	Design received from user groups, evaluating for RFQ
Yass Learn to Ride Centre	122,000	121,857	143	1/09/2021	30/11/2021	COMPLETED
Swimming Pools	**40,000**	**19,309**	**20,691**			
Yass Pool Bunding for Clorination Tanks	-	-	-			repurposed for urgent pump shed repairs
Yass & Binalong Pool sand filter upgrade	20,000	19,309	691			completed
Pool remediation - TBC	20,000	-	20,000			
Cemeteries	**84,000**	**47,700**	**36,300**			
New Toilet at Lawn Cemetery	54,000	47,700	6,300			work commencing March 2022
Construction of Yass Lawn Cemetery Concrete Plinth	30,000	-	30,000	1/01/2021	30/03/2022	quotes being sort start work End March 22
Plant & Equipment	1,270,733	**773,318**	**497,415**	Jul-21	Jun-22	New grader delivered July. 3 x Roads delivery utes, Leaseback vehicles for Manager Facilty and Waste Assets, Support Engineer, Risk Coordinator, Director Corporate and Community on Order. Patching Truch , 2. backhoes & Rr load Garbage Truck Ordered Feb 2022.
Portable Weighing Scales	27,540	**27,540**	**0**	Jul-21		COMPLETE
Commercial Waste Truck	267,360	-	**267,360**			
Caravan Park	**128**	**128**	**0**			
Amenities Upgrade	-	-	-			Pending outcome of CRIF grant application.
Concrete Steps & damaged path replacement	128	128	0			Pending outcome of CRIF grant application.
Property Management	**147,641**	**61,730**	**85,911**			
Solar panel Installation	130,000	45,693	84,307	1/11/2021	28/03/2022	Order placed contractor to start 21 march 2022
Depot Amenities Awning	17,641	16,037	1,604	Jul-21	Aug-21	Awning has been installed final inspection of works required / Update 8/11/21 all works completed

Yass Valley Council Capital Works Program 2021/22						
Project description	Total Budget	March 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Water Supply Network	**4,174,077**	**894,344**	**3,279,733**			
Integrated Water Cycle Management Plan	119,181	546	118,635		Jun-22	Issues paper under review.
Village Water Main Extension	20,000	-	20,000		Jun-22	To be carried-out when requested by customers within the Water Supply Area.
Water main replacement	-	-	-			
Water Pump / Motor Replacement (Capital)	147,801	-	147,801		Jun-22	Raw Water Pump Station upgrade is part of Stage 1 Construction. Refer comments under WTP Upgrade Stage 1 Construction
WTP Improvement	100,000	1,710	98,290		Jun-22	Preliminary considerations commenced on upgrade of WTP service water system
Yass to Murrumbateman WS Easements	20,000	6,684	13,316		Apr-22	Paperwork of a deceased landowner was complete.Lockdown caused delays with obtaining signatures on original documentation. All documentation were ready in Dec 2021 for lodging to OLG for registration by PWA.
Yass to Murrumbateman WS Construction	148,000	95,502	52,498		Apr-22	Work to modify the chlorination system and minor works design was finalised and POs were issued. Work to start in early Jan 2022.
Developer Servicing Plan	27,503	-	27,503		Jun-22	To be commenced upon completion of IWCM
Telemetry System Upgrade Strategy - Water & Sewer	124,931	58,981	65,950		Jun-22	RFQ was issued in early November and four bids were received. Contract to be awarded in mid-Feb 2022. ACMA Licence was obtained for the digital network. Preparatory work on upgrading the telemetry communication infrastructure at Mount Manton.
Water Quality Improvements Yass	700,000	134,450	565,550		Jun-22	Contracts for Packages 1,2 &3 were issued in Feb 22 and construction to commence in Feb 22. Funding Deed is with Treasury for execution. Stage 2&3 Design and Business Case to commence.
Water Reservoir Upgrade program	383,661	53,587	330,074		Jun-22	O'Connell Town Reservoir: Design of chlorination system, REF and negotiations with landowner is in progress. Field work is delayed due to lockdown.
Water Reticulation Upgrade program	120,000	4,397	115,603		Jun-22	Unserviceable valves and hydrants programmed for replacement. Hydrant and valve replaced at Grampian Street.
Water Main Extension Murrumbateman North	100,000	38,700	61,300		Apr-22	PWA was engaged tp prepare design and tender documents. Geotechnical investigations completed. Drawings are reviewed and being updated. Delays due to lockdown etc.
Water Source Strategy	100,000	42,583	57,417		Mar-22	Multi-criteria Assessment of Options Workshop held on 10 Dec with Council, DPIE and GHD. Water supply from Canberra is the highest ranked option. Meeting with ACT Government and ICON Water was held on 16 Dec 2021 to initiate discussions on road map for cross border water supply. Preparation of Draft Strategy is in progress. A briefing session to Councillors is planned.
Water Meter Replacement	120,000	-	120,000		Jun-22	Scope and tender documents to be prepared.
Morton Low Level Reservoir Repair	760,000	-	760,000		Jun-22	Under preparatory stage. Will commence upon availability of staff.
WTP Upgrade: Stage 1 Construction (HAF)	1,183,000	457,204	725,796		Feb-22	Contracts for Package 1,2 and 3 namely for Electrical and Mechanical Works, Civil and Building works and integration works were issued in early Feb 2022. Delivery of long-lead items (compressor, switchboard, water quality equipment and chemical dosing skids) are expected in February to April 2022. were issued. Council signed the Funding Deed and awaiting the signing by Treasury which is expected in Feb 2022.
Sewer Network	**1,688,257**	**780,493**	**907,764**			
Sewer Main Upgrade program	90,000	45,121	44,879		Jun-22	Condition assessment of sewer mains including 'smoke testing' to detect stormwater infiltration in the Depot/BP SPS area completed in Jan 2021. Smoke testing will be carried-out in Hatton Park 3 (Martin Close) where stormwater infiltration is suspected. Relining of two sewer mains in BP SPS area to be completed in early Feb.
Ford Street SPS Generator Design	256,008	220,989	35,019		Apr-22	Commissioning was completed. Payments to contrcator completed. PWA be finalised in Feb/Mar. QR2 Budget Review requested to cater for the expenditure on underground power supply across Ford Street and security fencing of the whole site.
Wellington Road Sewerage Pump Station	757,337	452,119	305,218		Apr-22	PS is in operation since 16 Dec 2021. Security fencing completed. Asphalt surfacing and hedging (screening planting to neighbours) to be completed. Contractor to complete minor works. QR2 review requested to cater for the cost increae due to rock, retaining wall design changes etc.
Integrated Water Cycle Management Plan - Sewer (capita	85,000	-	85,000		Jun-22	Issues paper under review.
Wastewater Treatment Plant Upgrade program	82,344	34,965	47,379		Jun-22	Septic Receival pumps were installed and commissioned in Jan 2022. Issues to be resolved with regard to the operation. Refurbishment of Sludge Drying Bed 1 was completed.
Wastewater Pump Station Upgrade Program (Capital)	177,568	26,194	151,374		Jun-22	Primary School SPS: Tender documents to be finalised. New pump for Ford Street SPS was ordered.
Telemetry Upgrade	90,000	1,106	88,895		Jun-22	RFQ was issued in early November and four bids were received. Contract to be awarded in mid-Feb 2022. ACMA Licence was obtained for the digital network. Preparatory work on upgrading the telemetry communication infrastructure at Mount Manton.
laidlaw street SPS - decommissioning	150,000	-	150,000		Jun-22	deed of agreement is drafted

Yass Valley Council Capital Works Program 2021/22						
Project description	Total Budget	March 22 YTD Actual	Variance	Start Date	End Date	Progress Comments
Waste Services	**558,686**	**85,051**	**473,635**			
3 x 23m3 Bulk skip bins with Tarps	60,000	57,732	2,268	1/10/2021	1-Dec-21	Complete
Murrumbateman Stage 2 Landfill Rehabiliation	246,535	-	246,535	1/11/2021	30/06/2022	Tender doc advertised February 22 report to Council March 22
Landfill Closure Plans	25,000	-	25,000	Dec-21	May-22	external consultant to be engaged seeking quotes
Closure Murrumbateman Landfill	200,000	168	199,832	1/11/2021	30/06/2022	Tender doc advertised February 22 report to Council March 22
Gundaroo Transfer Station Trailer Pad	27,151	27,151	0			Completed (Overspend to be funded from PC 5024005) all within the waste reserve
Engineering Management	**616,070**	**571,667**	**44,403**			
Crago Mill Precinct	616,070	571,667	44,403		Dec-21	Da Submitted. Business Case Development Commenced. Need financial data to complete. Awaiting LTFP.
Land Purchase	193,000	**193,437**	- 437			Completed in December 2021
Public Halth & Environment	**5,840**	**5,307**	**533**			
Weeds Inspection Tablet	5,840	5,307	533			finalised
Stormwater	**8,853**	**8,853**	-			Finalised
Yass Flood Risk Management Plan	1,953	1,953	-			Finalised
Murrumbateman, Binalong, Bowning, Bookham Flood Stu	6,900	6,900	-			
Total	**29,580,012**	**14,710,665**	**14,869,346**			
Funding Source:						
General Revenue	505,996	9,559	496,437			
Grant	13,322,253	5,357,313	7,964,940			
Unexp Grants	4,324,166	3,030,711	1,293,455			
Water	2,228,992	309,683	1,919,309			
Water s64	150,000	38,700	111,300			
Sewer	1,561,757	780,493	781,264			
Sewer s64	150,000	-	150,000			
Waste	826,046	85,051	740,995			
Dev Cont	2,942,535	1,978,840	963,695			
Stormwater	8,853	8,853	-			
GR carry forward	984,093	841,915	142,178			
Infrastructure	1,679,175	878,000	801,175			
Plant & Equip	856,018	800,858	55,160			
Victoria Park	30,128	10,128	20,000			
Binalong Pool	10,000	9,309	691			
over budget unfunded	-	571,252	- 571,252			
	29,580,012	**14,710,665**	**14,869,347**			

LEGISLATIVE COUNCIL

PORTFOLIO COMMITTEE NO. 2

Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Report 57

May 2022

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LEGISLATIVE COUNCIL

Portfolio Committee No. 2 - Health

Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

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Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

"May 2022".

Chair: Hon. Greg Donnelly, MLC.

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Terms of reference

That Portfolio Committee No. 2 - Health inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote NSW, and in particular:

(a) health outcomes for people living in rural, regional and remote NSW;

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

(h) the current and future provision of ambulance services in rural, regional and remote NSW;

(i) the access and availability of oncology treatment in rural, regional and remote NSW;

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and

(l) any other related matters.

The terms of reference for the inquiry were self-referred by the committee on 27 August 2020.[1]

1 *Minutes*, NSW Legislative Council, 15 September 2020, p 1274.

Committee details

Committee members

The Hon Greg Donnelly MLC	Australian Labor Party	*Chair*
The Hon Emma Hurst MLC	Animal Justice Party	*Deputy Chair*
The Hon Lou Amato MLC*	Liberal Party	
Ms Cate Faehrmann MLC	The Greens	
The Hon Wes Fang MLC	The Nationals	
The Hon Chris Rath MLC**	Liberal Party	
The Hon Walt Secord MLC	Australian Labor Party	

Contact details

Website	www.parliament.nsw.gov.au
Email	PortfolioCommittee2@parliament.nsw.gov.au
Telephone	(02) 9230 3672

* The Hon Trevor Khan MLC substituted for the Hon Lou Amato MLC from 22 June 2021 to 6 January 2022.

** The Hon Chris Rath MLC replaced the Hon Shayne Mallard MLC as a substantive member of the committee from 29 March 2022. The Hon Shayne Mallard MLC replaced the Hon Natasha Maclaren-Jones MLC as a substantive member of the committee from 25 January 2022.

Chair's foreword

The delivery of health services in New South Wales is a joint responsibility between the Australian and New South Wales governments. In simple terms, the Australian Government is responsible for the provision of GP services, and the State Government is responsible for the public hospital system. Eleven years ago, as a result of the Garling Inquiry, the State Government established 15 Local Health Districts to deliver health care that was to be tailor made for the communities that they served.

While recognising that the provision of health services to an area as large as rural, regional and remote New South Wales is challenging and complex, throughout this inquiry the committee heard repeatedly about individuals and families let down by the health system. We heard stories of emergency departments with no doctors; of patients being looked after by cooks and cleaners; of excessive wait times for treatment; and of misdiagnoses and medical errors. This evidence is by no means a reflection on the NSW Health staff working tirelessly in challenging circumstances; rather it is an indictment of the system that has allowed this situation to develop. Overall, the committee has found that residents of rural, regional and remote New South Wales have poorer health outcomes and inferior access to health and hospital services, and face significant financial challenges in accessing these services, compared to their metropolitan counterparts. This is a situation that can and should not be seen as acceptable.

The issues are, of course, inextricably linked to the significant and longstanding workforce challenges facing doctors, nurses and other health service providers beyond the metropolitan areas of Newcastle, Sydney and Wollongong. The shortages in these workforces are, in some locations, at critical levels. Unsustainable working hours, poorly coordinated recruitment and retention strategies, inadequate remuneration, lack of resources, threats to physical safety and a culture of fear are pushing some to breaking point, to the detriment of both the individual and the communities they serve.

The issues faced by the doctor and clinician workforce are undoubtedly complicated by the shared responsibilities between the Commonwealth and State governments, and their inability to achieve effective structural reform. There is an urgent need for ministerial level intervention to establish clear governance arrangements and a strategic plan to deliver on the health reforms recommended in this report. In respect of the doctor and clinician workforce, these reforms include the implementation of a single employer model for GP trainees across rural, regional and remote New South Wales, the establishment of a Rural Area Community Controlled Health Organisation pilot, as well as the development of a 10-year recruitment and retention strategy and an increase in rural and regional training positions.

On the issue of nurses and midwives, the evidence has shown a disconnect between the reality of the daily challenges faced by them working in rural, regional and remote areas, and NSW Health's perception of the situation. In order to expand and develop the workforce, the committee has recommended that NSW Health expedite its review of the nursing and midwifery workforce with a view to urgently increasing nurse and midwifery staffing numbers based on local need across rural, regional and remote New South Wales. We also recommend wider implementation of the Nurse Practitioner model of care and greater employment of geriatric nurses. The committee has also made recommendations to support the existing workforce, including in relation to remuneration of on call arrangements, plans to address security issues, and greater professional development opportunities for nurses and midwives.

The committee also examined a number of specific health services – including oncology, palliative care, allied health, other health and ambulance services – as well as the delivery of virtual care, otherwise known

as telehealth. Overall, the evidence demonstrated that the services provided in rural, regional and remote locations do not always accord with community need. While acknowledging that not all services are able to be viably run in all locations across the State, more must be done to ensure that regardless of postcode, residents can seek, access and receive treatment in a timely and cost-effective manner. It was also very clear that, as with their doctor, clinician and nursing colleagues there is a critical shortage of health professionals across rural, regional and remote New South Wales.

The fragmented nature of health care provision outside of metropolitan cities also raised concerns about patients getting lost in a vast and complicated system thus resulting in sub-optimal outcomes for them. Improved coordination and communication between service providers, such as through the use of shared medical records, would undeniably improve the current situation. Similarly, it was concerning to discover that there is a lack of palliative care and palliative care services, and as a result it is critical that a taskforce be established to map palliative care services, establish an agreed, uniform state-wide platform for the collection of palliative care and end of life care data, and promote innovative models of palliative care services.

It was however heartening to hear about innovations that offer promising solutions to some of the more challenging issues that come with servicing dispersed populations. From the use of Remote Video Assisted Chemotherapy Services to expanding the Far West NSW Palliative and End-of-Life model of care, there are innovative initiatives and programs that are better able to serve community needs. Additionally, the committee welcomes the flexibility offered by virtual care, but cautions that this flexibility must not be used as a basis to reduce or substitute for face-to-face health services and care, but rather complement and enhance them. The committee has recommended that where telehealth is used, additional staff be rostered on and that they be provided with training on how to effectively use telehealth and other virtual models of care.

On the issue of First Nations people's experiences with health services, the evidence was that factors such as discrimination, racism, poor experiences with healthcare professionals, lack of transport, and the lack of affordable and culturally appropriate healthcare services contribute to a reluctance by some First Nations people to seek medical assistance. A key focus for improvement must therefore be around increased cultural safety, and the committee has recommended engagement with local Elders to develop strategies in this regard. Complementing these strategies, priority must also be given to increasing the Indigenous workforce across all disciplines, job types and locations. Furthermore, in order to support the delivery of health services and improve the health outcomes of First Nations people in New South Wales, the committee has recommended the formalisation of partnerships with the local Aboriginal Community Controlled Health Services and Indigenous representation on the governing board of each Local Health District.

Governance ultimately underpins many of the issues raised in this inquiry. Our report documents serious concerns about the governance of the health bureaucracy in this state, particularly in the areas of transparency, accountability, culture and communication. For example, the committee was very concerned to hear that the Regional Health Minister is proceeding with the development of the new rural health plan without having undertaken and publishing an informed and comprehensive evaluation of *NSW Rural Health Plan: Towards 2021*. Further, the committee has found that there is a culture of fear in relation to employees speaking out and raising concerns and issues about patient safety, staff welfare and inadequate resources. The committee has therefore recommended a complete overhaul of the complaints management process and the establishment of the Health Administration Ombudsman. The Local Health Districts must also commit to reinvigorating the Local Health Advisory Committees and effectively engage with communities in genuine consultation and decision making processes.

There is much work to be done across so many areas. In order to ensure that focus and momentum for change is not lost, the committee has recommended a further inquiry to report on the progress and developments that have been made to address the matters raised in the report in two years' time.

Finally, the committee thanks all those who participated in this inquiry through their submissions and oral evidence. I also wish to acknowledge and thank my committee colleagues for the collegiate way in which they have engaged and participated in this important and long-running inquiry. Can I conclude by thanking all the committee staff for their hard work and professionalism, without which this report could not have been produced.

The Hon Greg Donnelly MLC
Committee Chair

Findings

Finding 22 **181**

That there is a lack of information and support for patients in rural, regional and remote areas when they leave the hospital system – especially those discharged in remote communities – resulting in poor health outcomes.

Recommendations

Recommendation 41 **181**

That the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of Local Health Districts and NSW Health from staff, doctors, patients, carers and the public. The Health Administration Ombudsman is to be empowered to review administrative decisions of NSW Health and Local Health District management, including but not limited to, alleged cover-ups of medical errors or deaths, false or misleading data, inaccurate communications and/or media reporting, Visiting Medical Officer accreditation decisions, staff blacklisting, and bullying or harassment of whistle-blowers. Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.

Recommendation 42 **182**

That the rural and regional Local Health Districts:

- review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning
- investigate methods of better informing communities about the services that are available to them, and publish additional data such as wait times and minimum service standards for the facilities within their remit.

Recommendation 43 **182**

That the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.

Recommendation 44 **183**

That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.

Conduct of inquiry

This inquiry is the first time a parliamentary committee in this state has specifically sought to examine and make an assessment of health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Indeed, to the committee's knowledge it is the first time such an exercise in examination and assessment on this scale has been undertaken in New South Wales.

It is appropriate to acknowledge and indeed thank the many individuals and organisations who, prior to the commencement of this inquiry, spoke-up both privately and in the public domain about the need to undertake this task. The call for this inquiry did not come out of thin air and has been building for a period of time; particularly over the last five years or so.

The committee has sought, with the resources and information at its disposal, to undertake as thorough an inquiry as is possible leading to the production of this report, its Findings and Recommendations. Having said this the committee is acutely aware of both the size and complexity of the health system that seeks to service citizens that live in rural, regional and remote New South Wales. There are parts of the state the committee did not visit, particularly because of the challenges caused by COVID-19. There are also aspects of the health system that have been commented on only briefly or in general terms by this report. There is no doubt that a valid case can be made for these matters to be further inquired into.

The terms of reference for the inquiry were self-referred by the committee on 27 August 2020.

The committee received 720 submissions and 29 supplementary submissions. It should be noted that in a number of submissions both individuals and organisations indicated that they were expressing the views and sentiments of many in their local communities.

The committee held a total of 15 public hearings between March 2021 and February 2022: five were held at Parliament House in Sydney, three were held virtually due to the COVID-19 pandemic, and seven were held in regional areas, namely Deniliquin, Cobar, Wellington, Dubbo, Gunnedah, Taree and Lismore. It is to be noted that the hearings held in Wellington and Dubbo on 18 and 19 May 2021 respectively, were the first regional hearings to be webcast live in the history of the Legislative Council. This is now standard practice for Upper House committees.

The committee also conducted two site visits to the Deniliquin Health Service and the Wellington Health Service.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents and answers to questions on notice.

Chapter 1 Background

This chapter provides an overview of the health sector in rural, regional and remote New South Wales. It commences with an explanation of the health system, including health funding, the responsibilities of different levels of government, and the roles of the Primary Health Networks, NSW Ministry of Health and the Local Health Districts. It then briefly profiles the rural health workforce, before looking at population demographics in regional, rural and remote areas, and health outcomes.

The committee notes that what is considered 'rural', 'regional' and 'remote' can vary according to different definitions. For the purpose of this report, these terms collectively are used to refer to areas of the state outside of metropolitan Sydney, Newcastle and Wollongong.

The health system

1.1 Australia's health care services are predominantly delivered, operated and funded by national, state and territory governments, with the private and not for profit sectors also operating facilities and providing health insurance products.[2] The health system consists of various services that provide:

- primary health care, comprising general practice, allied health services, pharmacy and community health
- specialist or 'secondary' care, which provides services for people with specific or complex health conditions and issues, including mental health services, cancer treatment, palliative care, and surgery, as well as diagnostic services such as pathology and imaging
- tertiary care in hospitals, which provides 'acute' care for admitted and non-admitted patients; non-admitted care includes outpatient clinics and emergency department care
- public health promotion and disease prevention, which focus on the causes of poor health and preventing avoidable health conditions.[3]

Health funding and expenditure

1.2 The New South Wales health system is funded primarily by the Australian and New South Wales governments, with non-government organisations, private health insurers and individuals paying for unfunded (or only partially funded) products and services.[4]

1.3 In New South Wales in 2019-2020, $43.6 billion of combined funding from the NSW and Australian governments was spent on:

- public hospital services – $18.5 billion
- primary health care – $12 billion

2 Australian Institute of Health and Welfare – Health system overview (23 July 2020), https://www.aihw.gov.au/reports/australias-health/health-system-overview

3 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), pp 40-42.

4 Australian Institute of Health and Welfare, *Health expenditure Australia 2018–19* (2020), pp 2-4.

- referred medical services – $5.2 billion
- capital works – $2.5 billion
- research – $2.1 billion
- private hospitals – $1.4 billion
- patient transport services – $800 million
- other services – $1.1 billion.[5]

1.4 The NSW Government's 2021-2022 budget committed $25.8 billion to recurrent health expenses and $3.2 billion to health-related capital expenditure, of which $900 million was allocated to regional hospitals and health facilities.[6] The health budget represents approximately 30 per cent of the NSW Government's overall annual budget.[7]

1.5 In terms of recurrent expenditure, NSW Health informed the committee that:

- the growth in expense per capita for metropolitan Local Health Districts (LHDs) was 26.6 per cent compared to 35.6 per cent in rural and regional LHDs
- despite the population growth rate of rural and regional LHDs (7.1 per cent) being less than half of metropolitan LHDs (15.2 per cent), growth in recurrent expenditure from 2011-2012 to 2019-2020 was almost the same for metropolitan LHDs (45.2 per cent) and rural and regional LHDs (45.9 per cent)
- although 25 per cent of the state's population lives in rural, regional or remote areas, in general, about a third of the overall capital expenditure is currently allocated to rural and regional New South Wales.[8]

1.6 NSW Health also advised that of the 40 hospital redevelopments or upgrades underway or commenced in 2019-2020, more than 65 per cent were in rural and regional New South Wales, and that it has delivered specific programs targeted to rural and regional areas.[9]

Health sector responsibilities

1.7 The Australian Government's main health roles and responsibilities include:

- providing a universal public health care scheme – Medicare
- subsidising prescription medicines through the Pharmaceutical Benefits Scheme
- supporting primary health care services, through Primary Health Networks

5 AIHW Health Expenditure Database, *Health Expenditure Australia 2019-20* (17 December 2021), Table B.S3: Total health expenditure, constant prices, New South Wales, by area of expenditure and source of funds, 2019–20 ($ million).

6 NSW Government, *Budget Statement 2021-22* (22 June 2021), p A1-12; NSW Government, *Infrastructure Statement 2021-22*, p 2-2; Submission 630, NSW Government, p 44.

7 NSW Government, *Budget Statement 2021-22* (22 June 2021), p 5-2.

8 Submission 630, NSW Government, p 45.

9 Submission 630, NSW Government, p 44.

- funding population-specific services, such as community-controlled Aboriginal primary health care, and aged care
- ensuring that health professionals are distributed equitably across the country
- collecting health and welfare information and statistics through the Australian Institute of Health and Welfare.[10]

1.8 Additionally, the Australian Government utilises the Modified Monash Model geographical remoteness classification system to determine eligibility for a range of health workforce incentive programs that aim to attract health professionals to remote and smaller communities.[11]

1.9 NSW Health is responsible for fulfilling the NSW Government's health responsibilities, which include:

- managing and administering public hospitals, including employing doctors and engaging General Practitioners (GPs) as Visiting Medical Officers
- ambulance and emergency services
- delivering preventive services, such as cancer screening and immunisation programs
- funding and managing community mental health services
- implementing patient transport and subsidy schemes
- regulating health care providers and private health facilities
- operating health complaints services.[12]

1.10 The Australian and NSW Governments have joint responsibility for:

- educating and training health professionals
- regulating the health workforce
- funding palliative care
- funding public hospitals
- funding and delivering health services, including:
  - public health programs
  - community health services
  - Aboriginal health services
  - mental health services

10 Department of Parliamentary Services – Parliament of Australia, *Health in Australia: a quick guide* (31 August 2018), pp 1-2; Department of Health, *The Australian health system* (7 August 2019), https://www.health.gov.au/about-us/the-australian-health-system .

11 Department of Health, *Medicare Statistics: Explanatory Notes*, p 5; Department of Health, *The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians* (15 October 2021), pp 12-13.

12 Submission 630a, NSW Government, p 5; Department of Health, *The Australian health system* (7 August 2019), https://www.health.gov.au/about-us/the-australian-health-system .

– health infrastructure.[13]

1.11 Local governments in New South Wales do not have a formal role in health care provision, but are often involved in providing environmental health services (for example, water fluoridation and waste disposal) and some community-based health and home-care support services.[14] Additionally, some local councils proactively seek to attract doctors to their regions and support them by offering accommodation, financial incentives, equipment and facilities.[15]

1.12 The private and not-for-profit sectors operate public and private hospitals, pharmacies and medical practices, and provide private health insurance products.[16] Private hospitals are owned and operated by the private sector but are licensed and regulated by governments.

Primary Health Networks

1.13 Primary Health Networks are independent primary health care organisations established by the Australian Government to coordinate health services. Primary Health Networks support general practices and partner with Local Health Districts to provide services that focus on mental health, Aboriginal health, population health, the health workforce, aged care and eHealth.[17] There are 10 Primary Health Networks across New South Wales.

1.14 Additionally, Primary Health Networks:

- assess the health needs of their local area and engage health services from hospitals, GPs, nurses, specialists and other healthcare professionals to meet patient care needs, particularly for those at higher risk of poor health outcomes
- coordinate care for patients moving between services or providers (for example, between a hospital and a GP, when a patient is discharged)
- provide continuing education for GPs.[18]

1.15 In September 2021, NSW Health, Primary Health Networks and the Australian Government released a joint statement expressing their commitment to formalise collaborative arrangements,

13 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), p 43; Department of Parliamentary Services – Parliament of Australia, *Health in Australia: a quick guide* (31 August 2018), p 2.

14 Submission 686, NSW Farmers Association, p 4; Australian Institute of Health and Welfare, *Australia's health 2016* (2016), p 24.

15 Submission 345, Local Government NSW, p 3; Submission 345a, Local Government NSW, pp 7-8.

16 Australian Institute of Health and Welfare – Health system overview (23 July 2020), https://www.aihw.gov.au/reports/australias-health/health-system-overview

17 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), p 41; Australian Institute of Health and Welfare, *Australia's health 2016* (2016), p 25; Department of Health, *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians*, pp 80-81; Evidence, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network, 19 March 2021, p 10.

18 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), p 41; Australian Institute of Health and Welfare, *Australia's health 2016* (2016), p 25; Department of Health, *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians*, pp 80-81; Evidence, Ms Kitcher, 19 March 2021, p 10.

inform shared governance arrangements and agreements, and facilitate shared ownership, initiation, implementation and evaluations of programs, projects and services.[19]

NSW Ministry of Health

1.16 The NSW Ministry of Health, often referred to more generally as NSW Health, is the system manager for the state's public health system. The NSW Ministry of Health supports the Secretary, the Minister for Health and the Minister for Mental Health, Regional Health and Women to perform their executive government and statutory functions. These functions include promoting, protecting, developing, maintaining and improving the health and wellbeing of New South Wales residents, while considering the needs of the state and the available finances and resources.[20]

1.17 Additionally, in recent months the NSW Government has made significant announcements regarding the regional health bureaucracy, namely:

- on 20 December 2021 the NSW Government announced the appointment of the Hon. Bronnie Taylor MLC as Minister of the newly created Regional Health portfolio[21]
- on 8 April 2022 Minister Taylor announced the establishment of a new Regional Health Division in NSW Health, to be led by a Coordinator-General reporting directly to the Secretary of NSW Health[22]
- on 14 April 2022 the NSW Government called for expressions of interest from members of the community to be appointed to the Regional Health Ministerial Advisory Panel.[23]

1.18 These announcements are explored further in Chapter 7.

Local Health Districts

1.19 In 2011, following the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, otherwise known as the 'Garling Inquiry', NSW Health established 15 Local Health Districts to deliver healthcare across New South Wales. Each LHD has a Chief Executive and a governing board, responsible for setting strategic direction and ensuring operational efficiency. The core purpose of the LHDs is to operate public hospitals and institutions and to provide health services to communities within their geographical area.[24]

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19 NSW Government – NSW Health, The NSW Primary Health network – NSW Health Joint Statement, 17 September 2021, https://www.health.nsw.gov.au/integratedcare/Pages/joint-statement.aspx

20 Submission 630, NSW Government, p 4.

21 Evidence, Hon Bronnie Taylor MLC, Minister for Women, Minister for Regional Health and Minister for Mental Health, Budget Estimates 2021-2022, 3 March 2022, pp 7-8.

22 NSW Government – NSW Health, NSW Government to deliver a strengthened focus on regional health, 8 April 2022, https://www.health.nsw.gov.au/news/Pages/20220408_02.aspx

23 NSW Government – NSW Health, Expressions of interest open for Regional Health Ministerial Advisory Panel, 14 April 2022, https://www.health.nsw.gov.au/news/Pages/20220414_00.aspx

24 NSW Government - Health, Local health districts and speciality networks, https://www.health.nsw.gov.au/lhd/Pages/default.aspx .

1.20 Seven Local Health Districts are located in regional and rural areas of the state:

- Far West LHD
- Hunter New England LHD
- Mid North Coast LHD
- Murrumbidgee LHD
- Northern NSW LHD
- Southern NSW LHD
- Western NSW LHD.[25]

1.21 A further four of the LHDs are classified as 'metropolitan' but include regional areas, namely Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains and South Western Sydney LHDs, as per Figure 1. At the time of writing the NSW Government is yet to clarify whether the Minister for Regional Health will have responsibility for those parts of 'metropolitan' LHDs classified as regional areas.

Figure 1 New South Wales Local Health Districts

Source: NSW Government - Health, Local health districts and speciality networks, https://www.health.nsw.gov.au/lhd/Pages/default.aspx

1.22 Each LHD is an independent authority that is directly accountable for hospital performance and operates under an annual service agreement, which sets out the NSW Government's service delivery and performance requirements.[26]

[25] NSW Government - Health, Local health districts and speciality networks, https://www.health.nsw.gov.au/lhd/Pages/default.aspx.

1.23 LHDs are funded by the NSW and Australian governments through a combination of activity based and block funding. Activity based funding pays public hospitals according to the number and mix of patients they treat, and their complexity.[27] According to the Bureau of Health Information, approximately 90 per cent of LHD budgets are allocated through activity based funding.[28] Block funding supports:

- public hospital functions that do not directly relate to the treatment of patients, such as teaching, training and research
- certain public hospital services that are more appropriately funded through block funding, such as non-admitted mental health services
- small rural hospitals, when economies of scale prevent hospitals from being financially viable under activity-based funding.[29]

1.24 In the 2019-2020 State budget, the seven rural and regional LHDs were allocated $4.5 billion. Additionally, the National Rural Health Alliance highlighted that in 2019-2020, per capita expenditure from the NSW and Australian governments on public hospitals was higher in rural and regional LHDs than metropolitan LHDs. [30]

1.25 Collectively, the rural and regional LHDs cover approximately 778,516 square kilometres and are responsible for 149 hospitals.[31]

1.26 In order to provide effective services to their local communities, facilities in regional, rural and remote areas have been organised according to a 'hub and spoke' model where larger hospitals that provide higher level services (hubs) support lower level facilities (spokes). This model allows patients that require more intensive care to be transferred from 'spoke' to 'hub' facilities for treatment, and to later return to a 'spoke' facility to recover.[32]

1.27 LHDs are also responsible for Multipurpose Services, which integrate health and aged care services in one facility. They are typically located in small and remote communities where it would not be viable to have a separate aged care home and hospital.[33] There are currently 63 Multipurpose Services located across New South Wales.[34]

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27 Independent Hospital Pricing Authority, *Activity based funding,* https://www.ihpa.gov.au/what-we-do/activity-based-funding.

28 Submission 453, Australian Salaried Medical Officers' Federation (NSW), p 21.

29 National Health Funding Body, *Funding Types,* https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-types .

30 Submission 630, NSW Government, p 45; Submission 478, National Rural Health Alliance, p 7.

31 NSW Government – NSW Health, Local health districts and speciality networks, 15 June 2018, https://www.health.nsw.gov.au/lhd/Pages/default.aspx.

32 Evidence, Ms Amanda Larkin, Chief Executive, South Western Sydney Local Health District, 1 February 2022, p 38.

33 Department of Health, *About the Multi-Purpose Services (MPS) Program* (4 February 2022); https://www.health.gov.au/initiatives-and-programs/multi-purpose-services-mps-program/about-the-multi-purpose-services-mps-program and My Aged Care – Support for people living in rural and remote areas, https://www.myagedcare.gov.au/support-people-living-rural-and-remote-areas

34 Submission 630, NSW Government, p 11.

1.28 Furthermore, many LHDs offer an integrated model of healthcare that brings together federally funded general practice and state-funded primary and community healthcare services in one location. These facilities, known as 'HealthOne' facilities, are focused on providing care to people in the community who require coordinated care, which often includes private providers. For example, the Coraki Campbell HealthOne facility near Lismore offers community nursing, physiotherapy, occupational therapy, speech therapy for children, women's health, chronic disease clinics and, periodically, oral health care.[35]

The health workforce

1.29 The health workforce in New South Wales comprises a diverse range of health care occupations, including GPs, surgeons and other medical specialists, nurses, dentists, allied health professionals such as occupational therapists, physiotherapists, psychologists and Indigenous health workers, and administrative and other support staff.[36]

1.30 Many health practitioners must register through the National Registration and Accreditation Scheme to work in the health system. Fifteen professions have joined the scheme, including medical practitioners, nurses and midwives, paramedics, pharmacists and several allied health professions. Each profession in the scheme is represented by a National Board that is responsible for implementing the scheme, including registering practitioners and students, and setting the professional standards that their cohort must meet.[37]

1.31 However, many health sector employees work in occupations that are not registered, including receptionists, nursing support and personal care staff, medical technicians and cleaners.[38]

1.32 Additionally, migrant and overseas-trained health workers form a substantial part of the health workforce. In 2016, they made up 41 per cent of doctors in rural and remote parts of Australia.[39]

The size and distribution of the health workforce

1.33 The health care and social assistance industry is the largest employment sector in regional New South Wales, comprising 14.5 per cent of the regional workforce.[40]

1.34 There were 41,916 registered health professionals based in regional New South Wales in 2020, including 5,694 doctors, 24,259 nurses and midwives and 5,061 full-time equivalent allied health workers.[41]

35 NSW Health, *Guidelines for Developing HealthOne NSW Services* (March 2012), pp 6-7; NSW Health, *HealthOne NSW* (30 April 2018), https://www.health.nsw.gov.au/healthone/Pages/default.aspx ; Evidence, Mr George Thompson, Member, Coraki Health Reference Group, 17 June 2021, p 3.

36 Australian Institute of Health and Welfare, *Australia's health 2016* (2016), p 46.

37 Australian Institute of Health and Welfare, *Australia's health 2016* (2016), p 31.

38 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), p 67.

39 Australian Institute of Health and Welfare, *Australia's health 2018* (2018), p 67.

40 NSW Parliamentary Research Service, *Regional NSW: A demographic and economic* snapshot (March 2020), p 8.

41 Department of Health, *Health Workforce Data: Professions and Remoteness Area* (2020); Submission 630, NSW Government, pp 46 and 48.

1.35 The distribution of doctors, nurses and other key health practitioners by differing levels of remoteness is outlined in Table 1.

Table 1 Frequency of selected health professions in New South Wales per 100,000 people

Profession	Very Remote	Remote	Outer Regional	Inner Regional	Major Cities	All NSW
Doctors	197	128	152	329	437	400
Nurses and Midwives	1,686	909	950	1,302	1,173	1,184
Paramedics	161	180	119	83	47	58
Aboriginal Health Practitioners	161	24	8.1	3.6	0.3	1.5
Dentists	-	17	38	68	87	81
Pharmacists	72	45	66	85	104	98
Physiotherapists	54	24	47	98	123	114
Psychologists	126	24	44	103	139	127
All registered health professions	2,529	1,395	1,515	2,291	2,348	2,289

Sources: Department of Health, Health Workforce Data: Professions and Remoteness Area.

Rural, regional and remote population demographics

1.36 Almost 2 million people live in rural, regional and remote areas of New South Wales, which represents approximately 24 per cent of the state's population. The population has grown annually by 7 per cent since 2013.[42] Rural populations decrease with increased remoteness, with the Australian Bureau of Statistics estimating that current populations are:

- inner regional – 1.51 million residents
- outer regional – 443,000
- remote – 28,800
- very remote – 5,600.[43]

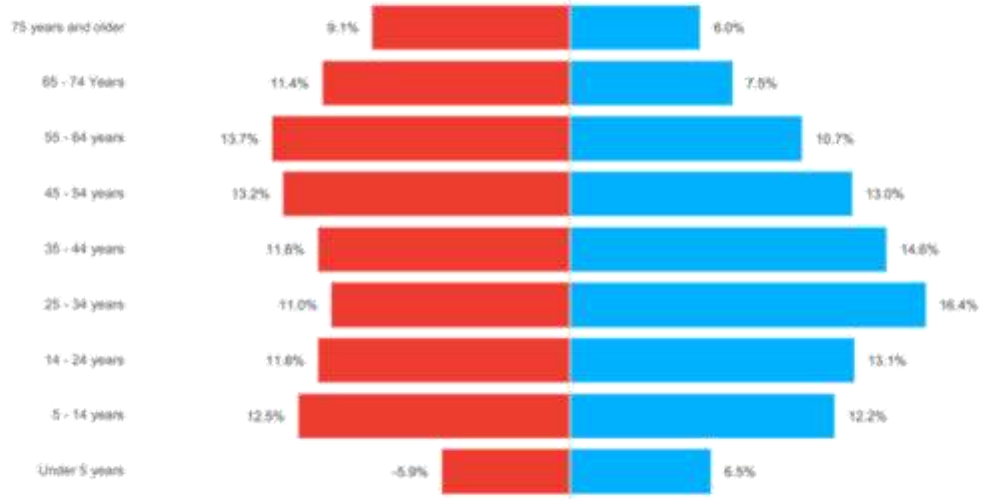
1.37 Compared to Greater Sydney, the population of regional New South Wales is older (see Figure 2). It is predicted that by 2036, residents aged over 75 will become the largest demographic in

42 Evidence, Dr Nigel Lyons, Deputy Secretary – Health System Strategy and Planning, NSW Health, 19 March 2021, p 54.

43 Estimated resident populations on 30 June 2020; Australian Bureau of Statistics, *Regional population, 2019-20: Table 2. Estimated resident population, Remoteness Areas, Australia.*

rural, regional and remote New South Wales and that they will make up 15.9 per cent of the population by 2041.[44]

Figure 2 Age distribution, Regional New South Wales (red) and Greater Sydney (blue) in 2016



Source: Submission 705, Rural and Remote Medical Services Ltd, p 18.

First Nations people

1.38 In 2016, there were 142,600 Aboriginal people living in regional areas of New South Wales, which represents 7.4 per cent of the regional population. The proportion of Aboriginal and Torres Strait Islander people in communities also increases with remoteness, as shown in Table 2.[45]

Table 2 Aboriginal and Torres Strait Islander population in New South Wales based on remoteness, in 2016

Remoteness	Aboriginal population	Proportion of total population that is Aboriginal
Major cities	123,099	2.1%
Inner regional	91,618	6.3%
Outer regional	41,229	9.3%
Remote	7,311	24.2%

[44] NSW Parliamentary Research Service, *Regional NSW: A demographic and economic snapshot* (March 2020), p 14.

[45] Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians* (Table 1 and Table 3), June 2016.

Very remote	2,428	41.2%

Source: Australian Bureau of Statistics, Estimates of Aboriginal and Torres Strait Islander Australians (Table 1 and Table 3), June 2016.

Culturally and linguistically diverse communities

1.39 According to the 2016 Census, New South Wales is home to approximately 2 million people that were born overseas.[46] However, people from culturally and linguistically diverse backgrounds are not just limited to those born overseas, but also include citizens, permanent residents, overseas students, skilled migrants, dependents of skilled migrants, refugees, asylum seekers and temporary residents.[47]

1.40 The committee heard that, whilst also experiencing the same challenges relating to limited access to services, cost, distance and transportation,[48] the provision of services to culturally and linguistically diverse communities must also take into account different language backgrounds and religious and cultural practices.[49] Further, the small size of some culturally and linguistically diverse populations may make it unfeasible to support local language-specific programs and services.[50]

1.41 Stakeholders highlighted that written information provided in language and/or access to interpreters is often critical for members of this community to be able to access health services. However, as noted by the Council on the Ageing NSW[51] and the Australian Association of Social Workers,[52] this is not always readily available.

1.42 For this reason, The Australian and New Zealand Society of Palliative Medicine reported that 'Non-English speaking patients often rely on family or community members to act as interpreters which raises issues of confidentiality and privacy'.[53]

1.43 Additionally, the committee heard that there are growing refugee populations in regional, rural and remote New South Wales that may require additional specialist support to address complex physical and emotional issues that is not currently available.[54]

Rural, regional and remote population health outcomes

1.44 In its submission to the committee, NSW Health reported that life expectancy, which is the most common measure to describe population health, decreased with increasing levels of rurality and remoteness, despite a pattern of increasing life expectancy over time across all

46 Submission 478, National Rural Health Alliance, p 13.
47 Submission 630, NSW Government, p 35.
48 Submission 630, NSW Government, p 35.
49 Submission 630a, NSW Government, p 14.
50 Submission 630, NSW Government, p 35.
51 Submission 176, Council on the Ageing NSW, p 4
52 Submission 254, Australian Association of Social Workers, p 8.
53 Submission 458, The Australian and New Zealand Society of Palliative Medicine, p 8.
54 Submission 475, Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, p 5.

remote areas of the state. On average, people living in regional and rural LHDs live 2.2 years less than people in metropolitan LHDs (81.4 years compared with 83.6 years, respectively).[55]

1.45 In relation to other population health outcomes, NSW Health informed the committee that:

- mortality rates and potentially avoidable deaths decreased across New South Wales over the 18 years to 2018 for all remote areas, however mortality rates increase with greater remoteness
- infant mortality rates decreased across New South Wales over the 18 years to 2018, particularly in remote areas, but in 2018 remained higher in non-metropolitan LHDs compared with metropolitan LHDs
- after experiencing a decline from 2001 to 2006, suicide rates steadily increased in rural, regional and remote areas between 2007 and 2018, with rates higher for non-metropolitan LHDs compared with metropolitan LHDs in 2018.[56]

1.46 Reflecting on overall population health, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health stated that the pattern of poorer health outcomes in rural, regional and remote areas was not unique to New South Wales, but evident across Australia and in other countries.[57] Dr Lyons also emphasised that many of the metrics used to measure health outcomes, including life expectancy, mortality rates and potentially avoidable deaths had improved in rural communities over the past 10 to 15 years.[58]

1.47 In regards to hospitalisations, NSW Health reported that:

- in the 15 years from 2004-2005 to 2018-2019, hospitalisation rates for coronary heart disease decreased across New South Wales and have remained stable in the last five years. However, death rates from coronary heart disease were higher in non-metropolitan LHDs
- in the 15 years from 2004-2005 to 2018-2019, hospitalisation rates for chronic kidney disease (including dialysis) increased across all remoteness areas, except in remote and very remote areas, which were relatively stable. Death rates from chronic kidney disease over a similar period were higher in remote and very remote areas
- the highest rates of stroke are found in outer regional and remote areas followed by inner regional areas. Although death rates have declined, they are still higher in non-metropolitan LHDs
- rates of both new cases and deaths from all cancers were higher overall in non-metropolitan LHDs, and outer regional, remote and very remote areas had lower survival rates than less remote areas
- there is a consistent pattern of lower rates of vaccine preventable disease hospitalisations in increasingly remote areas, which is consistent with higher childhood immunisation rates in rural and remote areas.[59]

55 Submission 630, NSW Government, p 6.
56 Submission 630, NSW Government, pp 6-7.
57 Evidence, Dr Lyons, 19 March 2021, p 53.
58 Evidence, Dr Lyons, 19 March 2021, pp 53-54.
59 Submission 630, NSW Government, pp 6-11.

1.48 The committee heard that First Nations people living in rural, regional and remote New South Wales tend to have worse health outcomes than their metropolitan counterparts, for example:

- Aboriginal people in remote and very remote areas of Australia have significantly lower life expectancies – 65.9 years for males and 69.6 years for females compared to 71.6 years and 75.6 years respectively[60]
- stroke hospitalisations in 2016-2017 were higher among Aboriginal people compared with non-Aboriginal people across all remoteness areas, with hospitalisation rates higher in rural and remote areas than major cities
- rates of babies with a low birth weight are higher among Aboriginal people across all remoteness areas
- infant mortality rates for Aboriginal babies are slightly higher than for non-Aboriginal babies
- rates of vaccine preventable disease are higher among Aboriginal people than non-Aboriginal people in rural and remote areas.[61]

Social determinants of health

1.49 The social determinants of health are the non-medical factors that influence health outcomes, and include the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[62]

1.50 Numerous submission authors highlighted that there is a higher prevalence of the social determinants of poor health in rural and remote areas of New South Wales, compared with metropolitan areas, including:

- lower median incomes and greater levels of poverty
- lower rates of employment, educational attainment and quality housing options
- higher rates of disability (particularly in older residents), obesity, domestic and family violence, smoking, alcohol and drug use
- reduced access to fresh food and fluoridated water
- more road traffic accidents and fatalities
- greater occupational and physical risks due to dangerous rural occupations, such as mining and farming.[63]

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60 Australian Bureau of Statistics, *Life Tables for Aboriginal and Torres Strait Islander Australians* (29 November 2018), https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/life-tables-aboriginal-and-torres-strait-islander-australians/2015-2017.

61 Submission 630, NSW Government, pp 34-35.

62 World Health Organization, *Social determinants of health*, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

63 See for example: Submission 454, Centre for Rural and Remote Mental Health, pp 4-5; Submission 478, National Rural Health Alliance, pp 2-3; Submission 474, Australian and New Zealand College of Anaesthetists, p 2; Submission 276, New South Wales Medical Staff Executive Council, p 9;

1.51 When considered together, the NSW Rural Health Research Alliance argued that these factors largely explain life expectancy disparities between rural and metropolitan areas. Dr Alex Stephens, Chair, NSW Rural Health Research Alliance explained to the committee that:

> … a person's position in society, their living conditions and opportunities for education and employment have a direct bearing on their exposure to risk factors for disease and poor health that ultimately impacts their life expectancy. [64]

Committee comment

1.52 As a starting point in considering the many issues examined in this inquiry, it is important to acknowledge the evidence demonstrating that health outcomes, including key measures of life expectancy and mortality rates, are generally poorer for people living in rural, regional and remote New South Wales compared with those living in metropolitan areas.

1.53 Accordingly, the committee finds that rural, regional and remote patients have significantly poorer health outcomes, greater incidents of chronic disease and greater premature deaths when compared to their counterparts in metropolitan areas.

Finding 1

That rural, regional and remote patients have significantly poorer health outcomes, greater incidents of chronic disease and greater premature deaths when compared to their counterparts in metropolitan areas.

1.54 The committee acknowledges that this inquiry was undertaken and completed in the shadow of the COVID-19 pandemic. The issues explored in this report were not in and of themselves caused by the pandemic, but rather, were magnified by it.

1.55 The committee expresses, on behalf of all New South Wales citizens its sincere thanks and appreciation to all the employees of NSW Health who have worked tirelessly during the COVID-19 pandemic to protect and care for the whole population.

Submission 604, Aged and Community Services Australia, p 5; Evidence, Ms Colette Colman, Director – Policy and Strategy Development, National Rural Health Alliance, 19 March 2021, p 3.

64 Evidence, Dr Alex Stephens, Chair, NSW Rural Health Research Alliance, 5 October 2021, p 27.

Chapter 2 Patient contact, experience and outcomes

This chapter focuses on the experiences of residents in regional, rural and remote New South Wales as they engage with medical services provided in and around their local areas. As members of the public generally do not make a distinction between the level of government that is providing them with a specific service, much of the evidence heard by the committee crosses jurisdictional boundaries.

The chapter first documents community experiences with health care heard through the inquiry, then focuses on the perspective of culturally and linguistically diverse communities, support for rural patients and NSW Health's perspective. Within these sections themes such as the challenges faced by residents in regards to availability of and access to health and hospital services, modes of travel, the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) program and the reliance on financial and other support provided by charity and community groups are explored.

Community experiences with health care: overall themes

2.1 During the conduct of this inquiry the committee received more than 700 submissions and over the course of 11 months conducted 15 hearings, visiting 7 locations and hearing from 220 individual witnesses.

2.2 Many of these written and oral accounts spoke of health care professionals doing their best with limited resources. However, in numerous cases the perceived standards of care and the timeliness with which these services were delivered was considered to be below or of a very poor standard.

2.3 A broad range of issues were documented by community members, organisations and peak bodies. Common issues conveyed to the committee included:

- emergency departments with no doctors
- severe shortage of nurses and midwives
- care being delivered by non-health care professionals
- excessive wait times to access or receive treatment
- misdiagnosis and medical misadventure
- lack of culturally safe and sensitive services for First Nations people (discussed in detail in Chapter 6)
- the distance travelled to access care
- cost.

2.4 The following represents a sample of the stories provided to the committee by members of the community, documenting these issues:

- 'At what point did it become acceptable to have a multipurpose service open for business with an emergency and ambulance sign out the front and no doctor inside the walls? It is false advertising. It fills the community with false hope that they will receive appropriate

care should they need it when in fact that could not be further from the truth. The system is failing'.[65]

- 'I had the misfortune of falling ill late one night. I presented to the local hospital. We have no doctor at the hospital, there was no local Doctor on call, so I was told I would have to go to Wagga Wagga, but there were no ambulances available either (the ambulance drivers had been on duty for 14 hours already). So in considerable pain, my husband drove me the 100 kilometres to Wagga Wagga hospital. When I got there I presented to emergency, I waited in the waiting room for over 2 hours, then went into the other triage room where I was for the next 10 hours'.[66]
- 'One of our neighbours lacerated his forehead. He went to Nyngan and was told there was no doctor. They rang Warren. They were told that they had a doctor but no suture kit, so he had to drive half an hour to Nyngan and then he had to drive an hour to Warren carrying his own suture kit'.[67]
- 'Recently, the cook from the hospital was forced to sit with a patient in a car park outside our facility who had had a stroke. This was because the two nurses who were on duty were too busy in the emergency department and in the ward … We are talking about two weeks ago. There was no ambulance in town to provide backup assistance ... The patient was forced to wait in the car for 15 to 20 minutes until the fire brigade could attend to provide assistance'.[68]
- 'We have got the situation now where we have cleaners in the emergency department, which I never thought I would say, who are sitting with patients who may be confused or demented … They have also been asked on the wards to actually sit and monitor the dementia patients because we no longer have a 16-bed dementia ward, which was closed without any consultation whatsoever with the community'.[69]
- 'I recently had a bad experience with telehealth at Condobolin emergency. Long story short they misdiagnosed my illness … The Telehealth doctor told me I had gastro when I actually had appendicitis. I believe the nurse thought it was a serious stomach issue however was overruled by the telehealth doctor. Unhappy with this diagnosis I travelled to Forbes hospital (100km away) where a doctor assessed me in person then admitted me and commenced treatment for an infection. Further testing found it was to be appendicitis. My appendix were then removed 5 days later. This potentially fatal mistake I believe could have been averted if there was a doctor in person at Condobolin emergency department'.[70]
- 'It is extremely difficult to get an appointment to see a doctor in Moree. There are two medical practices, wait times for an appointment at either of them is typically three to six weeks if one is even available'.[71]

65 Evidence, Mrs Hayley Olivares, Private individual, 18 May 2021, p 35.
66 Submission 3, Name suppressed, p 1.
67 Evidence, Mrs Sally Empringham, Private individual, 18 May 2021, p 39.
68 Evidence, Pen McLachlan, Nurse, Condobolin, 30 April 2021, p 12.
69 Evidence, Mr Eddie Wood, President, Manning Great Lakes Community Health Action Group, 16 June 2021, p 6.
70 Evidence, Ms Annie Ryan, Deputy Chair, Doctor Crisis Condobolin, 30 April 2021, p 31.
71 Submission 472, Gwydir Cotton Growers Association, p 6.

- 'Generally the average wait time is 18 months to two years, and that includes for early intervention. Kids who are referred to speech pathology through general practice, through the NDIS or through any means at preschool age are still looking at 18 months to two years for the vast majority of speech therapy services … If we are not getting to kids before they are five years old, a lot of the issues that they have are incredibly difficult to remediate'.[72]
- 'Right now at many stations across western New South Wales the closest declared mental health facility is two or three hours away. For example, Lake Cargelligo goes to Griffith for mental health patients. This takes the patient away from their support network, increasing their anxiety and often exacerbating their condition'.[73]
- 'There is a mental health unit there on Yambil Street, and their psychiatrist is fly-in fly-out and it takes every two weeks … But if you have to go privately … people have paid up to $700 to have access to online services for a psychiatrist. The mental health unit in Griffith tells you that if you want to access a psychiatrist and you have not been referred or you are not having an acute situation, you will not get access to that fly-in fly-out psychiatrist.'[74]
- 'For people who can afford to go private, ENT [ear, nose and throat] services are readily quite accessible, but anyone who is reliant on the public system is being informed of anywhere of three years plus for interventions and surgical interventions all need to take place either in John Hunter, at Maitland or Gosford. So families are incurring costs for travel as well. For some families, depending on the type of surgical intervention, they are asked to stay for two weeks within the vicinity of an emergency department with an ENT on call … On average, parents seem to be incurring debts of anywhere between $4,500 to one of our families anticipating approximately $20,000 because their second child has been identified to have issues as well and it is also linked to orthodontic work that will be required.'[75]
- 'It is expensive to travel out of town. People have to leave their jobs and their families and pay for travel, accommodation and food. If they were to take someone else to support them, that is even more expensive. Transport options are limited and it is stressful.'[76]
- 'There is no public transport, so travelling to distant medical services 100km or more away is difficult and expensive'.[77]

72 Evidence, Dr Edward Johnson, President, Services for Australian Rural and Remote Allied Health, 3 December 2021, p 3.

73 Evidence, Mr Scott Beaton, Vice President and Intensive Care Paramedic, Station Officer, Gilgandra Station, Australian Paramedics Association (NSW), 10 September 2021, p 10.

74 Evidence, Mrs Linda McLean, Agriculture and Environment Officer, Country Women's Association of NSW – Hillston Branch, 6 October 2021, p 14.

75 Evidence, Ms Bree Katsamangos, Convenor, Mid Coast 4 Kids, 16 June 2021, p 8.

76 Evidence, Ms Jenny Lovric, Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest, 3 December 2021, p 3.

77 Submission 227a, Mr Graeme (Mick) McLeod, p 1.

- 'Danielle and Tony, made 132 trips over 2½ years, travelling around 24,000 kilometres, seeking treatment for their seven-year-old daughter Halley and 74 per cent of this travel related to radiotherapy treatment. Whilst the treatment itself is often as short as 15 minutes, the frequency, length of treatment and its delivery as an outpatient makes it uniquely expensive for those that do not live close to these services. The indirect impacts are financially devastating. In Halley's case, her mum stopped full-time work, her dad dropped back to two days a week and Halley's grandmother left her part-time job'.[78]
- 'I was diagnosed with terminal stage 4 Ovarian Cancer in July 2017 at just 44 years of age … I'm writing this submission today because I'm exhausted … because there is just no access or support to obtain services for regional women with ovarian cancer … After diagnosis I travelled from Bellingen to Newcastle for extensive debulking surgery … After surgery I was referred to a specialist Oncologist in Sydney to oversee six months of chemotherapy … I was not able to claim any assistance for travel … because technically I was entitled to receive my chemotherapy infusions locally thru the Coffs Harbour Hospitals cancer centre but in order to do that I would be required to go on a waiting list … I also had to sell most of my possessions to cover my fuel costs … in 2019 I was offered an opportunity to join a trial … I eagerly joined the trial & for the past year have been attending the Prince Of Wales Hospital in Randwick to receive treatment & medication. But yet again I am unable to claim any assistance for travel. Trials are not deemed necessary medical procedures or appointments and as such not covered by the IPTAAS … I cannot begin to explain the added stress that travel & lack of financial support adds to a terminal cancer diagnosis on top of the inconvenience that constant travel for treatment has caused to my daughters schooling. Ultimately I am left with no choice but to relocate in my dying days from my regional home town & community to better access health services & financial support'.[79]

2.5 The committee also heard evidence from journalists Ms Liz Hayes and Ms Jamelle Wells, appearing in their private capacity to tell the stories of their fathers, both of whom died in tragic circumstances in rural hospitals.

2.6 Ms Hayes and Ms Wells both gave oral testimony at a public hearing on 10 September 2021. In their evidence, it was explained that in addition to their families' own personal experiences, many people and families from around the state had contacted them regarding issues with the health system.[80]

Case study: Mr Bryan Ryan as presented to the committee by Ms Liz Hayes

In August 2019, when my father was taken to Manning Base Hospital by ambulance, we, and he had no idea he'd never come home.

Dad was admitted to the public hospital's emergency department with what would be diagnosed as pneumonia. From the beginning there were concerning signs that Dad was not necessarily in the best of hands.

78 Evidence, Ms Emma Phillips, Executive Director, Can Assist, 5 October 2021, pp 2-3.

79 Submission 420, Ms Carla Bower, pp 1-2.

80 Evidence, Ms Liz Hayes, Private individual, 10 September 2021, p 4; Evidence, Ms Jamelle Wells, Private individual, 10 September 2021, p 4.

Despite having with him a Webster pack of the prescribed medications he took everyday, on three occasions at the hospital that night, he was given higher doses of medication than he normally took. In fact, Dad was overdosed twice the amount with one drug which slowed his heart to a concerning level.

Manning Base Hospital conducted what was called a London Protocol Investigation, which determined Dad's "near miss", as I describe it, was the result of human error. The report also investigated Dad's transfer from the public hospital via ambulance to the nearby Mayo Private Hospital where he was to fully recuperate. It was determined that that process too had failed Dad. He did not have with him a medical discharge summary. Had the paperwork been done properly we are left to wonder whether what happened next, might have been prevented.

Upon arrival at the Mayo Private Hospital, Dad was assessed and admitted. My father had a heart condition called Atrial Fibrillation. The medication treatment included a blood thinner considered crucial to helping prevent strokes. Despite not having a medical discharge summary with him there was a full list of Dad's prescribed medications. But for whatever reason, the doctor at The Mayo Private Hospital who undertook to chart that list, missed the blood thinner. Put simply, it was not written down.

It meant for the entire eight days of Dad's stay, he was not given this vital stroke prevention medication. And despite being nursed daily and attended to by other doctors during his stay, no one picked up the error.

My father suffered a catastrophic stroke.

It was only when my family and I attended Manning Base Hospital where Dad was taken for emergency treatment, did we learn of the error, written in his hospital notes. The doctor from the Mayo Private Hospital who had already gone home, later came to the emergency department and advised medical staff of the medication error. A Root Cause Analysis investigation cited human error.

In the end, my family was left flabbergasted that our father, a fully paid up private health insurance patient (not that that mattered) could have his life so shockingly compromised. That his and our trust in a health system was so poorly placed.

And it was shattering to learn that this 79 bed private hospital with often elderly and vulnerable patients had only one doctor rostered on, and who bundied off in the evening. During our family meeting with hospital management, it was explained that this situation of just one doctor to cover all patients, was because 'that's the case in most country hospitals'.[81]

Case study: Mr Allan Wells as presented to the committee by Ms Jamelle Wells

There were signs from the start [in 2019] that the hospital could not cope, and my Dad was treated like a bed-blocker. He had two operations in five days after something went horribly wrong with the first one. The wrong surgeon's name was above his bed and in his records. Just hours after we fought an attempt to discharge him, he went into cardiac arrest. Staff then suggested not resuscitating him, even though he had a full resuscitation plan in place. My Dad defied their expectations and he pulled through. What happened next was inhumane. Dad begged for food and water on a long weekend because a manager said the hospital could not afford to roster someone on to do a sip test to see if he could eat and drink safely.

[81] Submission 613, Ms Elizabeth Hayes, pp 1-2.

My father's ward ran out of morphine; it ran out of Panadol; staff were stretched beyond safety limits. An unsupervised junior intensive care unit doctor fought back tears over the distress he caused Dad by three botched attempts to insert a tube in his nose. Staff with no geriatric care training wrote 'dementia' in Dad's records, even though he never had any reason to be diagnosed with it and he passed all hospital mental acuity tests 100 per cent.

Dad was bundled out of Dubbo hospital back to Cobar by road ambulance in 40-degree heat. He arrived in Cobar at night and "not to be returned" was written on his discharge papers. He was soon discharged from an empty Cobar Hospital too.

I can still see my father's frightened face. He was in pain and still unable to walk. He knew Cobar Hospital staff did not want to look after him. Dad was taken to the nursing home on Melbourne Cup Day thinking he was not worthy of a hospital bed.

He grabbed my arm and cried as he said "They're giving up on me".

My father died five days later.

Months later I was gutted to see a photo of the New South Wales Health Minister, Brad Hazzard, and health executives on the front of a Dubbo newspaper, launching a new $30-million hospital carpark. Dubbo Base Hospital thought it was ok to let my 85-year-old critically ill father beg for pain relief, food and water to cut costs. They thought it was ok to publicly celebrate spending $30-million on a new carpark.

This is a cruel indifference to human suffering and to the elderly that I never thought I would see in a country like Australia. It's one of many examples of a badly managed Local Health District that is out of touch with the needs of the country people it is meant to be taking care of.[82]

Access to services: the tyranny of distance

2.7 Numerous stakeholders expressed concern that the lack of timely access to health and hospital services for rural, regional and remote residents, across all types of care and disciplines, means that health outcomes are inextricably linked to postcode.[83]

2.8 By way of context, of the Local Health Districts that exclusively service residents in regional, rural and remote New South Wales:

- the Mid North Coast Local Health District covers the smallest geographical area at 11,335 square kilometres with approximately 211,000 residents[84]

82 Evidence, Ms Jamelle Wells, Private individual, 10 September 2021, p 2 and Submission 351, Ms Jamelle Wells, pp 1, 3-4.

83 See for example: Evidence, Mr Jeff Mitchell, Chief Executive Officer, Cancer Council, 5 October 2021, p 3; Evidence, Ms Annie Miller, Director, Cancer Information and Support Services, Cancer Council, 5 October 2021, p 4; Evidence, Mrs Olivares, 18 May 2021, p 35; Evidence, Ms Kate Ryan, Registered nurse, 16 June 2021, p 23; Submission 173, Cancer Council NSW, p 19; Submission 345, Local Government NSW, p 13; Submission 172, Temora Shire Council, p 3; Submission 416, Mrs Barbara Seis, p 5.

84 NSW Government - Health, Local Health Districts - Mid North Coast, https://www.health.nsw.gov.au/lhd/Pages/mnclhd.aspx.

- the largest Local Health District is Western NSW which covers approximately 250,000 square kilometres reaching from the Queensland border down to Cowra and services approximately 270,000 people[85]
- the Hunter New England Local Health District services the highest number of residents at approximately 920,000 people and covers a region of 131,785 square kilometres.[86]

2.9 Despite the large geographical areas that these Local Health Districts encompass, residents of rural, regional and remote New South Wales generally accept that specialists services cannot be provided in all locations.[87] Nevertheless, as noted by The University of Newcastle Australia, Department of Rural Health, they do expect primary and basic emergency care to be accessible when required:

> They do not expect to have tertiary level resources delivered locally. They do expect high quality locally delivered extended primary care with aged care, palliative care and management of uncomplicated medical and surgical conditions at district hospitals. They expect the same level of service as in urban areas for basic emergency care … It is my experience as a GP that rural residents do understand the tyranny of distance and of workload. They ask for comparable service to those available in the urban areas.[88]

2.10 While the issue of doctor shortages is explored in detail in Chapter 3, this section focuses on what this means for patients.

2.11 At its hearing in Lismore, Mr George Thompson, Member, Coraki Health Reference Group, called the committee's attention to 25 areas in New South Wales that do not have or are experiencing a shortage of general and/or health practitioners:

> … I can tell you that the following submissions all draw attention to the absence of a GP or chronic shortage of health professionals: Bonalbo, Eurobodalla, Gunnedah, Deniliquin, Edward River, Manning Valley, Port Stephens, Temora, Glen Innes, Gulgong, Wee Waa, Wollondilly, Mid-Western Regional Council, Coleambally, Warren Shire Council, Broken Hill, Wentworth, Merriwa, Tenterfield, Parkes, Coonamble, Gwydir, Bourke, Hay and Leeton.[89]

2.12 In this regard, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network told the committee that in a survey of Western and Far West New South Wales, 41 towns were identified as being at risk of not having a practicing General Practitioner within the next 10 years.[90]

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85 NSW Government - Health, Local Health Districts - Western NSW, https://www.health.nsw.gov.au/lhd/Pages/wnswlhd.aspx.

86 NSW Government - Health, Local Health Districts – Hunter New England, https://www.health.nsw.gov.au/lhd/pages/hnelhd.aspx.

87 See for example: Evidence, Cr Ruth McRae, Mayor, Murrumbidgee Council, 29 April 2021, p 5; Submission 670, The University of Newcastle Australia, Department of Rural Health, p 8; Submission 470, Murrumbidgee Council, p 2; Submission 461, My Emergency Doctor, p 2.

88 Submission 670, The University of Newcastle Australia, Department of Rural Health, p 8.

89 Evidence, Mr Thompson, Member, Coraki Health Reference Group, 17 June 2021, p 4.

90 Evidence, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network, 19 March 2021, p 10.

2.13 It almost goes without saying that, where communities do not have access to a local General Practitioner, they are required to travel to access primary care.[91] The committee heard that this situation then leads to services in nearby towns becoming overwhelmed and community members being told that the General Practices' 'books are closed' to new patients.[92]

2.14 Asked about what happens when an individual cannot register with a new practice, Mrs Kate McGrath, former Chair and founding member of the Gunnedah Community Roundtable, responded: 'if you cannot get into a doctor, that's it—end of the line. You do not get to see a doctor'.[93]

2.15 The committee heard that even where community members are able to secure a booking, the reported wait time to see a General Practitioner can be anywhere from three to six weeks.[94] In her submission to the inquiry, Mrs Annette Piper made the following observation about wait times in her community:

> The local GP is overwhelmed with regular appointments for non-urgent things. If you are actually SICK and NEED to see a doctor you CANNOT get in. You need to wait a minimum of 3 weeks to get an appointment. The wait times in other centres over an hour away are similar.[95]

2.16 In this context, several stakeholders highlighted that where a person must accept the first available appointment at any practice, continuity of care is difficult to maintain as it is highly unlikely that the individual will be seen by the same doctor.[96]

2.17 Turning from primary to specialist care, the committee heard that the varying sizes of the Local Health Districts and the distribution of their respective facilities requires some residents to travel significant distances, including across state or territory boundaries, to access publicly available specialist services. The following examples are a sample of cases provided to the committee documenting this issue:

91 See for example: Evidence, Cr Jamie Chaffey, Mayor, Gunnedah Shire Council, 16 June 2021, p 4; Submission 403, Australian College of Rural and Remote Medicine, p 3; Submission 173, Cancer Council NSW, p 9.

92 See for example: Evidence, Cr Chaffey, 16 June 2021, p 4; Submission 379, Dr Simon Holliday, p 3; Submission 347, Mrs Sharon Bird, Bonalbo Pharmacy, p 1; Submission 412, Mr Brian Jeffrey, p 412; Submission 145, Name suppressed, p 1; Submission 215, Ms Sue Newbery, p 1; Submission 291, Name suppressed, p 3; Submission 358, Mr Simon Goddard, p 1.

93 Evidence, Mrs Kate McGrath, former Chair and founding member, Gunnedah Community Roundtable, 16 June 2021, p 8.

94 See for example: Submission 472, Gwydir Cotton Growers Association; Submission 231, Mrs Carol Richard, p 1; Submission 395, Name suppressed, p 1; Submission 251, Mrs Courtney Dawson, p 1.

95 Submission 233, Mrs Annette Piper, p 1.

96 See for example: Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 19 March 2021, p 54; Submission 573, Australian Medical Association, p 4; Submission 524, Name suppressed, p 1; Submission 582, Dr Joe McGirr MP, Independent Member for Wagga Wagga, p 3.

- Resident of Coolah – 'This week we have travelled 500kms on Monday, another 200kms on Tuesday & Wednesday when we were lucky to secure a specialist Cardiologist appointment in Coonabarabran … We went back to Dubbo yesterday [over 300 km round trip]'.[97]
- 'On many occasions my family members have had to travel 150km to Cobar which is the closest hospital to the farm, to only receive poor care or needing to travel an even further 300km to Dubbo'.[98]
- 'I live in Deniliquin … For ongoing complex care referrals are made across to other MLHD hospitals such as Albury, Wagga Wagga and Griffith. These are between 200km and 300 km away. Being close to the Victorian Border, it is often more accessible to go to Echuca, Shepparton, Bendigo and Melbourne - all based in Victoria'.[99]
- 'Patients from these towns [Moree, Nyngan, Bega] could be travelling anywhere from 450 to 600 kms return to access a regional radiotherapy service (in Tamworth, Orange or Nowra)'.[100]
- 'Broken Hill Hospital (Far West Local Health District) is limited to what surgical procedures can be conducted locally so I had to drive myself to Adelaide which is 500km from Broken Hill'.[101]
- '… the nearest dialysis machine from Wilcannia is 200 kilometres away. Travel three days a week for dialysis. That is a 1,200-kilometre-a-week trip for them. That is 5,000 kilometres a month that they have to do'.[102]
- 'There are some towns in NSW with very limited access to satellite dialysis units. One for example is Tenterfield where the closest units are Inverell (158km), Armidale (189km) or Lismore (158km). This would equate to over 300km a day round trip 3 times a week for patients and/or family to get to dialysis'.[103]

2.18 As well as the burden of travelling long distances, the wait times for publicly funded specialist and allied services can be extensive. Numerous submission authors highlighted that for some services, the wait time can be many months or even years, for example:

- 'Mid Coast 4 Kids have identified significant numbers of children falling through the gaps, failing to access services; encountering significant wait times … to address such issues as hearing loss, vision impairment, speech and language delay and behaviour … Parents are currently being advised of wait times anywhere between 4 and 6 years'.[104]

97 Submission 291a, Name suppressed, p 1.
98 Submission 313, Name suppressed, p 1.
99 Submission 27, Name suppressed, p 1.
100 Submission 34, Can Assist (Cancer Assistance Network), p 2.
101 Submission 73, Name suppressed, p 1.
102 Evidence, Mr Michael Kennedy, Private individual, 2 December 2021, p 38.
103 Submission 390, Ms Nicole Scholes-Robertson, p 5.
104 Submission Mid Coast 4 Kids, pp 3-4.

- '[M]y youngest needs to see a Paediatrician and has been on the waiting list for over two years. The Tamworth dr we are on the list to see called about a month ago to ask if we are still wanting to see a dr. We of course replied yes and were told till will be at least another 8 month wait'.[105]
- 'GPs based in the mid North [East] coast of NSW have reported wait times of longer than 18 months for access to speech pathologists, occupational therapists, and ENT specialists'.[106]
- 'For a significant number of specialities wait times for appointments are in excess of 6 [months], notable examples being ENT, rheumatology and psychiatry'.[107]

2.19 The Australian College of Rural and Remote Medicine and numerous other submission authors emphasised the seriousness of this situation, highlighting that the inability of residents to obtain timely access to services is leading individuals to not seek treatment or presenting when conditions have escalated, which results in poorer health outcomes, increased health care costs, loss of economic productivity and poorer quality of life.[108]

2.20 Due to this a number of submission authors noted that some residents are choosing to relocate from rural areas to be closer to health and hospital services.[109]

Modes of transport

2.21 As noted above, residents of rural, regional and remote New South Wales accept that some travel is generally required to access many health and hospital services. However, the committee heard that the limited accessibility of cost-effective modes of transport has become a further barrier to accessing services in the locations they are available.[110]

2.22 Submissions and evidence to the committee at its public hearings identified private vehicles, public transport, community transport and transport owned by private operators as being the four key modes of transport used to access health and hospital services. This section covers each of these in turn, addressing availability, accessibility and cost.

105 Submission 197, Mrs Dwyer Crystal, p 1.

106 Submission 629, The Royal Australian College of General Practitioners (RACGP), p 2.

107 Submission 607, Dr Geoffrey Stewart, p 2.

108 Submission 403, Australian College of Rural and Remote Medicine, p 4, see also; Evidence, Mr Mitchell, 5 October 2021, p 4; Evidence, Cr Chaffey, 16 June 2021, p 5; Submission 403, Australian College of Rural and Remote Medicine, p 3; Submission 252, Wee Waa Chamber of Commerce, p 1; Submission 429, Mrs Jenny Caslick, p 1.

109 See for example: Submission 278, Old Bonalbo CWA, p 2; Submission 434, Mr Andrew Johnson, p 2; Submission 43, Name suppressed, p 1; Submission 229 Ms Sarah Pringle, p 1;

110 Evidence, Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, 29 April 2021, p 50, see also: Evidence, Mr Brendon Cutmore, Executive Director, Aboriginal Health and Wellbeing, Western NSW Local Health District, 30 April 2021, p 23.

Private vehicles

2.23 The committee heard that the most common form of transport used to access services are private vehicles,[111] with a significant number of submission authors noting that they drive because it is their only option to access health and hospital services.[112] This was echoed in evidence from witnesses who appeared at the committee's hearings in Deniliquin, Cobar and Lismore.[113]

2.24 Furthermore, at its hearing in Lismore, Mrs Marilyn Grundy, Branch President, Ballina Cancer Advocacy Network told the committee that if you are unable to drive and live in an area that is not serviced by public transport, you are wholly reliant on the generosity of friends, family and neighbours.[114]

2.25 The committee also repeatedly heard that the significant distance to be travelled to access services and the associated cost of petrol can be an immediate disincentive to seek medical assistance,[115] and has been identified as the primary reason why individuals choose not to follow through with or seek treatment.[116]

Public transport

2.26 The limited public transport available in regional, rural and remote areas of New South Wales consists of bus and/or train services. However, the committee heard that current infrastructure and the majority of routes do not provide the community with services capable of assisting them to meet their travel needs for medical purposes.[117]

2.27 Whilst a more economic option, public transport services are not available in all locations, are often irregular and can result in long and difficult journeys,[118] as Cancer Council NSW highlighted:

111 Evidence, Mrs Empringham, 18 May 2021, p 39, see also; Submission 365, Mrs Jessica Elwell, p 1; Submission 370, Dr Tom Bennett, p 1.

112 See for example: Submission 387, Chamber of Commerce and Industry Lawson, p 6; Submission 386, Mrs Annette Holman, p 1; Submission 420, Ms Carla Bower, p 1.

113 Evidence, Mr Tim Burge, Private individual, 29 April 2021, p 32; Evidence, Ms Jenny Tyack, Chair, Doctor Crisis Condobolin, 30 April 2021, p 29; Evidence, Mrs Sharon Bird, Pharmacist and Proprietor, Bonalbo Pharmacy, 17 June 2021, p 10.

114 Evidence, Mrs Marilyn Grundy, Branch President, Ballina Cancer Advocacy Network, 17 June 2021, p 7, see also; Submission 278, Old Bonalbo CWA, p 1.

115 Submission 34, Can Assist (Cancer Assistance Network), p 2, see also; Submission 390, Ms Nicole Scholes-Robertson, p 2; Submission 562, Name suppressed, p 2, Submission 429, Mrs Jenny Caslick, p 1.

116 Submission 454, Centre for Rural and Remote Mental Health, p 6.

117 Submission 173, Cancer Council NSW, p 15, see also; Evidence, Cr Norm Brennan, Mayor, Edward River Council, 29 April 2021, p 10; Evidence, Mrs Alison Campbell, Member, Warren Health Action Committee, 18 May 2021, p 30.

118 Submission 173, Cancer Council NSW, p 15, see also; Evidence, Cr Brennan, 29 April 2021, p 10; Evidence, Mrs Campbell, 18 May 2021, p 30.

> If public transport is available, the limited reach of services, infrequent services, long wait times, and poor connections makes public transport a gruelling experience, if not impossible, for people who are already under significant physical and emotional strain.[119]

2.28 Furthermore, as Edward River Council pointed out, services in most areas do not cater for same day travel.[120] Numerous stakeholders noted that as a result, overnight accommodation is often necessary if a resident relies on public transport to attend medical appointments.[121] Accommodation then becomes a further financial burden.[122]

Community transport

2.29 In recognition of the lack of publicly available transport options, the committee heard that some local councils and a number of private providers[123] offer community transport services to help meet the needs of residents.[124]

2.30 For example, Cr Neville Kschenka, Mayor, Narrandera Shire Council informed the committee that in conjunction with the NSW and Australian Governments, the Council funds and operates a community transport service that has provided over 10,400 trips, with 85 per cent of these attributable to community members travelling out of town for medical reasons. This service is utilised by 1,400 of the 6,000 people that reside within the boundaries of Narrandera Shire Council.[125]

2.31 According to Local Government NSW, councils are often funded for these services through the provision of grants, however as the grants are administered by different government agencies at the state and federal level, situations arise whereby some residents qualify to access the service while others are excluded based on the terms of the grant.[126]

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119 Submission 173, Cancer Council NSW, p 15.

120 Submission 248, Edward River Council, p 1.

121 Evidence, Mr Brian Jeffery, Private individual, 16 June 2021, p 36; Submission 95, Deniliquin Health Action Group, p 1.

122 Submission 478, National Rural Health Alliance, p 4, see also; Submission 279, Dementia Australia, p 6; Submission 173, Cancer Council NSW, pp 2, 10, 14-16; Submission 34, Can Assist (Cancer Assistance Network), p 2.

123 Evidence, Mrs McGrath, 16 June 2021, p 7, see also; Submission 410, Wentworth District Community Medical Centre Inc, p 3; Submission 464, Blue Mountains City Council, p 9; Submission 484, Mrs Shirlee Burge, p 7.

124 See for example: Submission 345, Local Government NSW, p 9; Submission 172, Temora Shire Council, p 4, Submission 253, Wollondilly Shire Council, p 2, Evidence, Cr Neville Kschenka, Mayor, Narrandera Shire Council, 6 October 2021, p 4, Submission 97, Rotary Club of Warren, p 1, Submission 400, Yass Valley Council, p 1, Submission 402, Port Stephens Council, p 3.

125 Evidence, Cr Kschenka, 6 October 2021, p 4.

126 Submission 345, Local Government NSW, pp 8-9.

2.32 Stakeholders also pointed out that community transport services are generally staffed by volunteers,[127] and that as the rural, regional and remote population ages there may be fewer volunteers available to undertake this role.[128]

2.33 Nor is this a free service. Residents are charged a nominal fee to utilise community transport which, depending on the frequency of treatment, may leave the person unable to meet the cost of travel.[129] The committee was provided with the following case studies to illustrate the cost of community transport to individuals:

- 'George and Carol live 20 kms from Kempsey. George needed chemotherapy every 3 weeks for 6 months and was too unwell to drive himself and Carol didn't drive. George needed to attend Port Macquarie Base Hospital, approximately 60 km away but there is scarce public transport available. Even if it was available, it wasn't an option for him due to his health. The only other option was Community Transport but this costs $60.00 for the return trip and therefore added to George and Carols stress, worrying about money'.[130]
- 'There's also an impediment for the aged accessing the care they need with 'community cars' costing $75 for a pensioner to get them to an appointment in the nearest regional city where their specialists are available. This is too expensive especially if there are numerous appointments or where the specialist charges well beyond the Medicare rebate'.[131]
- 'Live Better Community Transport - Cost $40 to $50 Cheaper than taxi but still expensive for a pensioner. Also at times of high demand a car may not always be available at the required time of the day'.[132]

2.34 Similar to public transport, the committee heard that community transport is not always available to meet the needs of all residents.[133]

Private transport providers

2.35 Where an individual cannot drive and does not have access to public or community transport but must travel to access health and hospital services, the only remaining option available is private transport providers such as taxis. Stakeholders noted that these services generally offer

127 See for example: Evidence, Cr Kschenka, 6 October 2021, p 4; Submission 345, Local Government NSW, p 9; Submission 278, Old Bonalbo CWA, p 1; Submission 400, Yass Valley Council, p 1.

128 Submission 167, Manning Valley Push for Palliative, p 10.

129 Submission 34, Can Assist (Cancer Assistance Network), p 2, see also; Submission 464, Blue Mountains City Council, p 9; Submission 662, Name suppressed, p 1.

130 Submission 173, Cancer Council NSW, p 15.

131 Submission 291, Name suppressed, p 1.

132 Submission 662, Name suppressed, p 1.

133 See for example: Submission 95, Deniliquin Health Action Group, p 1; Submission 464, Blue Mountains City Council, p 10; Submission 109, Name suppressed, p 2; Submission 551, Name suppressed, p 1.

more flexibility in terms of availability and service hours,[134] but there are limited providers and/or cars located in regional and rural towns.[135]

2.36 The committee heard that this form of transport is often the last resort of residents as the cost is considered prohibitive, as a number of submission authors noted.[136]

2.37 In this regard, it was again acknowledged that residents in regional, rural and remote New South Wales on average face greater socio-economic challenges,[137] and that the additional burden of funding a mode of transport to attend medical appointments has resulted in some residents delaying or deciding not to seek treatment as they cannot afford the associated costs.[138]

Support for rural patients

2.38 The committee heard that patients located in rural, regional and remote New South Wales can access the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) but in some cases also rely on the charity sector for financial support to access healthcare. These matters are detailed below.

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

2.39 To alleviate some of the financial burden associated with the requirement to travel for medical treatment, the NSW Government funds the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). This scheme is specifically designed to subsidise travel and accommodation costs.[139]

2.40 In order to access the scheme residents must meet a number of eligibility criteria, and complete and submit an application. The rebate is then reimbursed on the provision of tax invoices pre or post travel.[140]

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134 See for example: Submission 387, Chamber of Commerce and Industry Lawson, p 5; Submission 96, Ms Margaret Morgan, p 1; Submission 410, Wentworth District Community Medical Centre Inc, p 3.

135 See for example: Submission 464, Blue Mountains City Council, p 9; Submission 410, Wentworth District Community Medical Centre Inc, p 3; Submission 113, Name suppressed, p 1;

136 Submission 176, Council on the Aging (COTA) NSW, p 5; see also Submission 186, Mrs Jillian Davidson, p 1; Submission 111, Name suppressed, p 1; Submission 662, Name suppressed, p 1; Submission 410, Wentworth District Community Medical Centre Inc, p 3; Submission 390, Ms Nicole Scholes-Robertson, p 4.

137 Evidence, Mrs Campbell, 18 May 2021, p 30, see also; Submission 272, the Royal Australian and New Zealand College of Psychiatrists (RANZCP), p 6; Submission 479, Isolated Children's Parents' Association of New South Wales Inc, p 3; Submission 176, Council on the Aging (COTA) NSW, p 2.

138 See for example: Evidence, Mrs Campbell, 18 May 2021, p 30; Evidence, Mrs Rebecca Dridan, Chair, Gunnedah Early Childhood Network, 16 June 2021, p 7.

139 Isolated Patients Travel and Accommodation Assistance Scheme, Home, http://www.iptaas.health.nsw.gov.au/.

140 Isolated Patients Travel and Accommodation Assistance Scheme, About IPTAAS, http://www.iptaas.health.nsw.gov.au/about .

2.41 However, evidence received in this inquiry suggested that general awareness of the scheme appears to be low.[141] According to the Regional Accommodation Providers Group and Can Assist (Cancer Assistance Network), approximately 35-40 per cent of guests that travel to their facilities for the purpose of medical treatment do not know about IPTAAS.[142] In this regard, the Gunnedah Early Childhood Network commented that the IPTAAS scheme relies heavily on practitioners and networks to inform potential recipients of its existence.[143]

2.42 For those that are aware of the scheme, one of the most common concerns expressed to the committee was around the complexity of completing IPTAAS forms.[144]

2.43 For example, the Regional Accommodation Providers Group told the committee that the complexity and administrative burden to the individual is such that they process and submit approximately 500 forms per month on behalf of clients.[145] In addition, the form requires individuals to ask their referring doctor to complete a section. In his submission, Mr David Moran expressed the guilt he feels at asking already busy doctors to complete yet another administrative task:

> I would like to see the IPTAAS scheme overhauled with a view to make it more easily accessible and simpler for both claimant and professionals … I often feel guilty and a nuisance for having to ask very busy Dr's to complete the forms and make the phone calls that are required for me to make a claim.[146]

2.44 Stakeholders also expressed that the rate of reimbursement for travel is considered to be wholly insufficient. At its hearing in Sydney, Mr Jeff Mitchell, Chief Executive Officer, Cancer Council reflected both on the complexity of the IPTAAS scheme and pointed out that the rate of travel reimbursement for IPTAAS is significantly lower than that available to New South Wales public servants:

> … as a government that wants to take care of the community, you really need to step back from this and think about why are there so many checks and balances and signatures and complexity put around a system that was put there with the intention of helping people who need the help? … if you are a New South Wales Government employee you are rightly reimbursed for travel, currently at the Australian Taxation Office rate, which is 72c per kilometre. IPTAAS is currently 22c per kilometre. That disparity should shock us, but the overriding point around accessibility, simplicity, that comes from what is the intent.[147]

141 See for example: Evidence, Ms Phillips, 5 October 2021, p 5, see also; Submission 479, Isolated Children's Parents' Association of New South Wales Inc, p 2; Submission 460, Mrs Kate Stewart, p 14; Submission 291, Name suppressed, p 1; Submission 51, Save Our Sons, Duchenne Foundation, p 20.

142 Submission 710, Regional Accommodation Providers Group and Can Assist, p 2.

143 Submission 270, Gunnedah Early Childhood Network, p 3.

144 See for example: Evidence, Ms Phillips, 5 October 2021, p 2; Submission 460, Mrs Kate Stewart, p 14; Submission 109, Name suppressed, p 2.

145 Submission 710, Regional Accommodation Providers Group and Can Assist, p 2.

146 Submission 598, Mr David Moran, p 1.

147 Evidence, Mr Mitchell, 5 October 2021, p 9.

2.45 In terms of accommodation, IPTAAS provides reimbursement at commercial and not-for-profit premises, however as Cancer Council NSW highlighted, this rate is too low to cover the out of pocket costs for not-for-profit accommodation providers, and does not come close to meeting the cost of accommodation charged by commercial providers. According to its submission, the rate of $43 (patient or carer) and $60 (patient and carer) per night for the first seven nights each financial year leaves individuals liable for a 'gap' payment regardless of the type of accommodation they are able to secure.[148]

2.46 The committee also heard that, in terms of eligibility for the scheme, individuals with private health insurance[149] and participants in clinical trials[150] are not eligible for reimbursement.

2.47 The discrepancy between the rebate and actual costs, eligibility issues and the difficulty in completing the IPTAAS forms led one submission author to reflect that the financial benefit is not work the effort.[151]

Reliance on the charity sector

2.48 The committee heard that the requirement to travel to access health and hospital services and the associated costs have led community members to rely more heavily on the charity sector for financial support.

2.49 According to Cancer Council NSW, the out of pockets expenses for people with cancer in regional locations are so high that one in five people report skipping health appointments because of the cost.[152]

2.50 Can Assist told the committee that it contributed $2.14 million in financial assistance to New South Wales residents in 2019, which represents a 40 per cent increase over a 5 year period.[153] While the spend varies from branch to branch, Moree, Nyngan, Bega, Armidale and Tumut report spending 60-70 per cent of their client assistance budget on travel and accommodation costs.[154]

2.51 Similarly, Cancer Council NSW reported that number of people supported by their accommodation service has tripled in the last four years.[155]

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148 Submission 173, Cancer Council NSW, pp 16-17, see also; Submission 620, Mr Roy Butler MP, Member for Barwon, pp 12-13; Submission 710, Regional Accommodation Providers Group and Can Assist, pp 3-4; Submission 390, Ms Nicole Scholes-Robertson, p 3; Submission 34, Can Assist (Cancer Assistance Network), pp 2-3.

149 Submission 51, Save Our Sons, Duchenne Foundation, pp 20-21.

150 See for example: Evidence, Ms Phillips, 5 October 2021, p 5; Submission 173, Cancer Council NSW, p 13; Submission 582, Dr Joe McGirr MP, Independent Member for Wagga Wagga, p 5.

151 Submission 146, Name suppressed, p 1.

152 Evidence, Mr Mitchell, 5 October 2021, p 3.

153 Submission 34, Can Assist (Cancer Assistance Network), p 1.

154 Submission 34, Can Assist (Cancer Assistance Network), p 2.

155 Submission 173, Cancer Council NSW, p 16.

2.52 The committee also heard that numerous community, charity and action groups such as the Rotary Club of Warren[156] and Manning Valley Push for Palliative[157] are actively raising money and contributing support, funds and resources to their local communities to improve access to treatment and medical equipment.[158]

2.53 As Ms Emma Phillips, Executive Director, Can Assist, told the committee at its hearing in Sydney, requests for assistance can come from anyone, regardless of socioeconomic status:

> I think a lot of us always think that it is the down-and-outs who put their hand out for help too, but I really want to table that the expense is across the spectrum. You could have someone that you think is asset and cash rich but behind the doors they are not. They are also calling out, and they can fall through the cracks. So it is not just those people who we means test; it is a real spectrum of people that need help.[159]

2.54 Additionally, the impact of a series of natural disasters and the pandemic has limited the ability of the community to contribute to charitable causes, which in turn has directly impacted their ability to support individuals and communities.[160]

The impact of COVID-19

2.55 While this inquiry was not established to specifically inquire into the impact of COVID-19 in rural, regional and remote New South Wales, many stakeholders discussed the way in which the pandemic impacted the health system. The committee heard that COVID exacerbated the pre-existing issues that were already faced by people living in these areas, a sentiment that was captured by the National Rural Health Alliance:

> The geographical disparity in health outcomes and services has also been worsened by the COVID-19 pandemic and consequent lockdowns, which have added to the pre-existing strain on public hospitals and primary health care services across the country.[161]

2.56 Other concerns raised by stakeholders included:

- border closures impacting those reliant on health services in a neighboring state or territory[162]

156 Evidence, Mr Harold Sandell, Former President, Rotary Club of Warren, 18 May 2021, p 32.

157 Evidence, Ms Judy Hollingworth, Founder and Deputy Chair, Manning Valley Push for Palliative, 16 June 2021, p 8.

158 Submission 345, Local Government NSW, p 20, see also; Submission 402, Port Stephens Council, p 3; Submission 710, Regional Accommodation Providers Group and Can Assist, p 3; Submission 284, Name suppressed, p 1.

159 Evidence, Ms Phillips, 5 October 2021, p 7.

160 See for example: Evidence, Mr Mitchell, 5 October 2021, pp 6-7; Evidence, Ms Hollingworth, Manning Valley Push for Palliative, 16 June 2021, p 9.

161 Submission 478, National Rural Health Alliance, p 4.

162 See for example Evidence, Mr Burge, 29 April 2021, p 32; Submission 95, Deniliquin Health Action Group, p 1; Submission 206, Mr Andre Othenin-Girard, p 1; Submission 218, Dr Florian Roeber, p 1; Submission 134, Name suppressed, pp 1-2; Submission 398, Broken Hill City Council, p 2; Evidence, Mr Philip Stone, General Manager, Edward River Council, 29 April 2021, p 4; Evidence, Cr Darriea Turley, Mayor Broken Hill City Council, 2 December 2021, p 8.

- increased wait times for elective surgery[163]
- regional areas growing in size post COVID, adding further strain on health services[164]
- increased mental health issues and difficulty accessing mental health services[165]
- increase in domestic violence due to lockdowns and difficulty accessing support services[166]
- a disconnect between the Aboriginal Community Controlled Health Services and the Local Health Districts, which impacted on the management of case numbers and providing support to Aboriginal communities.[167]

2.57 The impacts of the pandemic on the health workforce are discussed in Chapter 3.

NSW Health perspective

2.58 In their first appearance before the committee in March 2021, representatives of NSW Health observed that no health system, regardless of size or budget, is without its challenges. In particular, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health noted that poorer health outcomes increase with rurality and remoteness in part due to factors such as socio-economic status, but also because of distance from services and more limited access to primary care.[168] NSW Health acknowledged in its submission that a full range of services cannot be provided safely in every service location.[169]

2.59 In terms of patient experience in the state's public health system, NSW Health more recently highlighted that the majority of people that pass through public hospitals have good experiences. A recent survey conducted by the Bureau of Health Information found that from July 2019 to June 2020, of 4,500 adults who were admitted to rural public hospitals, 95 per cent said that the overall care they had received was very good or good. 9 in 10 patients said they were treated with respect and dignity, and 8 in 10 reported that the health professional would always explain

163 Submission 478, National Rural Health Alliance, p 5; Submission 573, Australian Medical Association, p 4.

164 See for example Submission 159, Name suppressed, p 1; Submission 228, Mrs Kate Mildner, p 2; Submission 349, New Yass Hospital with Maternity Working Group, p 2; Submission 379, Dr Simon Holliday, p 18.

165 See for example Evidence, Aunty Monica Kerwin, Community spokesperson, Wilcannia, 2 December 2021, pp 40-41; Submission 253, Wollondilly Shire Council, p 3; Submission 254, Australian Association of Social Workers, p 5; Submission 260, Royal Far West, p 3; Submission 272, The Royal Australian and New Zealand College of Psychiatrists, p 11; Submission 345, Local Government NSW, p 9; Submission 402, Port Stephens Council, p 3 and Evidence, Mr John Scarce, General Manager, Murrumbidgee Council, 29 April 2021, p 3.

166 Submission 445, Country Women's Association of NSW, p 3.

167 Evidence, Associate Professor Peter Malouf; Executive Director of Operations, Aboriginal Health and Medical Research Council of New South Wales, 5 October 2021, p 22.

168 Evidence, Dr Lyons, 19 March 2021, p 53.

169 Submission 630, NSW Government, p 44.

things to them in a way that they could understand.[170] Additionally, the committee heard that the five hospitals that had significantly more positive results than the rest of New South Wales were all in regional areas.[171]

2.60 While noting that a small fraction of all patients discharged from hospital will be involved in a clinical incident or mishap which requires investigation, 27 per cent of adverse events occurred in rural and remote health services.[172] In this regard, NSW Health acknowledged the regrettable patient experiences and outcomes reflected in the evidence to this inquiry, and reiterated its commitment to continual improvement and to ensuring that all patients receive high quality care.[173]

2.61 In relation to culturally and linguistically diverse communities, NSW Health stated that it has partnered with Multicultural NSW to address service gaps through the *Multicultural Policies and Services Program*, the *NSW Plan for Healthy Culturally and Linguistically Diverse Communities* and the *NSW Refugee Health Plan*.[174] NSW Health also told the inquiry:

- the NSW Health Care Interpreting Service is available for use by public health service patients and provides access to professional interpreting services onsite, by telephone and video call in more than 120 languages
- Multicultural NSW's Regional Advisory Councils escalate health related issues to the relevant NSW Government departments including NSW Health
- NSW Health has increased funding for specialised refugee health services in several regional and rural locations.[175]

2.62 NSW Health also acknowledged that the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) had been raised as a point of significant concern for inquiry participants. In its supplementary submission, NSW Health noted that the 2020-2021 NSW Budget allocated $25 million to IPTAAS, and that the scheme's forms and processes were reviewed in 2017-2018, resulting in changes designed to simplify and streamline the application process. NSW Health stated that it is committed to explore further opportunities to enhance IPTAAS and to raise awareness of the scheme.[176]

Committee comment

2.63 The provision of health services to a population that is dispersed over a very large geographical area is by definition challenging. The entities responsible for the provision of health services have, for many years, grappled with how best to provide equitable access and services to the communities of regional, rural and remote New South Wales.

170 Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 2 February 2022, pp 16-17.
171 Submission 630a, NSW Government, p 5.
172 Evidence, Dr Lyons, 19 March 2021, p 54.
173 Submission 630a, NSW Government, p 4.
174 Submission 630, NSW Government, p 35.
175 Submission 630, NSW Government, pp 35-36.
176 Submission 630a, NSW Government, p 13.

2.64 Over 15 months of hearings and in countless submissions, the committee heard many disturbing stories of people and families who have been let down by the health system. Emergency departments with no doctors; patients being looked after by cooks and cleaners; excessive wait times to access or receive treatment; misdiagnoses and medical errors – we heard these stories all too often.

2.65 Together, these stories paint a picture of a rural health system that is experiencing significant difficulties and challenges and in some instances is in crisis.

2.66 It is important to acknowledge that this by no means is a reflection on the NSW Health staff working in our rural communities, who are trying their best and giving their all in extraordinarily difficult circumstances. Indeed, the statistics indicating that the majority of people who pass through public hospitals have good experiences are a testament to the efforts of these staff. However, such performance measures do not tell the full story and, it must be said, are at odds with the evidence received in this inquiry.

2.67 Previous reviews, investigations and analysis have not brought about systemic improvements or change. While these issues are not new, it is abundantly clear to the committee that the residents of regional, rural and remote New South Wales are now at breaking point.

2.68 Accordingly, the committee finds that residents in rural, regional and remote New South Wales have inferior access to health and hospital services, especially for those living in remote towns and locations and Indigenous communities, which has led to instances of patients receiving substandard levels of care.

Finding 2

That residents in rural, regional and remote New South Wales have inferior access to health and hospital services, especially for those living in remote towns and locations and Indigenous communities, which has led to instances of patients receiving substandard levels of care.

2.69 The committee recognises that a considerable number of these issues are inextricably linked to the significant and longstanding workforce challenges facing both doctors and nurses. These are discussed in detail in Chapters 3 and 4. However in addition, in addressing this situation, NSW Health should review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.

Recommendation 1

That NSW Health review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.

2.70 In relation to the issue of distance to services, the committee accepts that a full range of services cannot be provided in every location and as such an element of travel often becomes necessary.

However, as it is the NSW Government that determines the viability and location of services, it should also be its responsibility to minimise the impact of that travel on an individual seeking treatment.

2.71 The main vehicle through which this occurs is the NSW Government funded Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). However, despite a 2017 review and the commitment of the Minister for Health, the Hon. Brad Hazzard MP in 2021 to again review the scheme, the failings of the program as disclosed in evidence to this inquiry are such that the committee feels compelled to comment.

2.72 The reimbursement rates per kilometre and for accommodation are completely unsatisfactory. How can the NSW Government justify reimbursing public servants at a rate of 72 cents per kilometre for travel and permit IPTAAS to remain at 22 cents? Put simply, it cannot. The reimbursement rates for accommodation are also wholly inadequate and need to be revised.

2.73 Separately, the eligibility criteria and the paperwork required to apply for IPTAAS are also of concern to the committee. The bureaucracy should aim to minimise 'red tape' and to ease a person's journey through the necessary administrative requirements, particularly when faced with the stress and vulnerability of having to seek ongoing medical treatment far from home. Instead, the system is unnecessarily complicated, disqualifies a large number of people from claiming the benefit, and ultimately provides an inadequate level of financial recompense.

2.74 We therefore recommend that the NSW Government review IPTAAS as a matter of priority. In particular, close attention should be paid to the inadequacy of the current reimbursement rates for accommodation and per kilometre travel, as well as the eligibility criteria, including for people participating in medical trials, those that hold private health insurance and those that are specifically referred to treatment centres that are not geographically closest to them due to the urgency of the treatment required. The review should also aim to overhaul and streamline the application process to make it easier for patients to access the scheme. Finally, the NSW Government should undertake on an ongoing basis a public awareness program of the scheme across the state in communities and among health professionals who can then inform patients.

Recommendation 2

That the NSW Government review the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) as a matter of priority, with a view to:

- increasing the current reimbursement rates for accommodation and per kilometre travel
- expanding the eligibility criteria, with consideration given to people participating in medical trials, those that hold private health insurance and those that are referred to treatment centres that are not geographically closest to them due to the urgency of the treatment required
- streamlining the application process to make it easier for patients to access the scheme
- undertaking on an ongoing basis a public awareness program of the scheme across the state in communities and among health professionals who can then inform patients.

2.75 In regards to the issue of transport, the committee recognises that private transport is not available to all citizens of regional, rural and remote communities. As such, the committee recommends that NSW Health, the rural and regional Local Health Districts and Transport for

NSW work collaboratively to ensure, where feasible, more frequent and appropriately timed affordable transport services are available to support people to attend medical appointments. Further, the committee recognises the essential service air transport provides to regional and remote communities and accordingly recommends that NSW Health review the funding available for air transport.

Recommendation 3

That NSW Health, the rural and regional Local Health Districts and Transport for NSW work collaboratively to ensure, where feasible, more frequent and appropriately timed affordable transport services are available to support people to attend medical appointments in rural, regional and remote areas.

Recommendation 4

That NSW Health review the funding available for air transport.

2.76 Looking at the support provided to regional, rural and remote communities, the committee would like to take this opportunity to recognise and commend the efforts of the many charities and community organisations that work tirelessly to support patients and their families, alleviate the financial burden of medical treatment and provide tangible resources for the benefit of their communities.

2.77 The reliance on charity and local community organisations to provide additional support and services does however concern the committee because it speaks to patients and communities left behind by the public health system. Consequently, the committee finds that residents living in rural, regional and remote communities face significant financial challenges in order to access diagnosis, treatment and other health services compared to those living in metropolitan cities.

Finding 3

That residents living in rural, regional and remote communities face significant financial challenges in order to access diagnosis, treatment and other health services compared to those living in metropolitan cities.

2.78 The committee therefore recommends that NSW Health and the Local Health Districts actively engage with local community groups and charities to understand the services and resources they provide, and to ensure that where possible and appropriate, service gaps are filled by government.

Recommendation 5

That NSW Health and the rural and regional Local Health Districts actively engage with local community groups and charities to understand the services and resources they provide, and to ensure that where possible and appropriate, service gaps are filled by government.

2.79 Finally, given the seriousness of the situation in our rural health system as documented in this and subsequent chapters, we recommend that on the two-year anniversary of the tabling of this report, Portfolio Committee No. 2 – Health undertake an inquiry and report on the progress and developments that have been made to address the matters raised by this inquiry.

Recommendation 6

That on the two-year anniversary of the tabling of this report, Portfolio Committee No. 2 – Health undertake an inquiry and report on the progress and developments that have been made to address the matters raised by this inquiry.

Chapter 3 The doctor and clinician workforce

This chapter focuses on issues that contribute to workforce challenges for doctors and clinicians in rural and remote locations, including doctor coverage; rural practice and models of doctor service delivery; the working conditions of doctors and the impact this has on quality of services; recruitment and retention; and education and training for doctors in rural settings.

The chapter commences with a profile of the doctor workforce, including the various roles and responsibilities. It then explores the impact that the above mentioned factors have on the doctor workforce in rural and remote locations, and presents stakeholder views on opportunities to improve in these areas. It also considers the impact of the health system in New South Wales being split between the Australian and NSW Governments which, despite being a broader system issue, presents particular challenges for the doctor workforce.

Profile of the doctor workforce

3.1 The doctor workforce in New South Wales is complex, reflecting the multiple layers of responsibility and funding, the array of differing business and employment models, and the range of diverse professionals that make up the workforce. The doctor workforce is made up of General Practitioners (GPs), specialists, trainees and other medical professionals. The table below provides a snapshot of the various types of doctors.

3.2 Doctors complete several years of undergraduate medical study, followed by compulsory 12 month internships in a hospital setting, before they can be registered as medical practitioners. Many then spend several years training in a medical specialty, such as gastroenterology, obstetrics, psychiatry or general practice. Once registered, doctors work in a variety of clinical and non-clinical settings, from private practice in the community, to salaried positions in community health clinics, to visiting medical officers (VMOs) in hospitals, to teaching and research.[177]

Table 3 Types of doctor roles in New South Wales

Role	Description
Intern	A first year doctor working under supervision to obtain general registration.
Residents	A doctor who has obtained general registration and who works in a hospital under the supervision of a specialist.
Registrars	A doctor with at least three years' experience in a public hospital, who supervises more junior doctors and is training to become a specialist.
Career Medical Officers	A hospital non-specialist doctor who may work in a variety of clinical settings in a hospital. A Career Medical Officer may practice in a variety of medical specialties including emergency medicine, psychiatry, obstetrics and gynaecology, intensive care and rehabilitation medicine.

[177] Parliament of Australia, Parliamentary Library Research Paper, *Health in Australia: a quick guide* (2018), p 4.

Staff specialist	A doctor who has finished their training in one of the medical specialties and has obtained employment as a specialist doctor. Staff specialists can be employed on a full-time or part-time basis, and can also see private patients within the terms of their employment arrangements.
General Practitioner	A doctor who has finished general practice specialist training to provide person-centred, continuing, comprehensive and coordinated whole-person health care to individuals and families in their communities.
Visiting medical officers	A doctor who has finished their training in one of the medical specialties and is engaged under a contract to provide services in a public hospital to public patients (rather than being an employee). Visiting medical officers will generally also have a private practice and the ability to admit their private patients to the hospital where they are engaged.

Source: NSW Ministry of Health, Training and working as a doctor in the NSW public health system, https://www.mapmycareer.health.nsw.gov.au/Pages/training-and-working-as-a-doctor-in-the-NSW-public-health-system.aspx?section=ms

3.3 In addition to these roles, Rural Generalists are medical practitioners who are trained to meet the specific health care needs of rural and remote communities and have advanced skills in one of a range of areas including obstetrics, emergency care, mental health, palliative care or anaesthetics. They work in a range of medical settings.[178]

3.4 Overseas trained doctors and international medical graduates perform an important role working under supervision in designated areas of workforce shortage, usually in rural and remote Australia.[179]

3.5 GPs provide primary health care to the community and are usually self-employed. They also operate as gatekeepers, referring patients to specialist medical services. Acute or secondary health care is provided through private or public hospitals.[180]

3.6 As set out in Chapter 1, the Australian and NSW Governments share responsibility for the delivery of health care in New South Wales and both have a role in the employment, training and supply of doctors, with the Commonwealth responsible for primary health care and the NSW Government responsible for public hospitals.

Doctor coverage in New South Wales

3.7 In relation to GPs, the committee heard that New South Wales has 120.7 full-time equivalent GPs per 100,000 population,[181] but is one of four states where the number of GPs has decreased

178 Submission 402, Australian College of Rural and Remote Medicine, p 3.

179 Parliament of Australia; *Health in Australia: a quick guide,* August 2018, www.aph.gov.au, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust

180 Parliament of Australia; *Health in Australia: a quick guide,* August 2018, www.aph.gov.au, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust

181 Royal Australian College of General Practitioners, *Health of the Nation 2020*, November 2020, www.racgp.org.au, https://www.racgp.org.au/getmedia/c2c12dae-21ed-445f-8e50-530305b0520a/Health-of-the-Nation-2020-WEB.pdf.aspx

over the most recent period.[182] The majority of the state's GPs, 86 percent, work in group practices. While GPs provide care across a range of other settings, only 2 percent work in a hospital as their main type of practice.[183]

3.8 In relation to the state's public hospitals, NSW Health advised that the number of medical practitioners working in public hospitals in rural and regional New South Wales is currently 4,773 full-time equivalent staff, an increase of 43 per cent between 2012 and 2020.[184] Many of the representatives from the Local Health Districts also pointed to increases in staffing numbers, including doctors, within their regions.[185]

3.9 However, despite these figures and developments, there was broad consensus among stakeholders to this inquiry that doctor coverage in rural and remote locations is inadequate, with many pointing to the maldistribution of doctors and a declining GP workforce as the reasons for the doctor shortage.[186]

3.10 In terms of maldistribution of the workforce, the Office of the National Rural Health Commissioner highlighted that while the numbers of doctors might be high, they are not distributed adequately across non-urban areas:

> While Australia has one of the highest ratios of doctors per head of population in the world this workforce is not distributed proportionately across the country. It is concentrated in the urban centres.[187]

3.11 The NSW Rural Primary Health Networks echoed these concerns, outlining that the majority of GPs are concentrated in major cities and inner regional areas and that some rural areas are suffering from a severe shortage in primary care workforce.[188]

3.12 In relation to the declining GP workforce, representatives from the Primary Health Networks provided the following insights:

- Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network noted that one of the factors causing pressure on rural hospitals is the declining

182 Correspondence from Mr Martin Rocks, Assistant Secretary, Department of Health, to Chair, 24 November 2021, Attachment 1, Department of Health, Submission 38 to *The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry*, 15 October 2021, p 19.

183 Royal Australian College of General Practitioners, *Health of the Nation* 2019, September 2010, www.racgp.org.au, https://www.racgp.org.au/getmedia/bacc0983-cc7d-4810-b34a-25e12043a53e/Health-of-the-Nation-2019-report.pdf.aspx; p 17.

184 Submission 630, NSW Government, p 46.

185 See for example: Evidence, Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District, 1 February 2022, p 6; Evidence, Ms Kay Hyman, Chief Executive, Napean Blue Mountains Local Health District, 1 February 2022, p 11;

186 See for example: Evidence, Dr Charlotte Hespe, Chair NSW and ACT, Royal Australian College of General Practitioners, 19 March, p 11; Submission 465, Remote Vocational Training Scheme, p 4; Submission 276, NSW Medical Staff Executive Council, p 5.

187 Submission 391, Office of the National Rural Health Commissioner, pp 5-6.

188 Submission 452, NSW Rural Primary Health Networks, p 5.

GP workforce, with the lack of access to GPs having 'serious impacts on hospitals and emergency care'.[189]

- Dr Robin Williams, Board Chair, Western NSW Primary Health Network told the committee that small towns are at crisis point, stating that there are '43 small communities which are at risk of losing GP services in the next five to 10 years'.[190]
- Ms Julie Redway, Acting Chief Executive Officer, Murrumbidgee Primary Health Network noted that across her network, there are 67 residential aged care facilities and 33 public hospitals, many of those staffed by GP VMOs, and that there are currently 37 GP vacancies.[191]

3.13 Dr Tony Sara, President of the Australian Salaried Medical Officers' Federation told the committee that this shortage is leading to preventable deaths, morbidity and permanent disability, and that 'many rural and regional emergency departments have no doctor on site in the evenings and overnight'.[192]

3.14 Doctors and community members from many rural and remote locations across New South Wales also provided insights into the shortage of doctors in their communities and the impacts this has had in their towns.

Case study: Deniliquin

Dr Marion Magee has been a GP in Deniliquin for 32 years. She is also one of five doctors that provide on call services to the hospital. She represents the Deniliquin Health Action Group, an advocacy group of community members formed in response to a growing community concern that their 'health needs were not being met by bureaucracy in government'.

Dr Magee told the inquiry that Deniliquin doctors are at 'tipping point' and are considering 'resigning en masse'. She explained that there are 11 GPs in town and five provide on call services to the hospital, which means they are doing one in five 24 hours. She said 'I do not work 12-hour days five days a week, I work 120 hours a week … it is rare for me to get a full night's sleep'. She said that new doctors who arrive in town look at the workload and just say 'No way in hell. I'm not doing that. I'm not joining in'. She said 'that is why there are 11 doctors in town and five are the only ones who are participating in the on-call roster'. She referred to the situation as a moral outrage and spoke about her sense of obligation:

189 Evidence, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network, 19 March 2021, p 10.

190 Evidence, Dr Robin Williams, Board Chair, Western NSW Primary Health Network, 19 May 2021, p 43.

191 Evidence, Ms Julie Redway, Acting Chief Executive Officer, Murrumbidgee Primary Health Network, 29 April 2021, p 40.

192 Evidence, Dr Tony Sara, President Australian Salaried Medical Officers' Federation, 19 March 2021, p 42.

> It is a morally outrageous situation to leave a hospital without cover. It is part of the reason why I do work such long hours because I cannot stand the thought of someone going to the hospital and not being seen.[193]

Case study: Parkes

Dr Kerrie Stewart, a GP practising in Parkes, said that there is a maximum of eight full time equivalent doctors serving a town of 12,000 people plus those living in the surrounding areas. This results in long wait times for appointments; zero on-the-day or emergency appointments; great difficulty in providing follow-up; and doctors working weekends as well as extra days to provide COVID and flu clinics.

She said that the situation is about to get significantly worse with three of their long-serving doctors indicating their imminent retirement. She said that the aged care facilities have been told they will no longer receive ongoing GP services in person, leaving '80 per cent of our aged care residents in Parkes without a GP post-30 June'. She explained that they 'do not have the capacity, with the remaining GPs in town, to pick up that patient load'. Dr Stewart also spoke of the impact of doctor shortages placing pressure on pharmacies and allied health care colleagues, and sounded the alarm in this way:

> … there comes a time when scarcity, limitation and reduction in resources is no longer a challenge but is in fact disabling. And there comes a time when critical resources are lost that make the continuation of a safe, quality service unsustainable and in fact unachievable when the gaps in resources make it unsafe for both patients and clinicians. I believe we are on the precipice of this scenario in Parkes. We are facing a huge shortage of general practitioners, in particular, and this has resulted in the inability of our current GP workforce to have the capacity to provide essential care to members of our community, including our aged care residents.[194]

Case study: Gunnedah

The Mayor of Gunnedah, Cr Jamie Chaffey, described the situation in his community as at 'crisis point'. He said that they are down to 4.75 full-time equivalent doctors and they are under enormous pressure and stress. Mrs Kate McGrath, a founding member of the Gunnedah Community Round Table, described health care as being a consistent barrier to the most vulnerable members in her community. She explained the flow on effect of the doctor shortage in Gunnedah:

> The lack of GPs in Gunnedah is creating crises. A GP referral is required to access specialists and most allied health services. When a person is unable to access a GP, they are shut out of the entire system. This one limitation of service creates a ripple effect. How do we access NDIS services with no diagnosis? How do we access counselling without a mental health plan? How do we go to hospital if no doctors with admitting rights are available? How can chronic illness be managed without continuity of care? How can we get a check-up with no-one to check us? These are the unanswered questions that plague our community.[195]

193 Evidence, Dr Marion Magee, Chair, Deniliquin Health Action Group, 29 April 2021, pp 11-16 and Submission 95, Deniliquin Health Action Group, p 1.

194 Evidence, Dr Kerrie Stewart, General Practitioner, Ochre Medical Centre, 19 May 2021, pp 2-3.

195 Evidence, Mrs Kate McGrath, former Chair and founding member, Gunnedah Community Roundtable, 16 June 2021, p 2 and Evidence, Cr Jamie Chaffey, Mayor, Gunnedah Shire Council, 16 June 2021, p 9.

3.15 Council members from Warrumbungle, Dubbo and Bathurst also expressed concern about doctor shortages in their communities:

- Warrumbungle Deputy Mayor, Dr Aniello Iannuzzi, described the situation in Warrumbungle as dangerous. He advised that in his shire it is not uncommon to have no medical cover at three of their four hospitals on a weekend and after hours.[196]
- Mayor of Dubbo, Cr Ben Shields, described the situation in Wellington as 'appalling'. He said that Wellington has a population of 10,000 and yet there is only one doctor practising at Wellington Hospital. He also said that people in Dubbo are struggling to get a GP so they present to the hospital.[197]
- The Bathurst Council reported noticing frequent staff vacancies at the hospital and an over-reliance on locums to fill these gaps.[198] Cr Warren Aubin, a local Councillor, explained that because of the staff shortage at Bathurst Hospital, residents are often transported to Orange or further afield.[199]

3.16 Inquiry participants also pointed to the impacts of COVID-19 on doctor coverage in New South Wales including:

- international border closures limiting overseas doctors coming to Australia, thus adding to understaffing problems[200]
- increased pressure on Emergency Department presentations because GPs were not seeing as many patients as they were pre-COVID[201]
- health services being unavailable as clinics or staff were re-purposed or re-deployed for COVID clinics.[202]

Rural practice

3.17 Stakeholders discussed the way in which doctors' services are delivered in rural and remote locations and explained the unique nature of the rural GP role, as compared to metropolitan environments.

3.18 The committee heard that in rural locations, GPs often have an enhanced scope of practice and provide the type of care that would ordinarily be provided by specialists in metropolitan areas, as well as also often playing a role in servicing local hospitals.[203]

196 Evidence, Dr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Shire Council, 18 May 2021, pp 3-4.
197 Evidence, Cr Ben Shields, Mayor, Dubbo Regional Council, 18 May 2021, pp 4 and 7.
198 Submission 245, Bathurst Regional Council, p 7.
199 Evidence, Cr Warren Aubin, Councillor, Bathurst Regional Council, 18 May 2021, p 3.
200 See for example: Submission 103, Name suppressed, p 1; Evidence, Dr Pat Giddings, Chief Executive Officer, Remote Vocational Training Scheme, 10 September 2021, p 43.
201 See for example: Submission 68, Mrs Rebecca Flett, p 1.
202 See for example: Submission 73, Name suppressed, pp 1-2; Submission 104, Name suppressed, p 1; Submission 106, Network of Alcohol and other Drugs Agencies (NADA), p 1; Submission 166, Mid Coast for Kids, pp 14 and 17.
203 Submission 452, NSW Rural Primary Health Networks, p 5.

3.19 The Australian College of Rural and Remote Medicine elaborated on this and provided the following outline of the rural context, the working environment and the way in which the scope of practice varies from rural to metropolitan:

> Health Professionals in rural areas work under circumstances and working environments, and with a scope of practice which can be very different to urban practice. They are often the only readily available health care professionals and as such may need to take on a range of roles which fall to more specialised services or larger health care teams in larger centres. The degree of responsibility for the complete care of the patient borne by the local practitioner/s will be influenced by their skill set; the available health support services, staff, and resources in each locality; and, the geographical distance and/or transport options available to and from needed services. These differing circumstances require practitioners to provide a varying and typically broader and more complex suite of services than their urban counterparts. These extended services are often delivered in ways that differ from typical urban practice models due to the limited resources and clinical teams in the local rural setting.[204]

3.20 Dr Charlotte Hespe, Chair, NSW and ACT, The Royal Australian College of General Practice also referred to the lack of specialists and allied health professionals as a key difference for rural GPs, effectively requiring them to deliver a broader scope of services. She echoed the views of the Australian College of Rural and Remote Medicine and stated that rural GPs 'often need to take on additional skills to meet their community's needs'.[205]

3.21 The Rural Doctors' Association explained that rural general practice and health care in rural hospitals are inextricably linked, with GPs providing the majority of care in the communities.[206] This model generally involves the GP/VMO model, whereby a medical practitioner in private practice provides medical services in a public hospital. In this regard, GPs are contracted by the Local Heath District as Visiting Medical Officers to provide specific medical services in nominated facilities.[207]

3.22 A number of stakeholders outlined concerns with this approach into the future, in light of the changing nature of health needs and demographics of rural residents, as well as increased demand on doctors. In particular, the NSW Rural Primary Health Networks explained that GP shortages in rural settings have a flow on effect for hospital emergency departments, in that people living in rural areas were more likely to report visiting an emergency department because a GP was not available.[208]

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204 Submission 403, Australian College of Rural and Remote Medicine, p 2.

205 Evidence, Dr Hespe, 19 March 2021, p 11.

206 Submission 446, Rural Doctors' Association, p 2.

207 NSW Rural Doctors Network, General Practice & Doctors: Common Questions, NSW Rural Doctors Network website, https://www.nswrdn.com.au/site/questions. Referenced in Submission 394, Rural Doctors' Network, p 2.

208 Submission 452, NSW Rural Primary Health Networks, p 6.

3.23 A number of doctors with experience working under the GP/VMO model agreed that the model is 'broken' and is 'not sustainable'.[209] These doctors provided the following views based on their personal experiences:

- Dr Charles Evill, President, Rural Doctors' Association, explained that a rural generalist in a small town has a general practice which is Medicare funded, will be on-call for emergencies and will have to do ward rounds in the hospital. He expressed the view that as a solo doctor that is an incredible imposition, adding that he has worked in some places where it is 'completely unsustainable'.[210]
- Dr Ian Dumbrell indicated that the GP/VMO model is not sustainable because the number of presentations to doctors has grown and the system needs more doctors than it used to. He said:

> I am the general physician on the ward, I am the emergency physician in the emergency department and I am the GP. … I am doing three roles wrapped up into one and it is becoming increasingly unsustainable because you just generate work like a squirrel. You see a patient in ED, then you take them to the ward, then you have got to take them onto your books. There is not enough of us to do that.[211]

- Dr Shehnarz Salindera, Councillor, Australian Medical Association, provided an example of her working week as a result of the burden of being on call under the GP/VMO model:

> I was on call in that week for four days straight. I provided care during the day. I had elective operating lists—clinics—in the mornings and emergency operating in the afternoon. I was required to attend the hospital. I was called at 11.00 p.m. and then 12.00 p.m. and then we prepared the operating theatre. I operated on an emergency surgery at 2.00 a.m. That surgery took me through until 5.00 a.m. …
>
> As our regional areas get busier, and even in our rural hospitals, you have less people to cover the load, so you are doing a more frequent on-call and then you are still required to deliver a service daily; so you are less likely to be in a position where you can have the next day off after being up all night. I personally do double the on-call that some of my friends in the city do and I do not have the backup or support to change that, we just have to get by with what we have got.[212]

- Dr Jodie Culbert, Chair of the Board, Murrumbidgee Primary Health Network, referred to the current model as 'antiquated', outlining that the way in which people access GPs has changed, with the average number of problems dealt with in one GP consultation now four at a minimum. She expressed concern that these same GPs are relied upon to service the hospital system. Drawing on her own experience to highlight the problem and calling for structural reform, she said:

> I have had this experience. I have worked in a small town for 12 months. I would be called to chest pain while I was there dealing with a chest pain. The staff would have to deal with 15 patients in the waiting room to sort out where they were coming from. I

209 See for example: Evidence, Dr Ian Dumbrell, Private individual, 29 April 2021, p 36; Evidence, Dr Magee, 29 April 2021, p 16; Evidence, Dr Charles Evill, President, Rural Doctor's Association of NSW, 19 March 2021, p 23.

210 Evidence, Dr Evill, 19 March 2021, p 23.

211 Evidence, Dr Dumbrell, 29 April 2021, p 37.

212 Dr Shehnarz Salindera, Councillor, Australian Medical Association, 19 March 2021, pp 3-4.

> might get back to them at 6.00 p.m. at night and try to deal with them. In the meantime that private entity does not generate revenue. They still have fixed costs for their service, they do not generate any revenue to pay staff and it is a continuous cycle. We need to look at some real structural reform.[213]

- Dr Nigel Roberts expressed concern with the VMO model from the perspective of patients, outlining how it adversely impacts on the most disadvantaged:

> Visiting Medical Officers admit patients to the hospital as public patients when required, treat them whilst they are inpatients as public patients, and operate on them as public patients. However, prior to admission or for follow-up of treatment these patients have to pay to see the VMO in his or her private rooms. This framework of care works well for the hospital, which does not have to pay for rooms in which patients are seen, the doctor, or administrative staff for these visits. It also works well for the doctor who gets to charge what they want for the visit. It does not work well for the most disadvantaged in society, who often forego the care they need or have to travel hundreds of kilometres to receive that care in a public clinic.[214]

3.24 Some stakeholders also highlighted the decline in the number of GPs taking on VMO work. For example, the NSW Rural Doctors' Network referred to its Primary Health Workforce Needs Assessment which identified an increasing trend of GPs either limiting their VMO availability or not seeking VMO privileges at all. The Network expressed its view about the consequence of this trend:

> The consequence for communities is often a gap in the range of GP services available in hospital including general inpatient care, emergency medicine and procedural medicine. Further, with GP proceduralists also ageing and retiring, the risk of having no services in the immediate future will impact on the ability of rural hospitals to survive.[215]

3.25 The University of Newcastle also raised the issue of the declining number of GP/VMOs, noting a recent finding that 'only 34% of GPs in MM4-7 communities were GP VMOs' which they argued has created a gap in the effectiveness and comprehensiveness of this model of care.[216]

3.26 The committee heard that the gaps created by the above issues are often filled by locums. Locums are non-specialist medical practitioners engaged on a temporary basis to provide cover for an absent member of the permanent non-specialist medical staff.[217] While stakeholders generally agreed that locums play an important role in this model, they expressed that the solution is not without its problems. For example, Dr Stewart explained that while locums fill

213 Evidence, Dr Jodie Culbert, Chair, Murrumbidgee Primary Health Network Board, Murrumbidgee Primary Health Network, 29 April 2021, p 48.

214 Submission 6, Dr Nigel Roberts, pp 1-2.

215 NSW Rural Doctors Network, 2017-2018 Primary Health Workforce Needs Assessment, NSW Rural Doctors Network website, https://www.nswrdn.com.au/client_images/2141375.pdf, p 10. Referenced in Submission 394, NSW Rural Doctors Network, p 2.

216 Submission 670, University of Newcastle, p 7.

217 NSW Health, *Employment and Management of Locum Medical Officers by NSW Public Health Organisations*, 4 February 2019, p 4.

an important gap, they also leave a backlog of results, investigations and patient care to follow up, which remaining GPs have little capacity take on.[218]

3.27 The NSW Rural Primary Health Network similarly identified continuity of care and poorer health outcomes as a consequence of this approach to gap filling:

> Due to the lack of supply of GPs and other primary care services, rural communities are heavily reliant on outreach and locum services from metropolitan centres, and also on overseas-trained doctors (OTDs). Relying on locums and a transient workforce cannot assure continuity of care and may lead to worse health outcomes for rural residents.[219]

3.28 In this regard, Local Government NSW acknowledged the role that locum GPs play in the community, stating they provide a 'valuable lifeline for some communities where there would otherwise not be any medical practitioner'. However Local Government NSW also identified the importance of medical professionals having knowledge of the local community and being able to provide continuity of care.[220] Other stakeholders expressed concern about the high cost of having locums fill the gaps, expressing the view that it ends up costing a lot more.[221]

3.29 Rural and Remote Medical Services Ltd also highlighted some of the challenges associated with the process of obtaining rights for GPs to work as Visiting Medical Officers in each Local Health District, which can exacerbate doctor shortages:

> GP practices like RARMS are required to make offers to GPs on the assumption they will be granted VMO rights which may not be forthcoming. This impacts on the capacity to recruit GPs to rural and remote practice.
>
> RARMS has had a situation where a highly qualified doctor with years of experience in emergency medicine in Sydney hospitals, and without any concerns or complaints lodged with the Australian Health Practitioners Registration Agency, was recruited to a small rural town and subsequently refused VMO rights on the ground that his metropolitan experience was not translatable to a small rural hospital. This forced the closure of our medical services in this town…
>
> A state-wide system of VMO approvals would enable common standards to be established for working in rural and remote hospitals, increase transparency and reduce the impact of local factors in decision-making.[222]

Rural Generalists

3.30 There was agreement amongst stakeholders that not all medical services and specialisations can be available in all locations at all times. However, both the Commonwealth Department of Health and NSW Health advised that they strive for services to be delivered as close to home

218 Evidence, Dr Stewart, 19 May 2021, p 3.
219 Submission 452, NSW Rural Primary Health Networks, p 6.
220 Submission 345, Local Government NSW, p 10.
221 See for example: Submission 94, Name suppressed, p 1 and Evidence, Cr Peter Abbott, Mayor, Cobar Shire Council, 30 April 2021, p 2.
222 Submission 705, Rural and Remote Medical Services Ltd, p 36.

as possible.[223] Throughout the inquiry there was continuous discussion about the types of doctors needed across the different types of rural settings, and how delivering services 'as close to home as possible' can best be achieved.

3.31 The inquiry heard general stakeholder support for the rural generalist model, particularly for the more rural/remote settings.[224] This was because rural generalism is based on the concept that in smaller rural towns, community needs can best be met by GPs having extra skills in areas such as mental health, palliative care, obstetrics and anaesthetics; whereas in cities, these services would be provided by a non-GP specialist.[225]

3.32 The National Rural Health Commissioner described the value of Rural Generalists in rural locations where specialists are not generally available:

> The setting for the Rural Generalist is primarily in smaller towns without the critical mass to support larger medical specialist teams, where they provide additional skills but are still part of regional networks of providers. It is in such towns of less than 20,000 people where the supply of health services is most under pressure. In communities where there are no consultant specialists, Rural Generalists can attend to the common and emergent health issues and are vital to delivering high quality care across Australia.[226]

3.33 The Commissioner expressed the view that NSW Health could increase support for the training of Rural Generalists and thus increase the proportion of the workforce that is suitably trained for rural practice. It said that where this has happened elsewhere in Australia, it significantly improves the numbers of doctors ready and willing to work in rural areas.[227]

3.34 Other stakeholders expressed support for the model but pointed to the declining numbers seeking to take up rural general practice as a concern. The Commonwealth Department of Health explained that despite the critical role of GPs, Australian medical students are 'preferring careers in non-GP specialty and sub specialty practice rather than in general practice and other generalist practice'. It said that this needs to be addressed.[228] The committee heard that the

223 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 18; Submission 630, NSW Government, p 24.

224 Submission 391, Office of the National Rural Health Commissioner, p 6; Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), pp 17-18; Submission 371, Dr Neil McCarthy, pp 1-3; Submission 403, Australian College of Rural and Remote Medicine, pp 3-4.

225 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 101.

226 Submission 391, Office of the National Rural Health Commissioner, p 6; see also Evidence, Dr Simon Holliday, Private individual, 16 June 2021, p 16; Submission 17, ONE – One New Eurobodalla Hospital, pp 10-11; Evidence, Dr Michael Holland, Co-Founder, ONE - One New Eurobodalla hospital, 6 October 2021, p 21.

227 Submission 391, Office of the National Rural Health Commissioner, p 6.

228 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 31.

Commonwealth is seeking to address this by recognising rural generalist medicine as a specialty within the specialty of general practice.[229]

3.35 Others also raised the declining numbers of people choosing rural general practice as an issue:

- The National Rural Health Commissioner stated that currently only one in ten General Practitioner registrars complete training to become Rural Generalists. She noted that this does not match the proportion of the Australian population who live in rural, remote or very remote locations, and is not enough to fill the existing employment vacancies in these areas, or replace the ageing cohort of existing rural doctors as they retire.[230]
- The Rural Doctors Network advised that ten years ago there were over 800 rural generalists working in remote and rural New South Wales whereas today there are fewer than 200, with over 50 per cent of those aged over 55 and getting close to retirement.[231]

Specialists

3.36 Although there was acceptance amongst stakeholders that not all services or specialisations can be available in all locations, some inquiry participants were of the view that there needs to be more focus on having specialists available in rural locations.[232]

3.37 For example, the NSW Medical Staff Executive Council highlighted the inadequate supply of specialists in rural locations, stating that access to specialist care remains a big problem due to reduced number of specialists per capita in regional and rural areas. It explained that 'the rate of specialists declines substantially with increasing remoteness from 143 per 100,000 population in major cities to only 22 in very remote areas'.[233]

3.38 The New South Wales Medical Staff Executive Council also expressed concerns about the approach to employing specialists in regional areas:

> In order for a specialist to locate to a regional area, usually requires an appointment of some kind to a regional hospital. In metropolitan centres specialists have more private options available, but these are very limited in a rural/regional setting. Public hospitals, under funding pressures, mostly employ specialist medical staff to replace those who have left or retired for the purpose of immediate inpatient care and it can often take a number of years to gain approval for an additional specialist to be employed, even if the business case is almost cost neutral. Without changes to this current system, addressing the major shortfall per capita in the number of specialists is unlikely to ever occur. The per capita deficit leads to poor access for outpatient care. Even large rural hubs are

229 Department of Health, Health Reform Steering Group, Draft recommendations from the Primary Health Reform Steering Group, referenced in Submission 630a, NSW Government, p 6.

230 Submission 391, Office of the National Rural Health Commissioner, p 6.

231 Evidence, Mr Richard Colbran, Chief Executive Officer, NSW Rural Doctors Network, 19 March 2021, p 21.

232 See for example: Evidence, Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council, 5 October 2021, p 11; Submission 17, One New Eurobodalla Hospital, p 8; Submission 27, Name suppressed, p 3; Evidence, Dr Salindera, 19 March 2021, p 9.

233 Submission 276, NSW Medical Staff Executive Council, p 5.

> mostly operating on half the number of specialists required per capita in order to service inpatient and outpatient needs.[234]

3.39 In her evidence, Dr Ruth Arnold, the Rural Co-Chair of the New South Wales Medical Staff Executive Council, discussed the specialist workforce distribution at a state-wide level and said that the myth that specialists do not want to work in rural locations must be dispelled. She said that the problem stems from lengthy approval processes and the lack of a state-wide vision on workforce distribution.[235]

3.40 Dr David Scott, Chair, Tamworth Medical Staff Council and Member, Physician Group Tamworth Base Hospital, expressed the view that the old model of a rural generalist is not the way of the future, and called for an increase in specialists and diversity of specialists to cover the load particularly for larger rural hospitals:

> While Gunnedah is an hour from Tamworth, Tamworth is four hours from Newcastle or five or six hours from Sydney. These are long trips that could be avoided if there was more diversity of local specialists. We have the busiest emergency department outside the metropolitan areas. We are one of the biggest hospitals. We are Tamworth. We get a lot of referrals from Tenterfield out to Coonabarabran and Walcha and Murrurundi. All of these places, they come to us. We are struggling to have enough specialists and enough diversity of specialists to cater for them.[236]

Funding models

3.41 A number of stakeholders discussed the challenges associated with the way in which doctors and doctor services are funded, including the viability of services in more remote locations and the two tiered funding system whereby the Commonwealth funds GPs and the state funds hospitals.

3.42 In respect of viability of services in small communities, the Commonwealth Department of Health explained:

> Providers may find private, fee-for-service practices challenging in smaller communities, particularly if the population is not large enough to sustain a private business. Therefore, the very rural and remote workforce is more likely to be employed in government block funded community or other block funding arrangements.[237]

3.43 Along similar lines, Dr Hespe from the Royal Australian College of General Practitioners referred to the Medicare funding model as problematic for certain communities, stating that it is insufficient to provide 'poor and socio-demographically challenged' communities with high quality healthcare because the funding model does not adequately cover the range of other health services required such as allied health and nursing. She said that because of this poorly

234 Submission 276, New South Wales Medical Staff Executive Council, p 5.

235 Evidence, Dr Arnold, 5 October 2021, p 11.

236 Evidence, Dr David Scott, Chair, Tamworth Medical Staff Council and Member, Physician Group Tamworth Base Hospital, 16 June 2021, p 15.

237 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 30.

funded model, it is challenging 'for a general practice to have a really comprehensive, multi-team approach—which is the best model'.[238]

3.44 The University of Newcastle and Dr Sara from the Australian Salaried Medical Officers' Federation raised issues with activity based funding models. Dr Sara said that rural sites are only marginally viable under activity based funding because of low levels of clinical activity. He said that thought needs to be given to 'minimum amounts of dollars and staffing for the rural sites to get to an acceptable level of health care'.[239] The University identified the most pressing workforce gaps in more remote communities and argued that these areas require 'block funding and increased support.'[240]

3.45 Other stakeholders raised the Commonwealth/State divide as contributing to ineffective funding models. The Deniliquin Mental Health Action Group captured this issue:

> [T]here appears to be many different pockets and streams of funding, such as State, Commonwealth, commission, services and crisis funding. In our opinion this contributes to both duplication and gaps in service delivery. We believe a more coordinated oversight is needed so specific communities get their specific needs met.[241]

3.46 Some called for a blended system. Dr Robin Williams advocated for a system whereby state funds are combined with Medicare money to develop a new model of care, moving away from the current fee for service model. Dr Williams provided the following explanation to support his view for a 'blended system':

> If a patient presents to Molong MPS with a condition and I go to see them and am paid for that by the State and then a week later I follow them up in my rooms then you have the same patient, the same condition, the same doctor and two funding streams—which is a nonsense. The first thing we need to do is to have a blended system between Commonwealth and State so that we can actually see where the money could be best spent.[242]

3.47 Similarly, Dr Hespe also pointed to the need for Commonwealth/State funding models to come together to deliver quality care:

> Because of the dislocation between Medicare funding for general practice, which is otherwise a private business, and the funding through NSW Health or otherwise for hospital and community services, we will continue to have an issue between how we do really, truly innovative models in our rural settings because of that dislocated funding. What we need is an ability to bring together the two streams of funding in a way that is not stymied by the very rigid nature of our Medicare system for GPs to really be able to deliver a quality-care, value-based service, rather than a volume flow through that does not actually truly cover the healthcare needs of the community that they are in.[243]

238 Evidence, Dr Hespe, 19 March 2021, pp 13-14.
239 Evidence, Dr Sara, 19 March 2021, p 43.
240 Submission 670, The University of Newcastle, p 7.
241 Evidence, Ms Lourene Liebenberg, Vice Chair, Deniliquin Mental Health Awareness Group, 29 April 2021, p 21.
242 Evidence, Dr Williams, 19 May 2021, pp 50-51.
243 Evidence, Dr Hespe, 19 March 2021, pp 13-14.

3.48 A number of stakeholders identified that for these issues above to be addressed, greater collaboration and coordination between the Commonwealth and State governments is needed.[244] Dr Holliday captured this sentiment, stating that improved healthcare outcomes requires all key players working together:

> The improvement of healthcare outcomes in NSW will only be achieved by working together across the state/federal boundaries and by including the NSW Ministry of Health and LHDs, the primary care sector, PHNs, other organisations, and the community to provide the best value care. …
>
> Without this, the health system enters a state of functional stupidity where competent bureaucrats work in a blinkered, piecemeal fashion, creating an incompetent whole.[245]

3.49 Dr Paul Mara, a rural doctor in Gundagai for 39 years and founder of the Rural Doctors Association, discussed the problems caused by the Commonwealth/State divide and what he referred to as a '30 year policy failure'. Dr Mara, like others mentioned above, advocated for a system wide perspective that addresses the system faults at both levels of government.[246]

3.50 Dr Mara told the committee that he has undertaken extensive work to promote a new and more sustainable model, which has been taken up as a pilot in the Murrumbidgee. The model involves the Local Health District taking responsibility for 'employing trainees for a two-plus-four-year specialist rural doctor training program', allowing trainees to work both in private general practice and in the hospital setting. He said that the program, known as the Murrumbidgee Rural Generalist Training Pathway (MRGTP), is supported by NSW Health and the Local Health District, and is providing 'more flexibility and higher quality training in both major hospitals and rural practices', as well as changing the 'churn culture'. [247]

3.51 Dr Mara said that while there seems to be general support for this 'single employer' model, the program is stymied because the Commonwealth Department of Health's position that the program is against health funding arrangements has limited the number of entrants to the program. Dr Mara added that in the meantime, millions of dollars are being spent on locums, ambulance transfers and propping up failed rural practices.[248]

3.52 Other stakeholders also expressed support for the pilot Murrumbidgee model, noting that the single employer approach is similar to the conditions of employment and services of other specialist trainees in public hospitals. For example, the Royal Australasian College of Medical Administrators advised that it supports the model, noting feedback from its members that currently, GPs and Rural Generalists do not always feel valued as team members working with NSW Local Health Districts.[249]

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244 See for example: Evidence, Dr Salindera, 19 March 2021, p 6; Submission 582, Dr Joe McGirr, p 3; Evidence, Ms Colette Colman, Director, Policy and Strategy Development, National Rural Health Alliance, 19 March 2021, p 3; Evidence, Dr Shannon Nott, Rural Director of Medical Services, Western NSW Local Health District, 30 April 2021, p 40.

245 Evidence, Dr Holliday, 16 June 2021, p 14.

246 Evidence, Dr Paul Mara, Private individual, 6 October 2021, pp 35-36.

247 Evidence, Dr Mara, 6 October 2021, pp 35 and 39.

248 Evidence, Dr Mara, 6 October 2021, p 35.

249 Submission 261, The Royal Australasian College of Medical Administrators, p 5.

Contractual arrangements and packages

3.53 The Commonwealth/State divide was also a source of concern for stakeholders discussing contractual arrangements and packages for doctors. There was broad consensus that the State should do more to engage with rural doctors and provide contracts and packages that recognise the breadth of work they are undertaking across their general practice and within hospital settings.

3.54 In his submission, Dr Simon Holliday identified that the funding model for rural GPs makes it unattractive to work rurally, and suggested salary packages and administrative support be provided that reflect the disproportionate obligations rural GPs have to nursing homes and hospitals.[250]

3.55 Along similar lines, Dr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Shire Council said that packages are so far behind that 'it is not worth our while', and explained how the two funding streams for GPs in small towns work:

> You have your office practice—your surgery—where you get money either through Medicare bulk billing or the patient pays you a private fee and then the patient gets the Medicare rebate. That is one stream of income. The other possible stream of income is your VMO work, which in New South Wales traditionally is on a fee-for-service basis. You get paid a fee for being on call and then a fee for service, depending on what you do. If you are not working, you do not get paid. If you work, you get paid. The fee varies depending on the time of day and what is wrong with the patient. Treating an emergency is paid more than treating a basic problem; getting called out at midnight is paid better than getting called out at 10.00 a.m.[251]

3.56 Dr Iannuzzi expressed that the fee for service model generally provides a fair approach[252] but, as identified by Dr Holliday, said that there has been a failure by NSW Health to engage well enough with rural doctors to 'address the obvious holes in the package that develop over time as clinical needs change, as expectations change and as the technology changes'. He said that there is a 'massive need to do a one-off indexation' of 20 to 30 per cent, and called for more recognition of the additional administrative burden on rural doctors that wasn't there 30 years ago when the packages were developed.[253]

3.57 In relation to the fee for service arrangement, Dr Michael Clements, the rural Chair for The Royal Australian College of General Practitioners advised that its members have expressed that the VMO model used in some rural areas can present a barrier because the arrangement relies on a good, trusting relationship between the Local Health District and the private practitioners. He added that those trusting relationships are not always there because there are sometimes 'competing interests'.[254]

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250 Submission 379, Dr Simon Holliday, p 17.

251 Evidence, Dr Iannuzzi, 18 May 2021, p 10.

252 Evidence, Dr Iannuzzi, 18 May 2021, p 10.

253 Evidence, Dr Iannuzzi, 18 May 2021, p 10.

254 Evidence, Dr Michael Clements, Chair, Rural, The Royal Australian College of General Practitioners, 19 March 2021, p 12.

3.58 Dr Clements discussed a promising Queensland model that addresses some of these aforementioned issues. He explained that in Queensland, a rural GP is given a retaining salary for being on call for the hospital, but then can continue to work in their private practice and bill patients accordingly. He said that this is essentially a way of the State Government subsidising or being able to fund these rural GPs in the services.[255]

3.59 Further to this point, Dr Clements emphasised the importance of Local Health Districts working with general practices, stating that 'if you have a thriving general practice with good supervision and a good, positive experience then the doctors will come'.[256]

3.60 Consistent with this evidence, numerous stakeholders, including the Australian Medical Association and the NSW Medical Staff Executive Council, expressed that doctors need to be offered contracts that support private practice options.[257]

Medical network approach

3.61 A consistent theme in the discussion about the doctor workforce was the lack of professional support that arises from doctor shortages and limited specialist availability. Dr Mara encapsulated the issue in his comment, 'doctors beget doctors'.[258]

3.62 While there was general agreement that doctors want to work where they are supported by other doctors and health professionals, there were different ideas about how this could be achieved, some of which have been canvassed above. Others identified the benefits of a 'networked' approach.

3.63 For example, Dr Stewart from Parkes expressed support for a 'local medical network' approach to better support rural doctors. According to Dr Stewart, this involves a pool of doctors in a larger area providing services to nearby areas:

> There have been some suggestions from fellow GPs about looking at pools of doctors. We have amazing centres such as Dubbo and Orange where we have a supply of general practitioners but also some hospital-based doctors. That potentially would be a pool that we could use to provide some services to Parkes. This would have a great effect, both providing experience and communication from those larger centres to Parkes and offering that excellent education and upskilling for our local health providers as well.[259]

3.64 The New South Wales Medical Staff Executive Council also supported a networked approach where doctors from larger areas support more rural or remote locations, identifying a number of benefits to this approach:

255 Evidence, Dr Clements, 19 March 2021, p 12.

256 Evidence, Dr Clements, 19 March 2021, p 18.

257 Submission 17, One New Eurobodalla Hospital, pp 10-11; Evidence, Dr Salindera, 19 March 2021, p 2; Submission 276, New South Wales Medical Staff Executive Council, p 9; Evidence, Mr Richard Nankervis, Chief Executive Officer, Hunter New England and Central Coast Primary Health Network, NSW Rural Primary Health Networks, 19 March 2021, p 13; Evidence, Dr Stewart, 19 May 2021, p 3.

258 Evidence, Dr Mara, 6 October 2021, p 35.

259 Evidence, Dr Stewart, 19 May 2021, p 3.

> A possible solution [to the specialist shortage] would involve "networking" the smaller and more isolated hospitals with larger regional and metropolitan hospitals, and this would allow a regular and reliable supply of Specialists to visit the more remote and rural hospitals as well as ensuring adequate retention of continuous professional development and clinical skills. This practice would also result in an improved standard and consistency of care. Networking between hospitals would also result in improved access to larger regional and metropolitan hospitals for patient transfers due to improved communication and handover between medical and surgical specialists.[260]

Localised responses

3.65 A consistent theme raised by stakeholders in discussing workforce issues was a concern about the lack of localised responses, developed in consultation with the community. Examples of these views are summarised below:

- Dr Seshasayee Narasimhan, Visiting Medical Officer, Acute Care Physician and Cardiologist, Department of Medicine, Manning Base Hospital questioned who was making decisions about staffing needs, and said that he is '100 per cent sure they are being made by people who do not live and work here'.[261]
- Ms Collette Colman, Director, Policy and Strategy Development, National Rural Health Alliance said that her organisation is of the view that trying to coordinate and pool funding at the local level is the best way forward because solutions are then community owned and managed.[262]
- Dr John Kramer, Chair, NSW Rural Doctors Network and said that you cannot have a 'one-size-fits-all' approach and that solutions need to be flexible and tailored.[263]

3.66 Ms Kitcher from South Eastern NSW Primary Health Network also referred to the importance of collaboration and localised responses:

> … from our vantage point as PHNs, any improvement in health outcomes and access will only be achieved by working together across the Federal and State boundaries and by including local clinicians from both primary and secondary settings as well as the community members themselves to design and implement new ways of working to integrate services and systems.[264]

3.67 She agreed with other stakeholders that there is 'no one-size-fits-all solution; each town or region will require a different solution tailored to their unique needs', and explained that the policy frameworks to support this approach do exist:

> The National Health Reform Agreement includes a commitment to exploring innovative approaches and outlines how governments can work together to provide high-quality services that are planned and delivered at a local level. The New South

260 Submission 276, New South Wales Medical Staff Executive Council, pp 5-6.
261 Evidence, Dr Seshasayee Narasimhan, Visiting Medical Officer, Acute Care Physician and Cardiologist, Department of Medicine, Manning Base Hospital, 16 June 2021, Taree, p 20.
262 Evidence, Ms Colman, 19 March 2021, p 7.
263 Evidence, Dr John Kramer, Chair, NSW Rural Doctors Network, 19 March 2021, p 28.
264 Evidence, Ms Kitcher, 19 March 2021, p 10.

> Wales joint statement, about to be signed, is between the 15 LHDs and the 10 PHNs in New South Wales. It states our shared vision to have one health system mindset, it promotes working together and it encourages us all to act beyond the current structures and boundaries in health care, with the patient at the centre.[265]

3.68 The Office of the National Rural Health Commissioner similarly outlined that locally designed rural models of care are needed to address rural health inequities, and that 'local determination of health services and the co-design of models of care with community' will result in services that are culturally appropriate and that residents accept and use. The Commissioner said that these models are currently being trialled in some rural and remote locations in Australia and that there have been some recent announcements in New South Wales regarding similar approaches:

> In New South Wales, the Australian Government has recently announced funding to implement five rural models of care designed by local communities and health services, in rural areas where thin markets and workforce shortages have existed for some time. These models are collaborative, have meaningful intersections across sectors, share workforces and operate at multi-town, sub-regional levels. These models are exploring how health services can integrate across public, private and not for profit sectors and associated funding streams, functioning as single subregional systems of care.[266]

Role of primary health care

3.69 A number of witnesses told the committee that, while primary health care is the responsibility of the Australian Government, New South Wales should play more of a role in primary health care due to the impact that poor primary health care services has on the state health budget, particularly as a result of increased hospitalisations when people can't access GPs. For example, Rural and Remote Medical Services Ltd stated:

> There is an urgent need for the NSW Government to make a strategic commitment to a central role for Primary Health Care in rural and remote communities. While the Rural Health Plan acknowledges the importance of "integration" of primary and hospital care, there is a lack of consistency in the approach across NSW to supporting the sustainability of Primary Health Care and general practice.
>
> [...]
>
> RARMS has spent 20 years engaging doctors to work in rural and remote NSW within their Primary Health Care and local hospital sectors; we have been delivering face to face quality care that has resulted in a reduction in potential preventable hospitalisations across our locations of 65 percent in the last 5 years; and, our communities are accessing health services at a higher rate than other towns without GPs because we have a model that has been shown to be among the most stable and sustainable of rural and remote health care models in Australia.[267]

265 Evidence, Ms Kitcher, 19 March 2021, pp 10-11.

266 Submission 391, Office of the Rural Health Commissioner, pp 7-8.

267 Submission 705, Rural and Remote Medical Services Ltd, pp 9, 28.

3.70 Similarly, the Australian College of Rural and Remote Medicine wrote in its submission:

> AIHW research indicates that lack of access is leading to people presenting when conditions have escalated, or when they are unable to seek appropriate primary care through their local GP. The rate of potentially preventable hospitalisations doubles in rural areas, leading to poorer health outcomes and consequent increased health care costs, losses in economic productivity and poorer quality of life.[268]

Recruitment and retention

3.71 There was widespread concern from stakeholders about recruitment and retention practices and the impact that the current approach has on the doctor workforce. Drawing on their own experiences and contexts, stakeholders provided a range of views about ways to improve recruiting and retaining doctors in rural locations.

3.72 A number of inquiry participants expressed that the problem is not that doctors do not want to work in rural locations, and indeed that many are attracted to rural settings because of the lifestyle, job availability and breadth of exposure and skill development opportunities.[269]

3.73 Nevertheless, there was also broad consensus that recruitment and retention remains a challenge in rural areas.[270] Many stakeholders identified poor working conditions as a key issue, describing high workloads, little opportunity for time off and continuous long hours, and juggling private practice and on-call demands.[271] Dr Holliday's submission included the words of one doctor's description of work-life balance in rural settings:

> 'It is crap to work in the rural area. You are on call nearly every weekend. You can't sleep, you can't take a day off if you are sick. It is all too difficult. Who likes to work in that environment? NO ONE!'[272]

3.74 Echoing this sentiment, one submission author captured the numerous barriers to rural practice including high levels of burnout:

> Consider this. Would anyone from a metropolitan area, choose to leave behind a healthy income, a comfortable lifestyle with a healthy work-life balance, in order to relocate to a regional, rural and remote area in NSW to practice, knowing that their workload would be plentiful, rest would be scarce and work-related burnout would be high? In addition to the knowledge that there would be nowhere to retreat from the burden of being the only on call doctor, often required to practice outside of your professional scope? No.

268 Submission 403, Australian College of Rural and Remote Medicine, p 3.

269 Submission 262, Australasian College for Emergency Medicine, p. 4. See also: Submission 573, Australian Medical Association, p 7; Evidence, Mr Colbran, 19 March 2021, p 27; Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 34.

270 See for example: Evidence, Dr Magee, 29 April 2021, p 13; Submission 345, Local Government NSW, p 15; Evidence, Dr Sara, 19 March 2021, pp 45-46; Evidence, Dr Stewart, 19 May 2021, p 3; Evidence, Mr Colbran, 19 March 2021, pp 20-21.

271 See for example: Submission 379, Dr Simon Holliday, pp 8-10; Submission 452, NSW Rural Doctors Network, p 7; Submission 573, Australian Medical Association, p 5.

272 Submission 379, Dr Simon Holliday, p 11.

> Consequently, regardless of the incentives being offered, without changes to these work limitations, nothing would make this an attractive offer to an urban health professional.[273]

3.75 In providing accounts of poor working conditions and extreme stress and pressure, some stakeholders also pointed to the resultant risks to patients and preventable deaths:

- Dr Sara submitted that rural doctors are overworked, stressed and unsupported by a system that blames them when things go wrong. He advised that members of the Australian Salaried Medical Officers' Federation have reported that some hospitals are purposely keeping the roster concealed from doctors so that they do not know they are working solo until they arrive for their shift. While he added that such a practice is unsubstantiated by his organisation, it is concerning nonetheless. His organisation highlighted the risk posed to patients by exhausted and overworked doctors.[274]
- Dr Narasimhan said that he has 'an extraordinary large workload with major responsibilities' and as a result has to consistently work 80 hours a week at a minimum to provide care to his patients. He attributed this to difficulties in attracting and retaining suitably qualified staff, chronic underfunding and because they are 'haemorrhaging qualified and experienced allied health practitioners'.[275]
- Another stakeholder expressed that doctor fatigue can be high which often results in a lack of care towards work and patients, poor clinical judgement, and overall risks to patients health and well-being. They added that 'sometimes the result is a preventable death'.[276]

3.76 Other factors raised by stakeholders as barriers to recruiting and retaining rural doctors included the lack of support for spouses and children, the lack of a professional support network, and that rural general practice can be seen as a lesser career direction with poor recognition.[277]

3.77 Against this backdrop, stakeholders had a range of suggestions and ideas for ways to improve recruitment and retention of doctors in rural settings. While some of these issues have been outlined earlier in this chapter, stakeholders suggested improvements in the following additional areas:

- clearer, simpler pathways for those interested in rural practice[278]
- mandatory service for doctors in rural settings, similar to the teaching profession[279]

273 Submission 711, Name suppressed, p 3.

274 Evidence, Dr Sara, 19 March 2021, p 43 and Submission 453, Australian Salaried Medical Officers' Federation, p 8.

275 Evidence, Dr Narasimhan, 16 June 2021, pp 14-15.

276 Submission 711, Name suppressed, p 3.

277 See for example: Submission 573, Australian Medical Association, p 5; Submission 452, NSW Rural Doctors Network, p 7; Evidence, Mrs Sharon Bird, Proprietor and Pharmacist, Bonalbo Pharmacy, 17 June 2021, p 11; Evidence, Mr John Scarce, General Manager, Murrumbidgee Council, 29 April 2021, p 9; Evidence, Mrs Tanya Forster, Psychologist and Director, Macquarie Health Collective, 19 May 2021, p 32; Submission 670, University of Newcastle, p 9.

278 Submission 629, Royal Australian College of General Practitioners, p 3.

279 Submission 643, Name suppressed, p 1; Submission 496, Name suppressed, p 2; Evidence, Dr Mara, 6 October 2021, p 35; Evidence, Dr Holliday, 16 June 2021, p 15.

- remuneration and incentives to attract doctors to rural locations.[280]

3.78 In relation to remuneration and incentives, Dr Sara from the Australian Salaried Medical Officers' Federation said that there are 'limited incentives for doctors to move to rural towns', and that there are 'no geographical allowances in the health system'. He explained that doctors get paid the same regardless of whether they are in Broken Hill or a metropolitan area. He expressed that incentivising doctors to rural areas is needed and provided some ideas:

> We believe that NSW Health must develop a comprehensive recruitment and retention plan with additional funding to incentivise junior and senior doctors to relocate to rural areas. This could include scholarships, HECS reimbursement, subsidising relocation costs and so on.[281]

3.79 Dr Sara further added that incentives could also include things like leave arrangements, professional support arrangements, money, child care, travel support, capacity for leave, and furnished accommodation located close to the hospital.[282]

3.80 At the committee's hearing in Wellington, Mrs Sally Empringham likened such incentives to those offered in the mining sector, commenting that 'no-one would choose to live in half the places that there are mines, but they pay enough money that people go there'.[283] This sentiment was supported by Cr Ruth McRae, Mayor, Murrumbidgee Council, who told the committee about the council taking its own steps to incentivise doctors to come:

> [W]hen we could not get doctors, you then became engaged in the incentivised program to try and attract people to come to town: you build houses, you build doctors' surgeries, you provide cars, you provide income guarantees, you almost sell your soul—not quite, but recognising the value of having that medical service in your town.[284]

3.81 Other stakeholders provided examples of incentives they have put in place to attract doctors to their towns:

- The Edward River Council has implemented a policy to encourage health practitioners to relocate to Deniliquin with financial support and incentives.[285]
- Murrumbidgee Council provided a $5,000 incentive for a local doctor to stay on in their community.[286]
- Parkes Council organises community sports days, competing for the 'GP Cup' to raise money. Cr Ken Keith OAM, Mayor told the committee they raised over $200,000 to go

280 See for example: Evidence, Dr Sara, 19 March 2021, p 43; Evidence, Mr Brian Jeffrey, Private individual, 16 June 2021, p 37; Evidence, Dr Salindera, 19 March 2021, p 2; Evidence, Ms Leonie Brown, Manager Corporate Services, Bourke Shire Council, 30 April 2021, p 4.

281 Evidence, Dr Sara, 19 March 2021, p 43.

282 Evidence, Dr Sara, 19 March 2021, pp 47, 48 & 50.

283 Evidence, Mrs Sally Empringham, Private individual, 18 May 2021, p 42.

284 Evidence, Cr Ruth McRae, Mayor, Murrumbidgee Council, 29 April 2021, p 4.

285 Evidence, Cr Norm Brennan, Mayor, Edward River Council, 29 April 2021, p 2.

286 Evidence, Mr Philip Stone, General Manager, Murrumbidgee Council, 29 April 2021, p 9.

towards the recruitment of GPs including subsidising their flights and moving expenses.[287]

- Dr Marion Magee, Chair of the Deniliquin Health Action Group said that as part of a broader recruitment and retention strategy in her town, they went from no houses to having nine that they can now offer staff who come to the town.[288]

Education and training

3.82 Education and training was a common theme that arose when discussing the challenges associated with recruiting and retaining doctors in rural settings. There was general consensus amongst stakeholders that training medical students in rural locations increases the likelihood of those students taking up practice in rural settings. For this reason, many inquiry participants advocated for increased rural training opportunities and pathways.[289]

3.83 In addition to the evidence regarding the need to train rurally and the benefits that come with it, stakeholders discussed opportunities to improve current approaches to rural training.

3.84 In this regard, the committee heard that the Commonwealth/State funding divide is causing issues. For example, Charles Sturt University noted that the rigidity of some Commonwealth funding reduces universities' flexibility to deal with local challenges, and argued that the NSW Government should consider providing its own funding to bridge some of the 'gaps' in Commonwealth funding. It recommended:

> For the NSW Government to ensure the best possible health services and health outcomes for regional communities, it needs to consider directly funding health, allied health and medical education and training in NSW universities, especially those in regional areas, and to integrate education and training with clinical placements and professional development in NSW Health facilities. This should include funding for more scholarships for students from, and to study in rural, regional and remote areas; and support for the professional development for practitioners in those areas.[290]

3.85 Dr Salindera from the Australian Medical Association also discussed the need for collaboration between State and Commonwealth Governments as well as with the universities. She said that it is a complex issue to identify and fill training positions, explaining:

> It is a complex problem because the training and college programs in collaboration with how our selection and allocation works on a State-based level and how the State hospitals fund and allow these positions—so it requires quite a bit of collaboration between all of those to get the position identified in the local hospital. That needs the

287 Evidence, Cr Ken Keith OAM, Mayor, Parkes Council, 19 May 2021, p 4.

288 Evidence, Dr Magee, 29 April 2021, p 11.

289 See for example: Evidence, Dr Salindera, 19 March 2021, p 6; Submission 401, Charles Sturt University, p 1; Evidence, Dr Hespe, 19 March 2021, p 15; Submission 670, University of Newcastle, pp 12-13; Evidence, Ms Rebecca Ryan, Member, Gunnedah Early Childhood Network, 16 June 2021, p 12; Evidence, Ms Jessica Brown, General Manager, Strategy and Growth Business Development, Marathon Health, 19 May 2021, p 31; Evidence, Dr Clements, 19 March 2021, p 18; Evidence, Dr Dumbrell, 29 April 2021, pp 29-30.

290 Submission 401, Charles Sturt University, pp 4-5.

> local health district to know that we need a position here. That then needs to follow on with the funding from the State or any national programs where that can be accessed, and accreditation by the college to create those posts.[291]

3.86 In order to address these issues, a number of stakeholders pointed to a single employer model for trainee GPs, such as the pilot Murrumbidgee Rural Generalist Training Pathway mentioned above. Local Government NSW explained that without a single employer model, trainees rotate through different hospitals and private practices (some funded by the state and others funded by the Commonwealth) and that this arrangement acts as a disincentive, as GP trainees on these short term contracts are unable to accrue leave and access other entitlements. Local Government NSW welcomed the announcement of the Murrumbidgee model and recommended that NSW Government work with the Commonwealth to achieve exemptions under the *Health Insurance Act 1973* (Cth) so that this model can operate across rural New South Wales.[292]

3.87 Another solution put forward by stakeholders was longer rural placements at both the undergraduate and postgraduate level. For example, the University of Newcastle commented: 'Providing students and doctors with extended rural opportunities throughout training should be components of government strategies for solving rural workforce problems'.[293]

3.88 Dr Neil McCarthy, a rural GP of 30 years' experience, said that very few Australian medical schools provide longitudinal clinical placements in rural general practice, and that such placements are more likely to result in doctors who wish to practice in rural areas.[294] Similarly, Dr Clements from the Royal Australian College of General Practitioners underscored the importance of the length of time training in a rural setting:

> The evidence is absolutely clear that the likelihood of converting a medical student or junior doctor to rural service depends on the breadth and the length of time that they spend training in that rural environment and the quality of that experience.[295]

3.89 Dr McCarthy said that James Cook University has long clinical placements in its undergraduate program and the University of New England advised that it is also introducing longitudinal placements into its curriculum from 2021. The University of New England explained that it will embed small groups of medical students for extended periods of time into rural and remote communities and pointed to a number of benefits:

> The longer placements will allow students to become more familiar with GP practice, to build stronger professional relationships with the GPs in RRR communities, and to be in place for a duration of time that allows them to follow patients on their individual healthcare journeys. Their placement period will also afford students the opportunity to be woven into the social fabric of a RRR community, and to become recognised members of the town and participants in community events.[296]

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291 Evidence, Dr Salindera, 19 March 2021, p 6.
292 Submission 345, Local Government NSW, p 14.
293 Submission 670, University of Newcastle, p 13.
294 Evidence, Dr Neil McCarthy, Private individual, 19 May 2021, p 28.
295 Evidence, Dr Clements, 19 March 2021, p 18.
296 Submission 466, University of New England, p 4.

3.90 On a separate issue, some stakeholders expressed concern about the inequity in incentives for junior medical officers doing their rural placements, based on whether they are rotating from a metropolitan area. Dr Jones from Tamworth explained the situation:

> Currently, under the junior medical officers [JMO] award and employment conditions, metropolitan-based junior doctors who are retained to work in regional and rural settings will be paid an increased salary and provided accommodation plus flights back to Sydney every seven weeks, simply because they are rotating. This means that two junior doctors who are at the same stage of training, working the same role in a regional or rural location, will be paid differently simply because one is rotating from a metropolitan hospital. This also impacts the rotation of the regional and rural based junior doctors to metropolitan locations as they will have to find their own accommodation and there is no change to their salary. This is a disincentive for junior doctors to work in regional settings.[297]

3.91 This was echoed by The Royal Australasian College of Medical Administrators, which confirmed that Junior Medical Officers who choose rural practice are not offered the same financial or accommodation subsidies that are available to metropolitan trainees on secondment to rural hospitals. It added that 'this negatively impacts the likelihood of a JMO independently choosing a rural training post as an attractive career option'. The College expressed the view that a single employer model during the training pathway for GPs and Rural Generalists in rural settings can address these discrepancies.[298]

3.92 Like other stakeholders, the Commonwealth Department of Health agreed that people who study and train in regional locations are more likely to live and work in those locations.[299] It pointed to the 2013 Mason Review which highlighted that the investment in rural university training was compromised by a lack of rural training opportunities after graduation, commencing with compulsory internship years for doctors which were primarily undertaken in metropolitan settings. It said that the lack of a clear pathway from undergraduate rural training into employment as a rural doctor was a key reason why students who are interested in rural health are regularly lost to the metropolitan health system.[300]

NSW Health perspective

3.93 Engagement with NSW Health took place throughout the inquiry. In response to the evidence that arose during the hearings, NSW Health provided a supplementary submission in January 2022 addressing some of the themes that emerged throughout the inquiry. NSW Health also advised that it had engaged the Sax Institute to review the health system and evaluate primary care models in 'Australia, Canada, New Zealand and the Northern Periphery and Artic region'. In doing this, The Sax Institute proposed future strategies, which NSW Health is considering.

3.94 The four strategies proposed by The Sax Institute are:

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297 Evidence, Dr Liz Jones, Emergency Physician, Tamworth Base Hospital, 16 June 2021, p 14.

298 Submission 261, The Royal Australasian College of Medical Administrators, p 3.

299 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 83.

300 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 47.

1. Lead processes to reduce federal/state divisions of responsibility for primary care
2. Identify and implement an integrated primary care model
3. Engage communities in local health service development
4. Strengthen the rural health workforce.[301]

3.95 While a number of the actions within these strategies address some of the workforce issues discussed in this chapter, strategy 4 is the most pertinent. This strategy includes two key components:

- Establish collaborative models with the Australian Government in order to select a health service model, such as the 'Rural Area Community Controlled Health Organisations' (RACCHO) model, that can be adapted for implementation in rural New South Wales settings where Medicare fee-for-service health care has failed.
- Implement the model initially on a pilot scale, evaluate and refine it, and then introduce it at scale in all the parts of New South Wales where existing rural health services do not meet community needs, recognising this transition may take several years.[302]

3.96 In response to this suggested strategy, NSW Health advised that it is currently considering ways to enhance the rural health workforce including:

- Considering how existing Award structures can be modernised to support recruitment and retention of health professionals in rural and remote regions.
- Supporting education and training and ongoing professional development of the health professional workforce in rural and regional areas, for example, ensuring supervisors have the appropriate supports, providing rural based trainees with metropolitan rotations to support training needs.
- Building on initiatives to support rural workforce wellbeing and engagement, and to enhance the attractiveness of rural communities as places to live and work.
- Enhancing mechanisms to identify and meet regional, rural and remote communities' specialist workforce needs, for example in oncology, palliative and mental health care.
- Building on existing strategies to increase the Aboriginal health care workforce.
- Enhancing training for the rural health workforce on digital health and technologies, including virtual care technology.[303]

3.97 Over the course of the inquiry, NSW Health provided evidence on a number of specific issues. Some of the key ones are discussed below.

Doctor shortages

3.98 NSW Health acknowledged the GP workforce shortage, pointing to the reduction in people choosing general practice, the declining number of GPs in rural locations with procedural skills, and the declining number of GPs providing hospital services as the cause.[304]

301 Submission 630a, NSW Government, pp 7-9.
302 Submission 630a, NSW Government, p 7.
303 Submission 630a, NSW Government, pp 8-9.
304 Submission 630, NSW Government, p 4.

3.99 Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, explained that these GPs shortages have flow on effects to the wider hospital system, which are felt in emergency department presentations, issues with medication management and potentially preventable hospitalisations.[305]

3.100 Dr Lyons spoke about the fact that having 24/7 doctor coverage in rural hospitals is an ongoing challenge and something that cannot be guaranteed because of the workforce issues.[306] Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health added that NSW Health expends significant money to try to attract locums to cover hospitals but this isn't always successful,[307] and that NSW Health continually works with the Local Health Districts to look at the current supply of staff across the workforce. He noted that on some occasions there might be 40 instances, across the entire state, where the supply is not where they would seek to have it.[308]

Commonwealth/State responsibilities and models of practice

3.101 NSW Health identified the split between Australian and State government responsibility as one of the biggest challenges for rural health care delivery.[309] Dr Lyons commented that insufficient local primary health care and the consequential impact on hospitals is 'the fundamental health problem facing rural and regional communities across the country', and identified that a coordinated effort is required to address the resultant workforce issues:

> Access to the full range of healthcare services requires a coordinated effort between State and Federal governments, local health districts, clinicians, patients and local communities. Together we must find a solution to a sustainable GP service and other workforce.[310]

3.102 Consistent with the evidence given by other stakeholders discussed above, Mr Minns said that while NSW Health has relied on the GP/VMO model to service rural hospitals, this model is under threat:

> In essence, once there are not enough GPs, or enough GPs willing to work as a GP/VMO, the traditional model for delivering services in these smaller facilities is threatened and needs to be either buttressed by locum medical officers or completely reinvented. The issues are also compounding. As GP numbers decline, the demands on those who remain increase. As trainee GP numbers decline, this reduces the time available in GP practices to support the local health facility. In this demanding context, coupled with a changing life and work paradigm, some GPs are not seeking VMO appointments at all, or, if they do, are looking for a less onerous appointment, meaning

305 Submission 630, NSW Government, p 46 and Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 19 March 2021, pp 53-54 and 66.

306 Evidence, Dr Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 2 February 2022, p 11.

307 Evidence, Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health, 2 February 2022, p 11.

308 Evidence, Mr Minns, 19 March 2021, p 58.

309 Submission 630, NSW Government, p 4.

310 Evidence, Dr Lyons, 19 March 2021, p 54.

> more GPs are required to support a medical presence in the facility than was previously required. Locum medical officers are therefore a critical fallback strategy.[311]

3.103 Although Mr Minns said that Local Health Districts continue to engage GPs to see if they are interested in VMO work at NSW Health facilities,[312] he also discussed the single employer model being trialled under the Murrumbidgee Rural Generalist Training Pathway pilot. He noted that the Commonwealth has granted an exemption under the *Health Insurance Act 1973* (Cth) to allow this to occur, and that 'there is potential to scale this model across New South Wales to improve employment arrangements for GPs'.[313] In subsequent evidence Mr Minns again referred to this trial as promising, calling it the 'best example' of innovative steps to address the GP shortage. He noted that an expedited evaluation in collaboration with the Commonwealth might assist with a more timely broader roll out.[314]

3.104 In relation to the Murrumbidgee Rural Generalist Training Pathway, NSW Health in its supplementary submission noted certain limitations to the *Health Insurance Act* exemption which require addressing before a broader roll-out of the model can occur.[315]

3.105 NSW Health also pointed to mechanisms in place that guide its collaboration with the Commonwealth. It described the Bilateral Regional Health Forum and its purpose to facilitate the discussion of rural health issues and monitor progress of Australian and NSW Governments' commitments to ensure a collaborative approach to improving regional health outcomes in New South Wales.[316]

3.106 Dr Lyons identified moving towards a more integrated approach such as this as the first of four key future strategies that NSW Health needs to address, acknowledging:

> We must move faster towards a national collaborative approach to the delivery of primary health care that rebalances responsibility in funding for primary care, and develop plans for integrated rural health services.[317]

3.107 In this regard, NSW Health outlined another example of a potential innovative approach for the delivery of health services in rural locations, namely the Rural Area Community Controlled Health Organisation model being suggested by the National Rural Health Alliance and also noted by the Sax Institute. While such a model is broader than workforce issues and goes to the full local health service system, the committee heard that from a workforce perspective it would see New South Wales working with the Commonwealth to allow health professionals to be employed by one employer and work across primary and secondary health care delivery.[318]

3.108 In discussing this model, Dr Lyons said that NSW Health would need to work with the Commonwealth to 'bring everything together' and he has promoted this concept as something to further consider:

311 Evidence, Mr Minns, 19 March 2021, p 55.
312 Evidence, Mr Minns, 19 March 2021, p 58.
313 Evidence, Mr Minns, 19 March 2021, p 55.
314 Evidence, Mr Minns, 2 February 2022, p 7.
315 Submission 630a, NSW Government, p 10.
316 Submission 630, NSW Government, p 4.
317 Evidence, Dr Lyons, 2 February 2021, p 3.
318 Submission 630a, NSW Government, p 7.

> There is a concept in there of the rural area community-controlled health organisation of something we could look to develop. If we can work with the Commonwealth to say that for a regional area, a rural area, let us bring everything together, this will be how it is funded, how the workforce across all of the services that we are responsible for and the Commonwealth deliver—it might be in private practice as well—how do we support them coming together to think about how they deliver to the needs of the local community in a way that the community has more involvement in directly? We have promoted that concept as something that could be explored as a way to address this issue. But we are very conscious that as a result of what we have heard, we need to do more to strengthen the relationship between our service providers and the communities that they deliver care in.[319]

3.109 From an Australian Government perspective, many of the challenges discussed by NSW Health officials were echoed by Commonwealth Department of Health. It is also advocating that the Commonwealth and States have a shared responsibility to ensure that all parts of the system operate in a coordinated and integrated way.[320]

3.110 The Commonwealth Government formed a Primary Health Reform Steering Group to provide recommendations for reform. The Steering Group's report identified significant weaknesses in the current structure and funding of the primary health care system and made recommendations that both seek to integrate primary, secondary and tertiary health care, as well as deliver funding reform to achieve this.[321] The Steering Committee identified a number of actions that are consistent with those being considered by the NSW Government, mentioned above:

- flexible funding models, employment models and service options tailored to community needs
- the need to address the Commonwealth/State divide
- creating Rural Area Community Controlled Health Organisations.[322]

3.111 NSW Health advised that it is committed to working with the Commonwealth on implementing these recommendations.[323]

Rural Generalists and specialists

3.112 NSW Health officials acknowledged the value of Rural Generalists in rural and remote settings. For example, Dr Shannon Nott, Rural Director of Medical Services, Western NSW Local Health District and Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, both

319 Evidence, Dr Lyons, 2 February 2022, p 19.

320 Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 11.

321 Department of Health, Health Reform Steering Group, Draft recommendations from the Primary Health Reform Steering Group, referenced in Submission 630a, NSW Government, p 6.

322 Department of Health, Health Reform Steering Group, Draft recommendations from the Primary Health Reform Steering Group, referenced in Submission 630a, NSW Government.

323 Submission 630a, NSW Government, p 6.

expressed support for the model, with Ms Ludford commenting that a 'rural generalist trained workforce can better provide rural services and improve access to care'.[324]

3.113 In particular, Ms Ludford spoke about the value of the Murrumbidgee Rural Generalist Training Pathway and also pointed to another GP teaching program called WESTEND, which aims to provide GPs the required emergency department experience to work in hospitals. She said that this program has built the number of doctors and reduced dependence on locums.[325]

3.114 In this regard, NSW Health advised that, while the Commonwealth has responsibility for the funding and distribution of medical graduates and GP training, NSW Health commenced a program in 2013 to train GPs 'to deliver services such as anaesthetics, obstetrics, mental health, palliative care, emergency medicine, and paediatrics to rural communities'.[326]

3.115 NSW Health also pointed to work being done through the Bilateral Regional Health Forum to further develop training programs to support GPs and rural generalists into rural practice, and to develop attractive funding and employment models for doctors in training to work across hospitals and general practice.[327]

Recruitment and retention

3.116 NSW Health agreed with the challenges identified by other stakeholders to recruit to rural areas. It summarised these challenges as:

- high workload and hours worked due to a lack of critical mass of medical practitioners in rural areas to maintain a sustainable after hours and on call service
- an expectation that practitioners will have a wider scope of practice in rural and regional areas than when working in metropolitan locations
- limited supporting health care infrastructure, including diagnostic equipment and other advanced technologies and professional isolation for some rural areas compared to metropolitan areas can limit professional opportunities
- less availability of career opportunities for partners and spouses.[328]

3.117 Health officials also provided information about efforts to recruit doctors to rural locations, including Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, who gave the following description of efforts to attract additional clinicians across the region:

> We are going to a lot of lengths to ensure that we can recruit in new and additional clinicians for every hospital right across the region… I would love to see doctors available 24/7 in our hospitals and to have enough nursing staff to cover all of our rosters. We have got extensive incentives and support programs that include providing accommodation for staff when they come into town, relocation incentives and other

[324] Evidence, Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, 29 April 2021, p 39; Evidence, Dr Nott, 30 April 2021, pp 47-48.

[325] Evidence, Ms Ludford, 29 April 2021, p 39.

[326] Submission 630, NSW Government, p 47.

[327] Submission 630, NSW Government, p 24.

[328] Submission 630, NSW Government, pp 46-47.

> supports to ensure that people can get home to their families and get good time off and time away from the workplace.[329]

3.118 In addition to some of the incentives described by Mr McLachlan, Dr Lyons said that accommodation is also provided in most Local Health Districts which is available for people recruited into the town.[330]

3.119 Mr Minns also referred to the support and incentives needed to encourage doctors to rural practice, but acknowledged that it is a multi-faceted issue:

> [A]t the end of the day if someone is seeking to engage in general practice they will need to have an appreciation that it is a viable and economic strategy for them so that comes down to the size of the town, what they can expect to achieve in earnings through the Medicare system and how many other GPs might already be there. They are all factors that flow into it. We need to work with the Commonwealth. We need to work with other New South Wales Government agencies to try to deal with things like the housing issue and education issues.[331]

3.120 Mr Wayne Jones, Chief Executive, Northern NSW Local Health District, explained that despite efforts to make packages attractive, it can still be very difficult to recruit, and agreed with other stakeholders that innovative models are needed to recruit and attract.[332] He spoke about the challenge they have faced in recruiting for doctors in Coraki:

> We even went to one of the corporates, which is against my DNA to do. They came and had a look, and they could not see any benefit in doing so. We have approached the GPs in surrounding areas, such as Casino, which is about 22 minutes or 23 minutes away to see if they would support. There is no support. We will continue to work with the local community but also with the primary health network [PHN]. I do recognise that general practice is a Commonwealth priority, but the reality is this is part of our community, so we work with the agencies, including the Commonwealth PHN, to try to get a GP.[333]

3.121 Mr Minns from NSW Health outlined that efforts are underway to explore different recruitment models including the use of pooled funding. In addition to the Murrumbidgee Rural Generalist Pathway program mentioned above, Mr Minns described the 4Ts program as another example of rural initiatives to address GP workforce issues:

> In October 2020, the Australian Government announced funding of $3.3 million over 18 months to support collaborative care workforce models in five areas of western New South Wales and Murrumbidgee. These include the canola fields, the "4Ts"—Tottenham, Tullamore, Trangie and Trundle—the Wentworth Shire, the Lachlan health region and the Snowy Valley health region. To look at one of these, the 4Ts program is exploring how to employ staff to work across the different sectors rather than hospitals and private practices trying to recruit separately. The program utilises pooled resources

329 Evidence, Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, 30 April 2021, p 22.

330 Evidence, Dr Lyons, 19 March 2021, p 68.

331 Evidence, Mr Minns, 2 February 2022, p 9.

332 Evidence, Mr Wayne Jones, Chief Executive, Northern NSW Local Health District, 17 June 2021, p 23.

333 Evidence, Mr Jones, 17 June 2021, p 37.

> of funding, data and people using a networked model, and it supports clinicians to work to full scope of practice.[334]

Education and training

3.122 Like many other stakeholders, NSW Health recognised the importance and benefits of training medical students and junior doctors in the regions and rurally. Mr Minns provided examples of two key developments in respect of rural training:

- The NSW Rural Preferential Recruitment Program was developed to enable junior doctors to work their first two postgraduate years in a rural location, and since the program started in 2007, over 1,000 doctors have completed their internship in a New South Wales rural hospital.
- Support for medical student places in rural and regional medical schools whereby students now have the opportunity to study at rural clinical medical schools in Albury, Armidale, Broken Hill, Bathurst, Dubbo, Coffs Harbour, Griffith, Lismore, Lithgow, Port Macquarie, Orange, Tamworth, Taree and Wagga Wagga.[335]

3.123 Dr Lyons told the committee that NSW Health has focused a lot over the past 10 years on how to organise training for medical students in rural and regional environments.[336] Dr Lyons pointed to the rural medical schools as delivering benefits in this regard, stating that there are the opportunities to do pre-vocation training rurally. However, he identified that more work with the Colleges is required to look at opportunities for specialist training and skill development within rural settings.[337]

3.124 In terms of progressing this work, Dr Lyons stated that this will be a focus area:

> I think that is the next step for us: How do we get agreement from the colleges that vocational training in the specialities and in general practice can occur in those rural environments, in a way that supports a pathway and a pipeline that enables people who are committed and who come from rural environments to live in those rural environments—and who are committed to staying in those environments—to be able to have all of their training in those environments and stay there for their careers and be supported?[338]

3.125 In its supplementary submission, NSW Health also emphasised the need to work together with the Commonwealth in order to increase rural training places in medical schools:

> Again, illustrating the complexities of our Federation, the Commonwealth Government is responsible for funding medical student places at university. Medical students undertake the majority of their clinical placements in public hospitals, with placements also in general practices and private hospitals.

334 Evidence, Mr Minns, 19 March 2021, p 56.
335 Evidence, Mr Minns, 19 March 2021, p 56.
336 Evidence, Dr Lyons, 19 March 2021, p 66.
337 Evidence, Dr Lyons, 2 February 2022, pp 9-10.
338 Evidence, Dr Lyons, 19 March 2021, p 66.

It is important that the Commonwealth and NSW Government work together in considering future distribution of medical student places, particularly opportunities to increase rural training places in medical schools.[339]

Committee comment

3.126 As already outlined in this report, the inquiry has heard evidence from a number of witnesses providing first-hand examples of inadequate health services and care in rural, regional and remote New South Wales. There is no doubt that doctor and clinician workforce issues are a key, if not the key to explaining many of these experiences. The committee acknowledges and appreciates the many doctors and clinicians who gave up their time and shared their expertise and personal experiences to inform the inquiry of the issues they face in rural and remote settings, including their ideas about ways to improve the current situation. These accounts provided detailed and thoughtful evidence as to both the challenges and opportunities to address them.

3.127 It is clear to the committee that the availability of doctors and clinicians in rural and remote locations is short, in some cases critically short of where it needs to be. While Chapter 2 detailed the impact this shortage is having on members of the community, the committee has also heard doctors and clinicians describe the unsustainable working conditions, particularly with respect to hours of work arising from insufficient supply of doctors and clinicians to cover the available work demands. The committee is concerned about doctor and clinician shortages and maldistribution in rural and remote settings, and the risks it poses to the health of community members, doctors and clinicians alike.

3.128 Consequently, the committee finds that rural, regional and remote medical staff are significantly under resourced when compared with their metropolitan counterparts, exacerbating health inequities.

Finding 4

That rural, regional and remote medical staff are significantly under resourced when compared with their metropolitan counterparts, exacerbating health inequities.

3.129 The committee welcomes the range of initiatives currently being trialled, piloted or considered in rural and remote locations including at the Commonwealth, state, local government and community levels. While it is apparent that there is broad awareness across all stakeholder groups of the doctor workforce problem, efforts to address the issue appear sluggish, patchy and stymied by complex layers of responsibility with little coordination across the multiple sectors. In a health system where primary and secondary care are interconnected, drawing from the same group of professionals, Commonwealth and State governments need to coordinate to find flexible and innovative solutions that effectively synergise the experience for doctors and service delivery for the community.

339 Submission 630a, NSW Government, p 10.

3.130 Indeed, there can be little doubt that the doctor workforce challenge is complicated and compounded by the division of responsibilities between Commonwealth and State. In fact, both levels of government acknowledged the Commonwealth/State divide as one of the most challenging aspects of health care delivery. But the existence of these challenges is not new. The committee is of the view that efforts to overcome them have been inadequate to date, ultimately failing to achieve the necessary structural reform. Consequently, the committee finds that the Commonwealth/State divide in terms of the provision of health funding has led to both duplication and gaps in service delivery.

3.131 The committee therefore recommends that the NSW Government urgently engage with the Australian Government to establish clear governance arrangements and a strategic plan to deliver on the reforms recommended below to improve doctor workforce issues. This should occur at the ministerial level to ensure the necessary political and policy momentum is maintained. We also believe that with a renewed commitment to work together to break down barriers and achieve health reform, progress can be made on those initiatives that both levels of government have identified as meritorious, but where progress has been slow or non-existent.

Finding 5

That the Commonwealth/State divide in terms of the provision of health funding has led to both duplication and gaps in service delivery.

Recommendation 7

That the NSW Government urgently engage with the Australian Government at a ministerial level to:

- establish clear governance arrangements and a strategic plan to deliver on the health reforms recommended in this report to improve doctor workforce issues
- progress those initiatives that both levels of government have identified as meritorious, but where progress has been slow or non-existent.

3.132 Despite the role played by the Australian Government, the committee also believes that, given the interdependency between primary health and hospital care, there is a need for the NSW Government to investigate ways to support the growth and development primary health sector in rural, regional and remote areas and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

Recommendation 8

That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

3.133 It was also apparent to the committee that there is no one-size-fits-all approach. There are fundamental differences between the operation of hospitals in metropolitan areas, as compared to hospitals in rural and remote areas (where there is a greater interdependency between primary health and hospital care), and it is essential that NSW Health implement specialist systems for the management of rural and remote hospitals which reflect the needs of each community. Each rural setting is different, requiring different numbers of GPs, Rural Generalists and specialists; with different skill sets; covering different service settings and population groups. While the committee recognises that it may not be possible to have each type of doctor in all locations at all times, coordination and collaboration is key to achieving the right approach for each location supported by a network of practitioners.

3.134 In this regard, the committee agrees with NSW Health and the Commonwealth Department of Health that integrating primary, secondary and tertiary health care and providing flexible and localised models tailored to the local community is required. The committee also finds that activity-based funding is not appropriate for all rural and remote based hospitals with many marginally viable at best under this funding model.

Finding 6

That activity-based funding is not appropriate for all rural and remote based hospitals with many marginally viable at best under this funding model.

3.135 Furthermore, NSW Health and the Commonwealth Department of Health have both identified merit in adopting a single employer model such as the Murrumbidgee Rural Generalist Training Pathway, under which the Local Health Districts employ GP trainees, rotate them across hospital training positions and GP practices for the duration of their training, and then potentially employ them as a specialist working in the NSW Health system.

3.136 The committee believes that there are significant benefits that would result from a wider roll-out of this kind of model that would make a real difference in addressing some of the doctor workforce issues identified in this inquiry. Providing trainees with certainty about location, income and working conditions; giving them early exposure to rural GP placements; ensuring a seamless transition between hospital and community-based GP training placements; and allowing them to build strong professional links within the region – all of these will help expand the doctor and clinician workforce, and the Rural Generalist workforce in particular.

3.137 A broader roll-out of this kind of innovative model will require significant and sustained collaboration with the Commonwealth, particularly to find alternatives to current arrangements involving an exemption under the *Health Insurance Act 1973* (Cth). Accordingly, the committee recommends that NSW Health work with the Australian Government and the Primary Health Networks to expedite the implementation of a single employer model for GP trainees across rural, regional and remote New South Wales.

Recommendation 9

That NSW Health work with the Australian Government and the Primary Health Networks to expedite the implementation of a single employer model for GP trainees across rural, regional and remote New South Wales.

3.138 In seeking to develop innovative, flexible and localised models tailored to local communities, the committee also sees real merit in the concept of Rural Area Community Controlled Health Organisations. This model would fundamentally restructure the way health services are provided in rural areas, in that each RACCHO would employ a multi-disciplinary team including GPs, nurses and midwives, and allied health professionals to enhance the provision of both primary and secondary health care. Benefits of such a model would include providing health care professionals with secure ongoing employment and professional support, and providing rural communities with ready access to 'one stop shop' healthcare services.

3.139 While the development and implementation of such a model across New South Wales would take several years, the committee believes that the scale of the challenges demands 'big thinking'. Having clear governance arrangements and an action plan with the Commonwealth in place, as recommended above, will be critical to moving forward with such a significant reform. As a first step, the committee recommends that the NSW Government work with the Australian Government to establish a RACCHO pilot, with a view to evaluating and refining it for roll-out in all areas of New South Wales where existing rural health services do not meet community needs.

Recommendation 10

That the NSW Government work with the Australian Government to establish a Rural Area Community Controlled Health Organisation pilot, with a view to evaluating and refining it for roll-out in all areas of New South Wales where existing rural health services do not meet community needs.

3.140 In addition, immediate attention must be given to creating a coordinated, targeted and sustainable recruitment and retention strategy that addresses the collective workforce shortages that have plagued the delivery of health services to rural, regional and remote locations for far too long. Therefore, the committee recommends that NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. In consultation with relevant stakeholders, it should set out a clear strategy for how NSW Health will work to strengthen and fund the sustainability and growth of rural, regional and remote health services in each town including quantifiable targets for tangible improvement in community-level health outcomes, medical and health workforce growth, community satisfaction, and provider coordination and sustainability. Furthermore, it must also address hospital and general practice workforce shortages including General Practitioner, nurses and midwives, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers, paramedics, allied health practitioners and Rural Generalists

Recommendation 11

That NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. This should be done in consultation with rural, regional and remote local government, schools, community services, human services, unions, professional organisations, general practice, pharmacists and community organisations. It should set out a clear strategy for how NSW Health will work to strengthen and fund the sustainability and growth of rural, regional and remote health services in each town including quantifiable targets for tangible improvement in community-level health outcomes, medical and health workforce growth, community satisfaction, and provider coordination and sustainability. It must also address hospital and general practice workforce shortages including General Practitioner, nurses and midwives, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers, paramedics, allied health practitioners and Rural Generalists.

3.141 The committee also heard extensive evidence regarding remuneration and incentives that have, to date, clearly failed to attract and retain satisfactory numbers of doctors and clinicians to rural and remote locations. We believe there is clear opportunity for the State and Commonwealth to work better together to break down funding limitations to not only deliver quality care across primary and secondary settings, but also to provide attractive contracts and packages that adequately remunerate, incentivise and support doctors in their full scope of practice. This includes remuneration and incentives in recognition of the broad and specialised services a rural doctor provides, as well as offerings that support to the doctor's family; accommodation; travel support to their home location; time off; professional development support and any other opportunities identified as necessary by those in the profession.

3.142 In this regard, the committee is of the view that work to roll out a single employer model and to progress RACCHO pilots provides an important opportunity to improve remuneration and incentives to attract doctors to rural and remote locations.

3.143 In addition, there was general agreement that the sustainability of the GP/VMO model is under serious challenge and that many doctors working under this model experience enormous pressure. The model also appears to create difficulties for NSW Health in trying to ensure doctor coverage in its hospitals. Of course, the GP shortage only adds to this problem. The committee welcomes evidence from NSW Health indicating a shift away from this model to one that trains and supports GPs to be specialists in rural hospitals. However, where GPs are continuing to provide services to public health facilities, the committee urges NSW Health to review their working conditions, contracts and incentives to ensure these models remain viable while broader innovation and reform progresses.

Finding 7

That the existing GP/VMO model is creating difficulties for NSW Health in ensuring doctor coverage in hospitals, and many doctors working under this model experience enormous pressure.

Recommendation 12

That NSW Health review the working conditions, contracts and incentives of GPs working as Visiting Medical Officers in public health facilities in rural, regional and remote New South Wales, to ensure that the GP/VMO model remains viable while broader innovation and reform progresses.

3.144 The committee notes the evidence received regarding the challenges surrounding the process of obtaining rights for GPs to work as VMOs, which currently is a separate and variable process for each Local Health District. The committee recommends that a state-wide system be established to accredit VMOs, which is independent of the Local Health Districts. As part of this system, NSW Health should ideally look to establish an online GP/VMO availability system where GP/VMOs can nominate dates and locations they are available to work that can be accessed by the rural and regional Local Health Districts and general practices in filling vacancies.

Recommendation 13

That NSW Health establish a state-wide system of GP/VMO accreditation, which is independent of the Local Health Districts. As part of this system, NSW Health should ideally look to establish an online GP/VMO availability system where GP/VMOs can nominate dates and locations they are available to work that can be accessed by the rural and regional Local Health Districts and general practices in filling vacancies.

3.145 The evidence received in this inquiry regarding the need to train medical practitioners in rural settings to increase the likelihood of them staying in those communities once their training is complete – the 'grow your own' concept – was compelling. The committee heard about some of the barriers to training within rural settings including limited places, fees and sufficient qualified staff to supervise trainees. The committee also notes the increase in rural medical schools and the offerings of rural medical study in those settings. NSW Health identified the need to undertake further work with the specialist medical colleges and with universities to look at how more training in rural settings can be provided with clearer and more accessible pathways into rural practice. The committee welcomes these developments and encourages these stakeholders to progress this immediately, as efforts will take some time to produce further doctors on the ground.

3.146 The committee therefore recommends that NSW Health work with the Australian Government, the Primary Health Networks, the university sector and the specialist medical Colleges to increase rural GP and specialist training positions, integrating these within the new employment and service delivery models recommended in Recommendations 9 and 10.

Recommendation 14

That NSW Health work with the Australian Government, the Primary Health Networks, the university sector and the specialist medical colleges to increase rural GP and specialist training positions, integrating these within the new employment and service delivery models recommended in Recommendations 9 and 10.

3.147 Further to the issue of rural training, the committee notes the views of those stakeholders who raised concerns about the different treatment afforded to metropolitan trainee doctors as compared to rural training doctors. Evidence to this inquiry has been clear: greater effort and encouragement needs to be made to facilitate getting medical graduates into rural practice. Disincentives that position rural trainees as inferior or less esteemed than their metropolitan counterparts are working against other efforts to encourage rural practice. This needs attention.

3.148 To this end, the committee recommends that NSW Health review the current employment arrangements and remuneration structure for trainee doctors with a view to aligning rural trainees' remuneration and incentives with those provided to metropolitan students travelling for rural training.

Recommendation 15

That NSW Health review the current employment arrangements and remuneration structure for trainee doctors with a view to aligning rural trainees' remuneration and incentives with those provided to metropolitan students travelling for rural training.

3.149 In concluding this chapter, the committee welcomes the analysis of The Sax Institute and NSW Health's consideration of the innovative strategies it has identified. We also acknowledge the developments outlined in the Commonwealth's Draft recommendations from the Primary Health Reform Steering Group. It is apparent from these papers that there is recognition from both levels of government of the significant challenges that impact on the doctor workforce. It is noteworthy that much of the evidence before this inquiry highlighted these issues and touched on opportunities to improve that are consistent with those outlined in these aforementioned papers. While the committee appreciates the challenges and realities of a federated system of government, it is apparent that the evidence base for reform, the expectations of the public and the collective will to act is palpable. This momentum should not be lost.

Chapter 4 The nursing and midwifery workforce

This chapter focuses on the nursing workforce, looking at nursing coverage, the nature of nursing in rural contexts, recruitment and retention as well as education and training. The chapter commences by detailing the make-up of the nursing workforce across New South Wales. To avoid having to repeat the term nursing and midwifery throughout the chapter, unless otherwise specified, the term nursing should be taken to include nursing and midwifery.

The nursing profession

4.1 The nursing workforce plays a critical role in both primary and secondary health care in rural and regional New South Wales. The nursing profession is made of a range of roles that vary according to qualification and specialisation; with nurses employed in general practices, hospitals, multi-purpose services and other allied health settings; and also covering a variety of specialisations.

4.2 The NSW Health website explains these roles and their requisite qualifications:

Table 4 Types of nurses and qualifications

Enrolled nurse	• Diploma of Nursing (Enrolled Nurse) • Provide physical and emotional care and includes giving medications • Employed in a variety of settings including hospitals, aged care services, General Practitioner (medical) clinics and in the private health sector.
Registered nurse	• Bachelor of Nursing • Registered with the Nursing and Midwifery Board of Australia • Employed across a diverse range of clinical settings and specialities.
Mental health nurse	• Advanced diploma of nursing specialising in mental health for enrolled nurses or registered nurses • Employed across a range of settings specialising in mental health.
Registered midwife	• Bachelor of Nursing with postgraduate studies in midwifery or Bachelor of midwifery • Provides care and support before, during and after birth • Employed across a range of settings.
Nurse Practitioner	• Master's degree, at least 3 years full time advanced practice experience and meets the NMBA National Practice Standards. • Employed across a range of settings and specialisations.

Source: NSW Health, Becoming a Nurse or Midwife, 2 September 2020, NSW Health website, https://www.health.nsw.gov.au/nursing/careers/pages/default.aspx

4.3 A recurring theme during the inquiry was the invaluable role of nurses and the significant responsibility and pressure they face in the performance of their duties, particularly in rural and remote settings. The majority of non-government stakeholders providing evidence regarding

nursing in rural contexts expressed the view that nurses are bearing the brunt of the doctor shortages in rural locations, as well as themselves being over-worked, underpaid and experiencing unsatisfactory working conditions, particularly with respect to hours of work as a result of resourcing, staffing shortages and demands on the health services.[340]

Nursing coverage in rural settings

4.4 Government representatives highlighted overall positive trends in terms of the numbers of nursing staff in rural areas. Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health told the inquiry that the nursing and midwifery workforce in rural and regional areas increased by 18 per cent, or 3,315 full time equivalent position, between June 2012 and June 2020.[341] The Commonwealth Department of Health said that the primary care nursing workforce has grown by 2.9 per cent compared to an annual population increase of 1.6 per cent.[342]

4.5 Further, the NSW Nurses and Midwives' Association acknowledged that 'the nursing workforce stands out as the best distributed health workforce in comparison to other professions'.[343]

4.6 However, despite these positive reports, many stakeholders expressed significant concern about insufficient nursing numbers and the impact that it has on the existing workforce, with a general consensus that additional nursing staff are required.[344]

4.7 In evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, which represents over 70,000 nurses and midwives in New South Wales, described the concerning state of the nursing workforce in rural areas and the impact it has on both nurses and patients. Mr Holmes referred to the situation as 'a crisis', particularly in smaller communities, and that smaller health facilities 'are reliant on bare minimum nursing staff levels and very often without the assistance of any doctors being present'.[345]

340 See for example: Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 19 March 2021, p 30; Submission 258, New South Wales Nurses and Midwives' Association, pp 8-10, Evidence, Dr Tony Sara, President, Australian Salaried Medical Officers Federation, 19 March 2021, p 42; Evidence, Mrs Kristyn Paton, Registered Nurse & Branch President, New South Wales Nurses and Midwives' Association, 19 March 2021, p 37; Evidence, Ms Jenny Tyack, Chair, Doctor Crisis Condobolin, 30 April 2021, p 29; Evidence, Ms Sheree Staggs, Registered Nurse, New South Wales Nurses and Midwives' Association, 18 May 2021, p 18.

341 Evidence, Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health, 19 March 2021, p 56.

342 Correspondence from Mr Martin Rocks, Assistant Secretary, Department of Health, to Chair, 24 November 2021, Attachment 1, Department of Health, Submission 38 to The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians inquiry, 15 October 2021, p 22.

343 Submission 258, NSW Nurses and Midwives' Association, p 8.

344 See for example Submission 445, Country Women's Association of NSW, p 6; Submission 446, Rural Doctors' Association, p 1; Submission 414, Name suppressed, pp 1-2.

345 Evidence, Mr Holmes, 19 March 2021, p 30.

4.8 In particular, Mr Holmes described the situation in the 90 Multipurpose Services across New South Wales, and the lack of adequate staff cover for emergencies:

> There are 90 MPSs across New South Wales and they all have the same problems with inadequate staffing. There is this idea that because statistically the incidents look small to the Ministry of Health it is unnecessary to staff for emergencies, and that you can rely on other emergency services, such as paramedics, being somehow available when the crisis occurs—assuming they are not elsewhere in the community. It is common that we have one registered nurse on duty, particularly after hours.[346]

4.9 In this context, the NSW Nurses and Midwives' Association called for minimum nurse to patients ratios, arguing that there is a limit to how many patients one nurse can care for safely and when the patient load exceeds that number, patients are more likely to have poor outcomes. The Association said that understanding the link between nurse to patient ratios and patient outcomes 'provides a compelling case for mandated minimum staffing in inpatient settings'.[347]

4.10 On this point, the Association described the impacts of understaffing on patient care:

> Understaffing has very serious consequences for the quality and safety of healthcare. Of all the members of the interdisciplinary healthcare team, the nurse is the only one who provides a continuous (24 hours/day, seven days/week) presence at the patient's bedside. Thus, the nurse is the member of the healthcare team most likely to pick up deterioration in a patient's condition and initiate interventions that minimise the impact of adverse events and prevent negative outcomes for the patient.[348]

4.11 Many nurses provided their own personal accounts to the inquiry about the impacts of insufficient coverage of shifts, for example:

- Mrs Kristyn Paton, a registered nurse working in the Multipurpose Service at Tumbarumba, described having to call on kitchen staff to help watch over patients during busy times and that such practice was not uncommon. She said nurses at her hospital are doing double shifts and that if someone calls in sick there is no-one to replace them. Mrs Paton said that they have had agency staff come to work at the hospital and when they find out they are the only registered nurse on shift, they 'turned around and walked straight back out again'.[349]
- Pen McLachlan from Condoblin also had an example of non-medical staff being used to assist patients because there were not enough nurses. She said that the hospital cook had to sit with a patient in their car who had had a stroke. She said that they were waiting for fire brigade or ambulance officers to assist because the nursing staff were too busy with nine patients in the hospital.[350]
- A nurse who provided her account through the NSW Nurses and Midwives' Association submission stated: 'Two nurses looking after a general ward and a four-bed emergency ward is in no way a satisfactory situation. Frequently both nurses are required in the ED,

346 Evidence, Mr Holmes, 19 March 2021, p 33; see also Evidence, Mr Eddie Wood, President, Manning Great Lakes Community Health Action Group, 16 June 2021, p 6.

347 Submission 258, NSW Nurses and Midwives' Association, pp 14-15.

348 Submission 258, NSW Nurses and Midwives' Association, p 13.

349 Evidence, Mrs Paton, 19 March 2021, pp 34, 36 & 37.

350 Evidence, Pen McLachlan, Private individual, 30 April 2021, p 12.

> this leaves the general ward unattended. If only one nurse is required in the ED, then both nurses are working in isolation. This is unfair on the staff, it is unfair on the patients, but more than that, it is unsafe'.[351]

- Another nurse who provided her account through the NSW Nurses and Midwives' Association submission stated: 'I work in charge of an emergency department out of hours which is generally fine however on night shifts when there is only one registered nurse, the acuity of the department quickly exceeds the capacity of one nurse and it doesn't matter how senior or experienced you are it is not safe. Recently in the ED by myself at night I have had a cardiac arrest, a STEMI , and an intubation/retrieval. I am looking at employment options outside NSW Health because I worry about being caught in a situation that causes serious harm to a patient'.[352]
- A third nurse who provided her account through the NSW Nurses and Midwives' Association submission stated: 'I get home exhausted. It's extremely hard to give patients what they deserve in the way of personal care, and frequently medication is either missed or late. Management are just not listening to staff. Nurses are being blamed and performance managed when patients miss medications and there is no acknowledgement of the role of the excessive workload as a factor in such incidents. Staff are totally exhausted, sick leave is very high due to burn out, and high overtime rates as shifts are not filled. Our patients deserve more as do our nursing staff'.[353]

4.12 In responding to concerns about staffing levels, Mr Scott McLachlan, then Chief Executive, Western NSW Local Health District, NSW Health stated that 'the staff on shift have the ability to call in additional staff if there are things going on' and added that they 'do regular stocktakes' of staffing numbers.[354]

4.13 Nurses, however, provided a different view on the ability to call in additional staff or obtain increases in staffing numbers. Ms Sheree Staggs, Registered Nurse, NSW Nurses and Midwives' Association, who herself has stopped taking extra shifts at the Gilgandra Multipurpose Service because of insufficient staffing numbers and inadequate backup, described the reality of filling vacant shifts in the hospital as well as with requesting additional staff:

> We recently required staff from other health services to come and work our unfilled shifts. It is a big ask to come and work in a facility that is unfamiliar to them. The nurse manager is also often required to attend to clinical care to cover the shortfall in the roster. If you cannot fill empty shifts or sick leave and staff that are already on overtime, who can we escalate to? As a branch, we have requested, through our reasonable workload committee, an increase in nursing hours and to change the escalation plans. Our requests were rejected, as on paper the numbers do not allow for increased staff from what it is today.[355]

351 Submission 258, New South Wales Nurses and Midwives' Association, pp 12-13.

352 Submission 258, NSW Nursing and Midwives' Association, p 14.

353 Submission 258, NSW Nurses and Midwives' Association, p 14.

354 Evidence, Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, 30 April 2021, p 43.

355 Evidence, Ms Staggs, 18 May 2021, p 13.

Impact of COVID-19

4.14 In addition to the issues outlined above, there was a general consensus that the COVID-19 pandemic has significantly impacted staff across all aspects of the health system and exacerbated already pressured and understaffed services.[356] The National Rural Health Alliance identified the insufficient surge capacity as having significant repercussions on the workforce in rural, regional and remote areas, stating that 'it is as though the workforce in these areas is already at surge capacity'.[357]

4.15 Professor David Perkins, Director and Professor of Rural Health Research at the Centre for Rural and Remote Mental Health captured the impact of COVID on frontline staff including nurses:

> Over the COVID experience, we know that frontline responses … have been suffering increased anxiety, increased depression, higher burnout scores and that many have announced an intention to leave and to find other employment. The pandemic has taken a significant toll on the people we wish to provide these services.[358]

4.16 These concerns were acknowledged by NSW Health. Mr Phil Minns said that Delta and then Omicron had created 'significant and challenging developments in all of our workplace settings'. Mr Minns added that the speed at which Omicron hit lead to 6,300 being staff unavailable due to being furloughed, and that most of their reserve strategies were exhausted with no additional capacity.[359]

Nature of nursing work in rural settings

4.17 Stakeholders explained that nurses in rural settings encounter challenges that their metropolitan counterparts do not. These challenges include having to undertake a greater scope of practice; not always having the support of a doctor on site; dealing with the impacts of telehealth; and having to rely on non-nursing staff or other services to provide back-up support during emergencies.

4.18 The NSW Nursing and Midwives' Association's submission outlined that rural nurses have to take on additional roles that would be staffed in metropolitan areas:

> Their scope of practice is often extremely broad because they are frequently the only professional available to respond to a wide range of needs. They also experience pressure to work outside their scope of practice which can have disciplinary implications. Nurses and midwives frequently take on nonnursing/midwifery roles that

356 Submission 414, Name suppressed, p 1; Evidence, Ms Betty Kennedy Williams, Enrolled Nurse, New South Wales Nurses and Midwives' Association, 2 December 2021, p 26; Evidence, Ms Christine Corby OAM, Chief Executive Officer, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service, 2 December 2021, p 47; Evidence, Mr Richard Colbran, Chief Executive Officer, NSW Rural Doctors Network, 19 March 2021, p 20.

357 Submission 478, National Rural Health Alliance, p 9.

358 Evidence, Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health, 3 December 2021, p 37.

359 Evidence Mr Phil Minns, Deputy Secretary, People Culture and Governance, NSW Health, 2 February 2022, p 8.

> would otherwise be staffed in metropolitan settings, such as pharmacy, pathology, x-ray, mortuary and domestic services.[360]

4.19 Consistent with this evidence, Pen McLachlan commented to the committee, 'we are management, admin, security, cleaners, transport bookers. You name it, we do it'. This was echoed by Ms Staggs, who explained that rural nurses do a range of tasks that are not direct clinical care:

> … the rural nurse does many tasks that are not direct clinical care … In larger facilities there are staff employed to do these tasks, such as wardsmen, social workers, pathology and the ordering and unpacking of nursing and pharmacy supplies. … We do all of this on top of our nursing care that is required by our patients and residents.[361]

4.20 The impact of not having a doctor on site was also raised in this context, with stakeholders commenting that this can result in rural nurses working more like junior medical officers or having to stand in the shoes of doctors.[362] For example:

- Mrs Paton said that in her facility, they had no doctors on call for four months and that 'it was just up to the nurses at the hospital'.[363]
- Ms Jenny Tyack, Chair, Condobolin Doctor Crisis Working Party spoke about the increased pressure on nurses with no doctor on site: 'The nursing staff on shift are required to provide diagnostic examination beyond their scope of practice which is leading to decreasing confidence in addressing complex presentations, especially as there is no doctor on site. We have had three experienced nurses leave the Condobolin hospital since January 2021 due to a lack of medical support'.[364]
- A member of the Nurses and Midwives' Association described the stress caused by having no doctor on site: 'As nurses, my colleagues and I are stressed, anxious and at times fearful going to work. Not having a doctor on site means we feel solely responsible for the journey and outcome of every patient that comes through the door'.[365]

4.21 Stakeholders said that these pressures are felt most keenly in emergency, where 'nurses are under stress from having to deal with emergencies on their own'.[366] Submission author Mrs Sally Milson-Hawke described the pressure nurses feel where sufficient medical coverage is lacking:

> Role ambiguity for nursing staff whose role changes day-to-day, based on the medical coverage availability, also adds to a feeling of vulnerability and a concern regarding extended scope of practice roles. Staff feel the responsibility is significant and the support is not always available in a timely manner. Many mid-career nurses leave the

360 Submission 258, NSW Nurses and Midwives' Association, p 19.
361 Evidence, Ms Staggs, 18 May 2021, pp 13-14.
362 See for example Evidence, Pen McLachlan, 30 April 2021, p 15 and Evidence, Mr Holmes, 19 March 2021, pp 13 and 30.
363 Evidence, Mrs Paton, Nurses and Midwives' Association, 19 March 2021, p 32.
364 Evidence, Ms Tyack, 30 April 2021, p 29.
365 Submission 258, NSW Nurses and Midwives' Association, p 25.
366 See for example: Submission 438, Name suppressed, p 1; Submission 557, Name suppressed, p 1.

> rural sector as they do not want to take on the independent responsibility of caring for emergency services patients.[367]

4.22 Stakeholders said that telehealth causes additional pressure for nurses. For example, Mr Holmes expressed concern about the use of telehealth in potentially life threatening situations where there is no doctor and only a nurse available, explaining that the nurse in this scenario must perform their clinical role and as well as act as 'the eyes, ears and hands of the doctor'. Mr Holmes described this scenario as unsafe and stated that it 'creates an unreasonable level of pressure for the nursing staff'.[368]

4.23 Stakeholders also told the inquiry about the need to call upon either non-nursing staff or staff from other services to provide support during busy times. For example, Mrs Paton said that, in addition to calling on kitchen staff to watch over patients, they have also had to seek back up from the Ambulance service and the aged care nursing staff from the Multipurpose Service during emergencies, which means that aged care residents 'have to lie there, stay there like that while we have got an emergency'.

4.24 These concerns were echoed by Ms Liz Hayes, who told the inquiry that she had sighted an email in which staff at the Manning Base Hospital were told to call on a range of different people to sit with patients:

> … I have cited an email from management at Manning hospital saying staff should make use not just of cleaners but wardsmen, administration staff, families, and even other patients to be sitters.[369]

4.25 Some stakeholders advised that nurses did not feel safe speaking up about their working conditions because they were fearful of what might happen in response.[370] This was expressed by the NSW Nurses and Midwives' Association, which provided de-identified accounts of members' experiences on the basis that many were concerned about repercussions from their management as a result of speaking up. One nurse described their fear:

> Nurses cannot speak up about the issues due to the potential for reprisals. This is the only employer in the town for nurses. The fear is that if they are targeted there is nowhere else to go for work.[371]

4.26 Similarly, Ms Hayes told the inquiry that she had 'literally hundreds' of people contacting her with their stories. She said that 'people are angry, frightened, frustrated and feeling very alone, and if they are health professionals they believe speaking out will cost them their jobs'. As a result of these accounts, Ms Hayes told the committee she believes there is a toxic environment where people do not trust the system to speak up about the problems:

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367 Submission 406, Mrs Sally Milson-Hawke, p 2.

368 Evidence, Mr Holmes, 19 March 2021, p 30.

369 Evidence, Ms Liz Hayes, Private individual, 10 September 2021, p 3.

370 See for example: Submission 258, Nurses and Midwives' Association, p 10; Submission 138, Name suppressed, p 3.

371 Submission 258, NSW Nurses and Midwives' Association, p 10.

> Clearly I am seeing that there is a toxic environment where people cannot speak their truth in an orderly fashion, obviously because they do not trust the system. So they have lost trust in their ability to speak up; they do not believe that anyone is listening and they believe there will be reprisals for speaking up.[372]

4.27 The Association expressed the view that nurses should feel empowered to raise concerns about issues impacting on patient safety, stating that 'it is a fundamental principle of safety and quality in healthcare'.[373]

4.28 Another issue raised by stakeholders around the working conditions faced by nurses in rural settings was safety, specifically the inadequacy of after-hours security measures.

4.29 Ms Samantha Gregory-Jones, a registered nurse from the Central West and member of the NSW Nurses and Midwives' Association, raised concerns about safety at her hospital, particularly after hours:

> We do not have a security guard. After hours, there may be myself as the registered nurse and one enrolled nurse … Our emergency department is accessed by a swipe card but everything else is not. We have doors inside the building which—you can just walk out the door from inside. They are not locked from the inside. Nobody can get in but anybody can get out. So often whilst we are running the ward, we can have a dementia patient who walks out the door. A couple of weeks ago we had someone who walked out the back door at three o'clock in the morning while two other nurses were attending patient care.[374]

4.30 In addition to patient safety, Ms Gregory-Jones raised concerns about the possible threat to nurse safety. She explained that the nurse station is not lockable and she recently had an experience with an aggressive patient who forced the nurses into the nurses station but the nurses could not lock the doors to protect themselves. Ms Gregory-Jones said they called the Ambulance for assistance, but it was deemed not urgent so they had to wait, meanwhile the patient had a blood pressure machine attached to them and was using it to try to break the glass. Ms Gregory-Jones also said that they have asked for swipe access to be installed but the building is too old to support it.[375]

4.31 The committee also heard concerns expressed by nurses around having to manage scheduled mental health patients unassisted,[376] and having to go outside a locked facility after hours to conduct COVID temperature checks.[377]

4.32 These concerns were echoed by Mr Holmes, who believes that without improvements to security, there will be further tragedies:

372 Evidence, Ms Hayes, 10 September 2021, p 4.
373 Submission 258, NSW Nurses and Midwives' Association, p 10.
374 Evidence, Ms Samantha Gregory-Jones, Registered Nurse, NSW Nurses and Midwives' Association, 18 May 2021, p 15.
375 Evidence, Ms Gregory-Jones, 18 May 2021, p 16.
376 Submission 258, NSW Nurses and Midwives' Association, p 18.
377 Evidence, Mrs Paton, 19 March 2021, p 33.

> Currently, the safety and security of our members, quite frankly, is at extraordinarily high levels of risk in these rural and remote settings. If this is not addressed, it is inevitable that there will be further tragedies in this area, and we will have all spoken about it and been warned. The question is: Will action have been taken? But if nothing is done, these facilities that operate in isolated areas, and do not have police or security available for hundreds of kilometres, then you must wonder how long it is before one of those tragedies occurs.[378]

Nurse Practitioners

4.33 The role of specialist nurses and the need to get the mix of skill sets right in rural areas was another key theme. In particular, stakeholders discussed the valuable role Nurse Practitioners play in rural locations. Support for these roles was generally linked to the broad scope of practice that these nurses are able to deliver to support doctors and to contribute to improved health outcomes in rural settings.

4.34 Stakeholders described Nurse Practitioners as nurses with advanced skills in particular areas, with Ms Barbara Turner, Health Services Manager/Nurse Practitioner, Australian College of Nurse Practitioners detailing the purpose of the role:

> The role of the nurse practitioner—to provide some background—is to improve access to treatment, provide cost-effective care, target at-risk populations, provide outreach services in rural and remote communities, and provide mentorship and clinical expertise to other health professionals. In some circumstances nurse practitioners provide patient rebates through Medicare through the Commonwealth, they can refer patients to hospitals and specialists, can order X-rays and diagnostic tests and are registered with the Nursing and Midwifery Board of Australia.[379]

4.35 Nurse Practitioners were also described as alleviating pressure on doctors and providing health care access where GP services are lacking.[380] Dr Marilyn Magee, Chair, Deniliquin Health Action Group explained that Nurse Practitioners are a specialty and that they 'function between a nurse and a doctor'. While she expressed that 'they are a fairly rare thing', she described the value of a Nurse Practitioner particularly in emergency to support GPs who also are trying to service their practices:

> The nurse practitioner in the emergency department was provided as a solution for us doctors so that we were not continually being pulled away from our practices to see patients in the emergency department during the day.[381]

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378 Evidence, Mr Holmes, 19 March 2021, p 30.

379 Evidence, Ms Barbara Turner, Health Services Manager/Nurse Practitioner, Australian College of Nurse Practitioners, 19 March 2021, p 31.

380 See for example, Evidence, Ms Kate Ryan, Private individual, 16 June 2021, p 29; Evidence, Dr Lenert Bruce, Senior Visiting Medical Officer in Anaesthesia and Executive Director, Medical Services, Murrumbidgee Local Health District and Professor of Medicine, Charles Sturt University, 29 April 2021, p 47; Submission 259, Australian College of Nurse Practitioners, p 1; Evidence Dr Marion Magee, Chair, Deniliquin Health Action Group, 29 April 2021, p 13; Evidence, Ms Kate McGrath, Former Chair and Founding Member, Gunnedah Community Roundtable, 16 June 2021, p 8; Evidence, Ms Elizabeth Worboys, Private individual, 16 June 2021, p 25.

381 Evidence, Dr Magee, 29 April 2021, p 13.

4.36 This was echoed by Ms Kate Ryan, a registered nurse based in Condobolin with seventeen years' experience, currently studying to become a Nurse Practitioner in her speciality area of diabetes. She explained the support that she will be able to provide doctors in the management of diabetes:

> I would be able to assess and diagnose and prescribe medications and refer patients who have diabetes for their whole occasion of care that they have, if you like. That helps alleviate pressure from GPs who either are not current or up to date with where the diabetes medications are.[382]

4.37 Dr Michael Clements, Chair – Rural, The Royal Australian College of General Practitioners, described the value of having a Nurse Practitioner in a town in North Queensland where the population does not justify a full time GP:

> We support a model of care where there is a nurse practitioner in a township called Karumba, which has 500 people. That is not enough to support a GP so we have a collaborative arrangement with a nurse practitioner. They live there and they are there five days a week. They provide scripts and chronic disease management. We support them, train them and then we fly into that town once every fortnight and back them up. In between those times we are able to do telehealth support to the nurse practitioner and the community. This is a massive enabler for small communities where they do not have enough workforce to support a full-time equivalent GP.[383]

4.38 The Australian College of Nurse Practitioners highlighted the additional benefits of the Nurse Practitioner model. These included:

- they care for patients with chronic diseases, managing their symptoms, aiming to avoid complications of disease, thus keeping people in their home towns longer and avoiding travel to higher care provision hospitals
- the availability of local health care support via Nurse Practitioners promotes early discharge from hospital and the prevention of complications
- Nurse Practitioners can improve access to health care by forming strong relationships within the community and local and wider health care professions
- Nurse Practitioners have been shown to improve access to care, and provide for equity of care, for emergency department patients where people would otherwise experience long waiting times, excessive times for management of conditions, and delays in diagnosis, treatment and discharge
- Nurse Practitioners working in residential aged care facilities reduce ambulance transfers to hospital and reduce admissions to acute services
- economically, Nurse Practitioners are very cost effective.[384]

382 Evidence, Ms Ryan, 16 June 2021, p 29.

383 Evidence, Dr Michael Clements, Chair – Rural, The Royal Australian College of General Practitioners, 19 March 2021, p 15.

384 Submission 259, Australian College of Nurse Practitioners, pp 2 and 4.

4.39 While there was general consensus about the valuable role that Nurse Practitioners play, stakeholders expressed the view that this model of nursing has not been properly implemented, with a number of stakeholders calling for more Nurse Practitioner positions in rural areas.

4.40 Ms Ryan told the committee that across Australia, less than 1 percent of the nursing workforce operate as Nurse Practitioners, with approximately 66 percent of those being situated in metropolitan areas.[385] She said that this was not the intention of the Nurse Practitioner model and believes that this needs addressing:

> It is my strong recommendation to this hearing that more nurse practitioners be introduced into rural and regional New South Wales and that there is a geographical equity in the distribution of nurse practitioners across LHDs when allocating positions.[386]

4.41 Similarly, the New South Wales Nurses and Midwives' Association called for the Nurse Practitioner model of care in rural and regional areas to be more widely implemented. It said that this will require funding to be directed towards the recruitment and development of additional Nurse Practitioners to work in rural and regional areas, particularly in sites without 24/7 medical officers reliant on virtual medical officer coverage.[387]

4.42 In addition to the need for more Nurse Practitioners in rural locations, the Australian College of Nurse Practitioners outlined the need to overcome some of the well documented barriers to these roles, including:

- there is no current plan in New South Wales to create innovative new Nurse Practitioner roles to optimise workforce capacity and meet current and future health care needs
- patients do not have equivalent subsidies for healthcare if they chose a Nurse Practitioner as their provider, creating financial disadvantage through increased out-of-pocket expenditure for professional attendances, diagnostic and therapeutic interventions, and diagnostic imaging
- New South Wales has not signed up for Pharmaceutical Benefits Scheme reform, meaning that publicly employed Nurse Practitioners cannot provide PBS prescriptions and Closing the Gap prescriptions
- Nurse Practitioners can independently assess, diagnose, and treat illness and injury but cannot certify Centrelink, Worksafe, and Comcare certificates/documents, and Driver's License Medicals, and cannot certify death.[388]

Recruitment and retention

4.43 Similar to the issues raised in respect of doctors in the previous chapter, stakeholders identified remuneration, on call arrangements and professional development and incentives as issues impacting on recruitment and retention of the nursing workforce.

385 Submission 239, Ms Kate Ryan, p 1.
386 Evidence, Ms Ryan, 16 June 2021, p 23.
387 Submission 258, New South Wales Nurses and Midwives' Association, p 2.
388 Submission 259, Australian College of Nurse Practitioners, p 3.

4.44 In relation to remuneration, the committee heard from the New South Wales Nurses and Midwives' Association that while the nurses award provides for an 'on call payment', Local Health Districts often get around this by saying there isn't an on call roster.[389] Mr Holmes explained that instead rural hospitals rely on the good will of nurses to help out their colleagues:

> But what local health districts have done for some time with these small communities is operated on the basis that they will use the guilt and camaraderie of nurses to look after their colleagues. So, they do not pay or set up an on call arrangement. They just rely on—for instance, if Kristyn is on duty and needs urgent assistance, she has to get on the phone and beg one of her colleagues to come in, because none of them are on an official on call because they would have to be paid to be on call. We have this problem right across rural New South Wales where there is this abuse of the goodwill of nurses, expecting that they will respond to any desperate call. It is a pretty hard thing not to; it is their community.[390]

4.45 In addition, Mr Holmes advised that nurses who are interested in rural practice 'have a financial choice', explaining that wages and incentives in New South Wales are below those of Queensland, South Australia and the ACT, with Victoria 'catching up'. He explained the difference:

> There are special benefits to working remote areas in Queensland that add up to about $25,000 difference in terms of the entitlements, plus they also get subsidised accommodation, professional development allowances, two weeks' professional development leave with paid travel, appointment and relocation costs are paid, fly-in and fly-out with their spouse and dependents, and recreation leave twice per annum.[391]

4.46 Dr Magee from the Deniliquin Health Action Group outlined the efforts undertaken by the group to recruit health professionals to their town, which she said has led to a fully staffed midwifery unit and additional Nurse Practitioners. She advised that their recruitment and retention strategy had two streams: 'grow your own', focused on educating and upskilling people who were already there and committed to the community; and providing packages that include accommodation, tenure, remuneration, opportunities for career development and mentorship.[392]

Education and training

4.47 Stakeholders identified the important role that education and training plays in the recruitment and retention of nurses to rural locations. As identified by Dr Magee above, the idea of 'growing your own' nurses and providing pathways to upskill nurses already in rural locations were two key themes.

4.48 A number of nurses told the inquiry that there is very little opportunity for professional development when working in rural settings, a perspective shared by the NSW Nurses and

389 Evidence, Mr Holmes, 19 March 2021, p 34.
390 Evidence, Mr Holmes, 19 March 2021, p 35.
391 Evidence, Mr Holmes, 19 March 2021, p 36.
392 Evidence, Dr Magee, 29 April 2021, p 11; see also, Evidence, Ms Ryan, 16 June 2021, p 30; Evidence, Ms Worboys, 16 June 2021, p 30; Submission 406, Mrs Sally Milson-Hawke, p 4.

Midwives' Association.[393] For example, Mrs Paton shared her concerns about inadequate training for nurses which, she explained, stems from having insufficient staffing levels: 'There is actually not enough staff to replace those who want to go away and do training and professional development'. Mrs Paton also noted the impact this has on staff retention, telling the committee that they have had a lot of new recruits over the years who have left because they are denied professional development opportunities and they want to expand their skills so they move on.[394]

4.49 Ms Ryan from Condobolin told the inquiry that she undertook post graduate studies herself without knowing whether there would be employment at the end of it, and emphasised the importance of pathways for nurses to develop skills:

> I have done this master's degree at my own expense and with the help of some scholarships, but I have done this on my own without knowing that I have a certain job at the end of it with NSW Health. Most people would only apply for the course, the master's course, knowing that they have a transitional nurse practitioner position, so they will have a job to go into. I think that having a pathway for nurses in the country to upskill is really important.[395]

4.50 Another stakeholder discussed the need for rural nurses to have training in the broad clinical knowledge required in rural settings. Mrs Milson-Hawke said that staff should be provided with options and alternative models to gain the skills required to work in rural facilities and to this end made the following suggestion:

> A rural education review should be undertaken identifying the procedures relevant to a rural generalist workforce. These would form the bases for a credentialing pathway as an alternative to FLECC. The rural generalist nurse is a sub-speciality in its own right and staff should develop skills that develop equally all aspects of the role. Post graduate offerings that develop these skills should be supported for example; Graduate Certificate in Rural Critical Care or Graduate Certificate in Nursing (Rural and Remote Stream).[396]

NSW Health perspective

4.51 NSW Health acknowledged a number of the challenges associated with the nursing workforce, stating that 'while there is generally a steady pipeline of nurses and midwives in New South Wales, there are some locations and specialities where workforce challenges exist'.[397] Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health told the committee that NSW Health is taking a complete look at workforce status, supply and demand issues and indicated that this would involve a 're-think' and 'starting over again'.[398]

393 Submission 258, New South Wales Nurses and Midwives' Association, p 23.

394 Evidence, Mrs Paton, 19 March 2021, p 36; see also Submission 258, New South Wales Nurses and Midwives' Association, p 23.

395 Evidence, Ms Ryan, 16 June 2021, p 29.

396 Submission 406, Ms Sally Milson-Hawke, p 3.

397 Submission 630a, NSW Government, p 11.

398 Evidence, Dr Lyons, 2 February 2022, p 9.

4.52 Dr Lyons also discussed a potential new model for the recruitment and training of nurses that he suggested will increase the nursing workforce:

> … training of nurses so often takes place in the NSW Health system and then they go out into the general practice for training. Having a single role that people come here for their employment means that people can have certainty about their employment arrangements to finish their training, I think, even though they work with the Commonwealth and they are trained it will ensure that there is more people.[399]

4.53 NSW Health acknowledged the broad range of skills nursing staff require in rural settings and said that it is developing a 'state wide pathway to support current and future rural nursing workforce'. It explained:

> This pathway will further support rural nursing skill development and enable nurses to work to their full scope of practice. Implementation will commence across rural LHDs in mid-2022.[400]

4.54 NSW Health also pointed to the reports it commissioned from the Sax Institute, which include a range of strategies to address nursing workforce issues. It also said that it is working with the Commonwealth to develop models to ensure nurses are attracted to work and stay in rural and regional areas.[401]

4.55 The Commonwealth Department of Health also recognised the need to support the role of nursing and midwifery in 'an integrated Australian primary health care system', and identified a range of actions to achieve this:

> This includes investigating and staged implementation of innovative funding and care models, workforce planning and distribution, collecting data and enabling development of local solutions to support access.[402]

4.56 In addition, NSW Health officials provided comments in respect of specific issues raised by stakeholders, as set out below.

Security

4.57 In response to concerns raised about the safety of nursing staff in rural settings, Mr Phil Minns, advised that the department had engaged the Hon. Peter Anderson AM to conduct an inquiry into the security issues, which 'was extended to particularly focus on rural and regional locations'. Mr Minns said that 107 recommendations were made in the report, including in relation to perimeter controls, access controls between clinical and public areas and havens for staff to retreat to as the best opportunity to minimise risk to staff. According to Mr Minns, the

399 Evidence, Dr Lyons, 2 February 2022, p 10.

400 Submission 630a, NSW Government, p 11.

401 Submission 630, NSW Government, p 24.

402 Department of Health, Health Reform Steering Group, Draft recommendations from the Primary Health Reform Steering Group, https://www.health.gov.au/sites/default/files/documents/2021/08/draft-recommendations-from-theprimary-health-reform-steering-group.pdf. Referenced in Submission 630a, NSW Government, p 6.

reviewer did not feel that 'security staff was the solution if the rest of the recommendations in his report were enacted'.[403]

4.58 Mr Minns advised that NSW Health has allocated funding to upgrade the physical environment in rural and regional facilities, and has been applying the abovementioned framework to 'design out risk'. Mr Minns said that given the nature of some of the locations of rural facilities, they would be unlikely to be able to recruit a security guard and are focusing on some of the other measures.[404]

Nurse Practitioners

4.59 NSW Health officials recognised the value of Nurse Practitioners and acknowledged that they should aim to have more Nurse Practitioners in rural locations. When asked about Nurse Practitioners, Mr Minns provided the following response:

> I think we will concede in the ministry that the ability to have more clinical nurse practitioners in rural and regional locations is something we should aim to do. We do have them there, but they have tended to be picked up more consistently in metro areas.[405]

4.60 This was echoed by Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District and Dr Lenert Bruce, Senior Visiting Medical Officer in Anaesthesia and Executive Director, Medical Services, Murrumbidgee Local Health District, who discussed their efforts to increase Nurse Practitioner presence. Mr DiRienzo pointed to Nurse Practitioners as one way to improve health services where doctors are lacking and said that 'Hunter New England has the largest number of nurse practitioners across any other local health district', clarifying however that less than half of these are in rural areas of the district. Mr DiRienzo said that they are 'running a major program' to gain more Nurse Practitioners and that there is funding within the district for nurses who want to undertake the training to become Nurse Practitioners, noting that it is a challenging program to complete.[406]

Recruitment and retention

4.61 NSW Health officials acknowledged challenges with recruiting and retaining nurses and provided information about efforts to address this. Mr Minns told the committee that NSW Health is exploring innovative strategies with the rural and regional Local Health Districts that are designed to try and fast-track the training of new graduate nurses. He said:

> In western New South Wales they are looking at programs to try and bring new graduates in, take them to the major centres, and expose them to a structured training program and supervised work practice such that they can then have them going back out with confidence into the smaller facilities.[407]

403 Evidence, Mr Minns, 19 March 2021, pp 62-63.

404 Evidence, Mr Minns, 19 March 2021, p 64.

405 Evidence, Mr Minns, 19 March 2021, p 62.

406 Evidence, Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, 16 June 2021, pp 37 and 41; see also Evidence, Dr Bruce, 29 April 2021, p 47.

407 Evidence, Mr Minns, 2 February 2022, p 14.

4.62 A number of representatives from the Local Health Districts discussed nurse staffing numbers in their areas as well as efforts to address shortages:

- Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District said that his district has undertaken their largest nurse graduate recruitment and has brought them on earlier than they usually would. Mr Dowrick said that they have also been working closely with the universities in the region to offer nursing opportunities.[408]
- Mr Scott McLachlan, in his capacity as Chief Executive, Central Coast Local Health District advised that his district currently has 2,700 full-time equivalent nurses with a vacancy of 200 that they are currently recruiting to. Mr McLachlan said that in response to workload issues they have brought on a significant number of new graduate nurses and recruited additional nursing staff to provide casual and as needs support. He said that they look at vacancies on a daily basis and that is the top priority each morning; to fill those vacancies drawing from the casual nursing pool.[409]
- Ms Margaret Bennett, Chief Executive, Southern NSW Local Health District outlined the challenges they face in filling nursing shifts, stating: 'the absence of sufficient nurses and midwives across our district presents a challenge every day'. She said that their average use of agency nurses is 34.8 each fortnight. Ms Bennett said that although they have taken on 80 new nurse graduates they are trying to recruit to about 100 nursing position in the district and that this is a major focus.[410]

4.63 NSW Health recognised the challenging working conditions for nurses, which has been exacerbated during the COVID-19 pandemic, and said that it has done a range of things to support nurses. These include the development of resources and training to support psychological safety and undertaking a workforce recovery project to help staff recover from the conditions experienced during COVID-19.[411]

Education and training

4.64 In relation to education and training initiatives to support the nursing workforce, Dr Lyons expressed support for the 'grow your own' concept identified by other stakeholders, and noted that there are pathways whereby nurses can come in under an arrangement commencing as an assistant nurse and receive support and training to become an enrolled nurse and then a registered nurse. He said that there are 'examples of this right across the system'. He explained that this provides an employment pathway for people who already live in, and are committed to remaining in, the community.[412]

408 Evidence, Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District, 1 February 2022, pp 6-7.

409 Evidence, Mr Scott McLachlan, Chief Executive, Central Coast Local Health District, 1 February 2022, pp 17-18.

410 Evidence, Ms Margaret Bennett, Chief Executive, Southern NSW Local Health District, 1 February 2022, pp 31-32.

411 Evidence, Dr Lyons, 2 February 2022, pp 8-9 and Evidence, Mr Minns, 2 February 2022, pp 8-9.

412 Evidence, Dr Lyons, 19 March 2021, p 60.

4.65 However, Dr Lyons flagged the need to provide specific rural training for enrolled nurses and that this requires Commonwealth action:

> We must more vehemently advocate for Australian Government investment in the vocational education and training sector to provide specific rural training opportunities for enrolled nurses and allied health assistants.[413]

4.66 Mr Lyons also identified the need to improve opportunities for nurses to gain skills and experience from within rural settings, avoiding them having to go to cities to gain that training. He identified the need to do more work with the College of Nursing to achieve this.[414]

4.67 Mr Minns and Dr Lyons also responded to concerns that rural nurses find it difficult to access professional development because of staffing shortages. Mr Minns indicated that NSW Health is aware of this challenge and that there are clinical nurses who travel to rural sites to provide 'outreach training'. Dr Lyons added:

> In these smaller facilities we know that taking the staff away will be difficult for somebody to backfill. There is also a benefit in training the team in the environment in which they are going to work, so there is a real focus on providing clinical nurse educators. They are allocated to those sites to provide ongoing support and education for the teams, but also providing outreach where there is a simulation bus that goes out to the sites with sophisticated technology available to provide support and can actually go to the rural sites. We also have the specialist teams that go out to a range of the districts and provide training in emergency management of patients in the facility where the staff are delivering the care. So those all exist in recognition of the fact that we need to make sure that we have appropriate education support into those facilities.[415]

4.68 Ms Katharine Duffy, Director of Nursing and Midwifery and Aboriginal Health, Northern NSW Local Health District supported this approach, advising that her district has 71 full-time equivalent clinical nurse and nurse educators working across all sites to support staff with clinically based education and skill development. Ms Duffy added that there are also processes where staff can apply for support for study leave to undertake post graduate studies, and scholarships which include being released for study time.[416]

4.69 NSW Health provided further information about its investment in education and training for rural nursing including:

- since 2011 it has awarded over 100 scholarships to the cost of $8 million under the Rural Postgraduate Midwifery Student Scholarship program
- in 2019-2020 it expended $3 million on 700 postgraduate scholarships to support nurses and midwives with more than a quarter of these scholarships being located in rural and regional areas.[417]

413 Evidence, Dr Lyons, 2 February 2022, p 3.

414 Evidence, Dr Lyons, 2 February 2022, p 9.

415 Evidence, Dr Lyons, 19 March 2021, p 63.

416 Evidence, Ms Katharine Duffy, Director of Nursing and Midwifery and Aboriginal Health, Northern NSW Local Health District, 17 June 2021, p 34.

417 Evidence, Mr Minns, 19 March 2021, p 56.

Committee comment

4.70 The committee is grateful to all of the nurses who took the time to contribute to this inquiry. Their personal accounts, in some cases having worked in the profession for decades, provided valuable insights into the reality of rural and remote nursing across New South Wales. The committee notes that although the inquiry has provided particular attention to current challenges and difficulties, there were many examples and accounts from nurses who are passionate about rural nursing and enjoy the unique and rewarding experiences that the work provides. We also acknowledge that the staff shortages, working conditions and the pressure experienced by nurses were magnified during the pandemic.

4.71 Evidence regarding nursing workforce issues highlighted somewhat of a disconnect between the reality of the challenges faced by nurses working in rural and remote parts of the state, and NSW Health's perspective on the situation. Nurses and their representative union, on the one hand, expressed broad consensus that there is a critical nursing shortage in such locations and that these shortages are creating unsatisfactory working conditions, concerning health outcomes and staff retention problems. Adding to this was the concerning evidence of a culture in which feedback and complaints are not encouraged or valued.

4.72 On the other hand, NSW Health expressed that staffing numbers in rural locations are increasing; as too is funding. Although NSW Health acknowledged some of the workforce challenges and concerns raised by the nursing profession, there was little sense that they fully appreciated the extent of the exhaustion and depth of concerns felt by many nurses who came before this inquiry.

4.73 The committee therefore finds that there is a perception by many frontline healthcare workers that NSW Health does not appear to appreciate the extent of the exhaustion and depth of concerns felt by many nurses and allied health workers in rural, regional and remote New South Wales.

Finding 8

That there is a perception by many frontline healthcare workers that NSW Health does not appear to appreciate the extent of the exhaustion and depth of concerns felt by many nurses and allied health workers in rural, regional and remote New South Wales.

4.74 The committee notes the range of challenges that impact on the ability to both attract and retain a fully staffed, well-resourced nursing workforce with the right skill mix and staffing numbers across rural, regional and remote areas of the state. These challenges include difficulties recruiting to rural locations; pressures caused by doctor shortages; distances between smaller and larger towns; difficulty in servicing the full suite of nursing specialisations; resourcing pressures; challenging working conditions; and limited professional development opportunities.

4.75 In this context, the committee acknowledges both the work undertaken by the Local Health Districts on a day-to-day level, and the range of initiatives being developed by NSW Health to enhance the nursing workforce, including work currently underway to comprehensively review the rural nursing workforce. The committee particularly welcomes the roll-out of a state wide

pathway to support current and future rural nursing workforce, to be implemented across rural Local Health Districts in mid-2022.

4.76 However, notwithstanding these developments, the evidence in this inquiry has demonstrated that the nursing shortage in rural and remote settings is at a critical point and that urgent action must be taken. We therefore recommend that NSW Health expedite its review of the nursing and midwifery workforce with a view to urgently increasing staffing numbers based on local need across rural, regional and remote New South Wales. The outcome should ensure there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment. Additionally, NSW Health should publicly report on an annual basis its performance in meeting this outcome.

Recommendation 16

That NSW Health expedite its review of the nursing and midwifery workforce with a view to urgently increasing nurse and midwifery staffing numbers based on local need across rural, regional and remote New South Wales. The outcome should ensure there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment. NSW Health should publicly report on an annual basis its performance in meeting this outcome.

4.77 The committee received persuasive evidence regarding the valuable role that Nurse Practitioners can play in the provision of health services, particularly in rural communities where GP services are inadequate or lacking completely. The benefits of the Nurse Practitioner model were many, including managing the care of patients with chronic disease with the aim of avoiding complications, thus keeping people in their home towns for longer and minimising the need to travel to a hospital, and improving access to health care by forming strong relationships within the community. In many ways this role seems tailor made for rural and remote communities, yet the committee heard that Nurse Practitioners are very limited in number beyond the metropolitan areas of Newcastle, Sydney and Wollongong.

4.78 We therefore recommend that the Nurse Practitioner model of care in rural, regional and remote areas be more widely implemented, including funding the recruitment and training of additional Nurse Practitioners to work in these areas, particularly in facilities without 24/7 doctor coverage, or that utilise virtual medical coverage. The committee also recommends that NSW Health work with the Australian Government to address the practical barriers to creating and supporting these roles identified by the Australian College of Nurse Practitioners, including around Medicare subsidies, PBS reform and certification of medical documents.

Recommendation 17

That NSW Health work to widely implement the Nurse Practitioner model of care in rural, regional and remote New South Wales, by:

- funding the recruitment and training of additional Nurse Practitioners to work in rural, regional and remote areas, particularly in facilities without 24/7 doctor coverage, or that utilise virtual medical coverage
- working with the Australian Government to address the practical barriers to creating and supporting these roles identified by the Australian College of Nurse Practitioners.

4.79 Additionally, the committee notes that demographically, the population of rural, regional and remote New South Wales is older than that of the Greater Sydney metropolitan area, and by 2036 residents aged over 75 will likely become the largest demographic in these areas. It is therefore essential that appropriately trained staff be available to care for their needs. Consequently, the committee recommends that NSW Health, where it has not done so already, employ in addition to peer group B hospitals, a geriatric nurse in all peer group C hospitals, and that where a geriatric nurse is not employed, NSW Health develop and provide staff members with annual training in geriatric care to ensure an ageing population is given the best health care when visiting a healthcare facility.

Recommendation 18

That in addition to peer group B hospitals, NSW Health employ a geriatric nurse in all peer group C hospitals. Where a geriatric nurse is not employed, NSW Health develop and provide staff members with annual training in geriatric care to ensure an ageing population is given the best health care when visiting a health care facility.

4.80 The committee is of the view that improving working conditions for nurses in rural and remote locations, particularly in after-hours emergency departments, must be made a top tier priority. In addition to staff shortages and the pressure and stress of having to work beyond their scope of practice without enough doctors on site, the committee believe that the support currently provided to nurses working in rural and remote settings is inadequate.

4.81 In particular, the committee was alarmed to hear that Local Health Districts are avoiding paying for nurses in rural settings to be on call as provided for in the industrial award, instead relying on their goodwill to respond to a call for assistance despite not officially being on the 'on call' roster. This situation must be rectified immediately.

4.82 Additionally, nurses already face immense pressure in their day to day work; insufficient security measures should not be adding to these pressures. The committee notes the security review undertaken by the Hon. Peter Anderson AM and its particular focus on rural settings. While the committee welcomes the update provided to the inquiry by NSW Health to that review, the approach being taken, namely to 'design out risk', appears to be progressing too slowly. The committee recommends each Local Health District engage with its emergency departments to develop an agreed plan for these works with clear accountabilities, timeframes and regular progress reporting.

4.83 Nurses also highlighted the importance of professional development and the limited opportunity that many of them get to undertake it. If anything, with the pressure on the rural and remote health system and expanded scope of practice for nurses in those settings, professional development should be prioritised. Nurses should not feel that accessing professional development is a luxury and that by undertaking it they are increasing pressures on their colleagues. The increase in staffing numbers, recommended above, and roster system must accommodate regular professional development opportunities.

4.84 The committee therefore recommends that the rural Local Health Districts formalise and adequately remunerate on call arrangements across all public health facilities in accordance with industrial awards; engage with emergency departments to develop agreed plans to address security issues with timeframes and regular progress reporting; and increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.

Recommendation 19

That the rural and regional Local Health Districts:

- formalise and remunerate on call arrangements for nurses and midwives across all public health facilities in accordance with industrial awards
- engage with the emergency departments in their area to develop agreed plans to address security issues with timeframes and regular progress reporting
- increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.

4.85 The committee believes an effective model with much potential for recruiting nurses to rural locations was through a 'grow your own' model, supported by effective programs that identify and incentivise metropolitan nurses to practice in rural locations.

4.86 The committee urges NSW Health to develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally based education, training and professional development to become qualified nurses to work in their local communities.

4.87 To support enhanced locally grown initiatives, the committee considers there to be value in rural and regional Local Health Districts partnering with their metropolitan counterparts and developing programs for both early career nurses, specialised nurses and experienced nurses to practice in rural and remote locations. Such programs should be supported by incentives that includes relocation assistance, flexible and tailored contracts, professional development opportunities, accommodation, balanced rostering and adequate professional support networks.

4.88 These partnerships, and subsequent actions, should be considered as part of NSW Health's review of the nursing workforce, and be informed by comprehensive consultation with the NSW Nurses and Midwives' Association, other nursing profession bodies and communities.

4.89 The committee therefore recommends that NSW Health, as part of its review of the nursing and midwifery workforce: develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based

education, training and professional development to become qualified nurses and midwives; develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations; and implement incentives for nurses and midwives who work in rural and remote locations.

Recommendation 20

That NSW Health, as part of its review of the nursing and midwifery workforce:

- develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives
- develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations
- implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.

4.90 Finally, the committee was concerned to hear evidence about a culture in which nurses appear fearful of raising issues or speaking out about their concerns. Nurses are at the leading edge of health services and care in communities and see firsthand where there are opportunities for improvement or failings that are placing patients or staff at risk. Further, they are well placed to inform the Local Health District about staffing problems, working conditions and skills or roster shortages. Feedback from nurses should not be a 'last resort' only for those who feel forced to speak out because they are near or at breaking point. Feedback should be encouraged and viewed as an invaluable source of intelligence for Local Health Districts. This is discussed further in Chapter 7.

Chapter 5 Specific health services and virtual care

During the inquiry the committee received evidence regarding access to and availability of specific health services – namely oncology, palliative care, allied health, other health and ambulance services – as well as the delivery of virtual care, otherwise known as telehealth. This chapter explores each of these areas in turn, including the unique challenges, NSW Health's role in service delivery, community concerns and the views of sector experts and stakeholders.

Oncology

5.1 This section discusses the provision of oncology services in rural, regional and remote New South Wales, including issues around accessing services, the out of pocket costs of treatment, and alternative service delivery options.

Sector overview

5.2 At its hearing in Sydney, Mr Jeff Mitchell, Chief Executive Officer, Cancer Council NSW acknowledged that while cancer outcomes in New South Wales are among the best in the world, for people living in rural and remote New South Wales outcomes remain poor compared to those living in metropolitan areas.[418]

5.3 According to the NSW Cancer Institute, it was projected there would be almost 49,000 people diagnosed with cancer and over 15,500 cancer deaths in New South Wales in 2020, more than stroke and heart disease combined. It is also estimated that every second person in New South Wales will be diagnosed with cancer by the age of 85.[419]

5.4 In its submission to the inquiry, Cancer Council NSW noted that cancer incidence in regional areas is higher than in metropolitan areas, and that there is a lower survival rate.[420]

5.5 NSW Health told the committee that as a result of its investment in oncology services, more than 95 per cent of residents now live within 100 km of a radiation oncology treatment centre, with nine publicly funded rural and regional cancer care centres and three private centres located throughout the state. These centres provide services such as radiotherapy, medical oncology, clinical haematology, palliative care and rehabilitation as well as referrals to diagnostic imaging, nuclear medicine, pathology, intensive care and pharmacy services.[421]

5.6 NSW Health also outlined that:

- it supports cancer screening and preventative initiatives such as the tobacco control campaign, BreastScreen NSW, bowel screening and the NSW cervical screening program[422]

418 Evidence, Mr Jeff Mitchell, Chief Executive Officer, Cancer Council NSW, 5 October 2021, p 3.

419 Cancer Institute NSW – Cancer statistics NSW - https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/cancer-statistics-nsw#//

420 Submission 173, Cancer Council NSW, p 7.

421 Submission 630, NSW Government, p 12.

422 Submission 630, NSW Government, pp 13-14.

- since 1 July 2016, $7 million has been allocated for medical trials to be conducted in rural and regional areas, with patients attending centres in Tamworth, Orange, Nowra, Coffs Harbour, Port Macquarie, Lismore, Gosford and Wollongong[423]
- the NSW Ministry of Health and its partners, including the Cancer Institute NSW and ACT Health, were awarded $30.6 million in October 2020 over five years to deliver increased and more equitable access to clinical trials for patients in rural, regional and remote New South Wales and ACT[424]
- the Cancer Institute NSW has begun developing the fifth *NSW Cancer Plan*, which will include the perspectives of people affected by cancer, including people from rural, regional and remote parts of the state.[425]

Access to services

5.7 Notwithstanding the evidence from NSW Health, the committee received many submissions pointing to significant challenges in accessing cancer screening, diagnostic services and treatment for residents in regional, rural and remote areas.[426]

5.8 For example, Cancer Council NSW noted in its submission that the limited availability of primary care and GP services in regional areas means that opportunities for early intervention are lost, and that when individuals eventually seek medical assistance they generally require more acute and complex care.[427]

5.9 In addition, the Council highlighted that the disparate nature of service provision for the treatment or prevention of cancer requires an individual to engage with multiple services and providers who often do not communicate, commenting: 'Confronted with multiple providers in multiple settings, there are many opportunities for people in regional areas to become 'lost' in the system'.[428]

5.10 While acknowledging that these difficulties existed before the COVID-19 pandemic, Mr Mitchell told the committee that the ongoing delays in screening, diagnosis and interruptions to cancer care will see cases rise and that the nature of the cancers diagnosed are likely to be more advanced.[429]

423 Submission 630, NSW Government, p 14.
424 Submission 630, NSW Government, p 14.
425 Submission 630, NSW Government, p 12.
426 See for example: Submission 6, Dr Nigel Roberts, p 1; Submission 107, Family Planning Australia, p 4; Submission 253, Wollondilly Shire Council, p 3; Submission 173, Cancer Council NSW, p 7; Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), p 9; Submission 391, Office of the National Rural Health Commissioner, p 5; Submission 403, Australian College of Rural and Remote Medicine (ACRRM), p 3; Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 3, Submission 633, Leeton Shire Council, p 4.
427 Submission 173, Cancer Council NSW, p 9.
428 Submission 173, Cancer Council NSW, pp 22-23.
429 Evidence, Mr Mitchell, 5 October 2021, p 4.

5.11 Further, the committee heard that the location of specialist doctors and allied health professionals, treatment facilities and their associated operating hours results in patients frequently having to travel long distances for treatment.

5.12 In evidence, Mr Mitchell explained to the committee that having to travel for treatment takes a heavy toll on the individual, which is compounded by the fragmentation of the sector:

> People in regional New South Wales are less likely to have access to a nearby public hospital and, for those that cannot be treated locally, travelling to and from treatment and staying away from home comes at an enormous physical, emotional and financial toll. Access to supportive care services can be limited in regional New South Wales and people with cancer can struggle to navigate the system, which is fragmented across different providers and locations.[430]

5.13 Along similar lines, in its submission to the inquiry, Can Assist noted that diagnostic tests, CT scans and PET scans are in short supply across regional and rural New South Wales, and that because patients are often required to undergo scans three or more times over their cancer journey, this requires significant and repeated travel to the nearest metropolitan city.[431] At one of the committee's hearings, Ms Emma Phillips, Executive Director, Can Assist, gave an example of a patient having to travel 24,000 kilometres over the course of their treatment.[432]

5.14 Members of the Australian Medical Association documented numerous issues with accessing cancer services in their local areas, including in Port Macquarie and Kempsey, Taree and Foster, the Macleay Valley and across Western NSW.[433]

5.15 Additionally, the Australian Medical Association reported that there are wait times of 3-4 weeks for treatment in some locations and lack of access to clinical trials more generally, which was noted as being detrimental to patients seeking oncology treatment in regional, rural and remote locations.[434]

Out of pocket costs

5.16 The committee received many submissions that raised significant concerns about the out of pocket costs associated with oncology treatment in regional, rural and remote New South Wales.[435]

5.17 Mr Mitchell explained to the committee that the lack of facilities in many areas has led to a situation where the out of pocket costs of seeking treatment are higher than for those living in

430 Evidence, Mr Mitchell, 5 October 2021, p 3.

431 Submission 34, Can Assist, p 2.

432 Evidence, Ms Emma Phillips, Executive Director, Can Assist, 5 October 2021, pp 2-3.

433 Submission 573, Australian Medical Association, pp 13-14.

434 Submission 573, Australian Medical Association, p 13.

435 See for example: Submission 173, Cancer Council NSW, p 10; Submission 210, Mr Garry Baker, p 1; Submission 276b, New South Wales Medical Staff Executive Council (NSW MSEC), p 4; Submission 368, Ms Trish Doyle MP, Member for Blue Mountains, p 9; Submission 420, Ms Carla Bower, pp 1-2; Submission 473, Services for Australian Rural and Remote Allied Health (SARRAH), p 9; Submission 479, Isolated Children's Parents' Association of New South Wales Inc., p 2; Submission 631, Bourke Shire Council, p 2 ; Submission 694, Australian Lawyers Alliance, p 11.

metropolitan areas. The committee also heard that this cost often varies between regional communities, particularly where the closest treatment facility is privately owned.[436]

5.18 In their respective submissions to the inquiry, Can Assist and Cancer Council NSW highlighted that facilities such as the Regional Cancer Centre Initiative that operate as private-public partnerships have resulted in patients having to choose between incurring higher out of pocket costs closer to home or travelling out of area to access public facilities.[437]

5.19 Further, Can Assist noted that where private services are engaged, very large gap payments may be incurred without the patient's prior knowledge, giving the following example:

> We are currently helping a pensioner from Finley who, after receiving her private health and Medicare rebate post radiotherapy treatment in Shepparton was presented with a near $14,000 bill. Referring doctors often ask simple questions like – "do you have health insurance?" and make no further cost enquiries. In times of crises, patients simply go where their doctors tell them to.[438]

5.20 As a result of situations such as these, both Cancer Council NSW and Can Assist strongly advocated for patients to be informed of out of pocket treatment costs prior to the commencement of treatment.[439]

5.21 The Australian Medical Association also noted that more financially well-resourced public units, particularly those in metropolitan areas, are able to absorb the cost of treatment, medications and novel diagnostics more readily than those in regional, rural and remote locations. Where a hospital cannot absorb the cost it is passed on to the patient, further increasing their out of pocket costs.[440]

5.22 In a number of submissions the committee was told that paying for treatment has left individuals financially ruined, as described in the following examples:

- 'My experience is if you are an adult who is working and has private health insurance you are going to be financially ruined. Everything is out of pocket or a large gap fee. Financially I have never recovered. After losing my husband raising two teenagers, working 3 jobs I will not be able to retire until I am 70. All our savings and other assets were sold to pay debts and living expenses'.[441]
- 'The continual out of pocket expenses and medication costs has taken all my savings and now rapidly depleting my superannuation pension. I find I am being punished for trying to prepare for my retirement. I also feel it is very unfair on my family to take unpaid leave from work to take me to Drs appointments. All my medical team advise me to move to the city where treatment assistance is available. Unfortunately because I live in a rural area

436 Evidence, Mr Mitchell, 5 October 2021, p 3.
437 Submission 173, Cancer Council NSW, p 2; Submission 34, Can Assist, p 2.
438 Submission 34, Can Assist, p 2.
439 Submission 173, Cancer Council NSW, pp 14-15; Submission 34, Can Assist, p 2.
440 Submission 573, Australian Medical Association, p 14.
441 Submission 173, Cancer Council NSW, p 21.

> I now have to make a choice of selling my home to continue treatment or stop treatment and end my life'.[442]

5.23 The Cancer Council also highlighted that 70 per cent of specialist medical services require patients to make a co-payment of $75 on average and that the introduction of public-private partnerships is driving up costs in communities that cannot access public cancer clinics. They further acknowledged that out of pocket costs placed a significant burden on cancer patients, finding between 28 per cent to 43 per cent of cancer patients reporting financial distress and a further 21 per cent of cancer patients skipping treatments due to costs. The Council called on NSW Health to investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services with no additional out-of-pocket costs.[443]

5.24 The situation is so grave that according to Cancer Council NSW, one in five people in regional New South Wales are choosing to skip health appointments because of the cost.[444]

5.25 In this context, a number of stakeholders called for the expansion of the eligibility criteria and reimbursement rates for IPTAAS to support cancer patients.[445] This issue is discussed in Chapter 2.

Service delivery options

5.26 Despite the challenges in providing oncology services to residents of regional, rural and remote New South Wales, the Australian Medical Association suggested that one possible solution could be the decentralisation of radiotherapy and chemotherapy services to reduce travel time for cancer patients, particularly in the Western NSW and North Coast NSW Local Health Districts.[446]

5.27 The committee heard that a successful example of this is the Remote Video Assisted Chemotherapy Service which commenced operation in October 2017 and operates out of Coonabarabran. The outreach service is provided by the Alan Coates Cancer Treatment Centre in Dubbo and the Coonabarabran Health Service, and allows patients to meet with their oncologist based in Dubbo via videolink before their treatment. After the consultation a trained chemotherapy nurse based in Coonabarabran oversees a local nurse to administer their treatment.[447]

442 Submission 173, Cancer Council NSW, p 14.

443 Submission 173, Cancer Council NSW, pp 14-15.

444 Evidence, Mr Mitchell, 5 October 2021, p 3.

445 See for example: Evidence, Mr Mitchell, 5 October 2021, p 9; Evidence, Ms Annie Miller, Director, Cancer Information and Support Services, Cancer Council NSW, 5 October 2021, p 5; Evidence, Ms Phillips, 5 October 2021, p 2; Evidence, Ms Adair Garemyn, Policy Manager, Country Women's Association of NSW, 6 October 2021, p 13; Submission 176, Council on the Aging NSW, p 6; Submission 479, Isolated Children's Parents' Association of New South Wales, pp 2-3; Submission 710, Regional Accommodation Providers Group, pp 1-4; Submission 270, Gunnedah Early Childhood Network, p 3; Submission 694, Australian Lawyers Alliance, p 29.

446 Evidence, Dr Shehnarz Salindera, Councillor, Australian Medical Association, 19 March 2021, p 3.

447 Submission 109, Name suppressed, p 3.

5.28 Cancer Council NSW also suggested that the expanded use of telehealth technologies for treatment and clinical trials could potentially lower costs, increase convenience and reduce geographic disparities in treatment availability. However, it cautioned that the expansion of virtual care technologies should not replace face-to-face consultation, and that evaluation must occur alongside adoption.[448]

Palliative care and palliative care services

5.29 This section explores issues around the provision of palliative care and palliative care services in rural, regional and remote New South Wales, including staffing levels, community advocacy and service delivery.

Sector overview

5.30 Palliative care refers to specialist services provided by palliative care professionals, often in an interdisciplinary team whose primary focus of work is people nearing the end of life.[449]

5.31 Dr Sarah Wenham, Specialist Palliative Care Physician / Clinical Director (sub-acute and non-acute care) – Far West Local Health District, The Australian and New Zealand Society of Palliative Medicine provided the committee with a working definition of the approach and scope of palliative care:

> Palliative care is an approach that improves the quality of life for patients and their families facing the problems associated with a life-limiting illness. Palliative care is not just for those in the last weeks or days of life, but occurs from diagnosis right through to death and supports families in bereavement. People who are dying and their families require care and support 24 hours a day, seven days a week.[450]

5.32 The committee heard that in Australia, while around one third of the population lives outside major cities, only 16 per cent of palliative care specialists work in rural communities. Older Australians are also more likely than the general population to live outside of major cities.[451] The committee was also told that the combination of an older population in rural locations and increasing rates of multimorbidities, chronic and progressive illness and complex disease, means that the need for palliative services is higher than in metropolitan locations.[452]

5.33 The Australian and New Zealand Society of Palliative Medicine highlighted that a key health outcome for patients living in rural, regional and remote areas includes a 'good death' or 'safe

448 Submission 173, Cancer Council NSW, p 23.

449 Answers to questions on notice, Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, received 8 February 2022, Attachment 1, Tonelle Handley PHD, 'End of Life Care in a sample of Regional and Rural NSW – what is the current situation and what are the problems? A white paper developed to support the work of NSW Regional Health Partners', 2019, p 8.

450 Evidence, Dr Sarah Wenham, Specialist Palliative Care Physician / Clinical Director (sub-acute and non-acute care) – Far West Local Health District, The Australian and New Zealand Society of Palliative Medicine, 10 September 2021, p 25.

451 Submission 629, The Royal Australian College of General Practitioners (RACGP), p 3.

452 Submission 473, Services for Australian Rural and Remote Allied Health (SARRAH), p 12.

death'. In terms of palliative care this could encompass 'a death in the home (including residential aged care), in a regional or district palliative care bed (hospice), in a regional or district public hospital, or in a regional private hospital'.[453]

5.34 In terms of the NSW Government's support for palliative care, the *NSW End of Life and Palliative Care Framework (2019-2024)*, which was developed in consultation with clinicians, patients, carers, families and other stakeholders, sets out the strategic priorities for NSW Health in this area, including the use of alternative care models such as telehealth and workforce enhancements to target non-metropolitan areas.[454] A key aspect of the framework is to improve access to specialist and supporting care options both in health facilities and in the community.[455]

5.35 The committee heard that, of the $201 million palliative care funding enhancements that have been announced since 2017, approximately $75 million was allocated to regional and rural Local Health Districts. Additionally, by 2022-23 there will be 133 new specialist palliative care workforce positions in regional, rural and remote New South Wales.[456]

5.36 Furthermore, NSW Health gave evidence that funding has been allocated in the following areas:

- $10 million of matched funds with the Australian Government to enhance specialist palliative care in residential aged care facilities through the *Comprehensive Palliative Care in Aged Care Measure*
- increased use of telehealth in residential aged care facilities
- support for multi-disciplinary approaches to end of life and palliative care for patients and their families/carers, including up to 35 allied health professionals across the state, with rural and regional Local Health Districts receiving funding for two full-time equivalent positions
- implementation of education and training to develop and grow the specialist palliative care workforce and enhance capability
- enhancement of bereavement and psychosocial support services
- supplementation to the End of Life Packages in the *Out of Hospital Care* program to allow more people to be cared for at home.[457]

Access to services

5.37 In relation to the provision of palliative care services in rural and remote areas, the Australian and New Zealand Society of Palliative Medicine characterised this as 'variable':

> In some areas, palliative care is mostly provided by GPs, community and palliative care nurses, and residential aged care staff. Other areas have more established specialist palliative care services, and some operate with a combination of specialist and generalist

453 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 4.
454 Submission 630, NSW Government, p 20.
455 Submission 630a, NSW Government, p 13.
456 Submission 630a, NSW Government, p 12.
457 Submission 630, NSW Government, pp 20-21.

services. These varied combinations of health professionals and services create disparities in access and quality of health services for rural and remote patients.[458]

5.38 The Society also observed that the provision of 24/7 on-call palliative care in rural and remote settings is challenging, as patients in these settings 'will generally have reduced access to GPs, nurses, palliative care beds, home equipment, and allied health professionals such as counsellors and psychologists'.[459]

5.39 In the same vein, the NSW Farmers' Association remarked that for those that live outside of towns with community health services, access to home-based services is limited or very often not available. This is further limited by the inability to secure in-home care packages and Age Care Assessment Team assessments.[460]

5.40 The Australian Association of Social Workers also reported that many people living outside of metropolitan areas need to go through private services which can be costly and difficult to access. The committee was told that where patients cannot afford to access private services or in-home care, they may remain as inpatients in hospitals longer than needed, or die in hospital against their wishes.[461]

5.41 Finally, the committee heard that the fragmented nature of the provision of palliative care and the lack of communication between service providers makes the palliative journey more difficult for a patient to navigate[462] and may lead to confusion and in some cases inconsistency of care.[463] Several stakeholders highlighted that this complexity is further compounded by funding for different elements of palliative care services being provided by the NSW and Australian Governments respectively.[464]

Lack of data

5.42 The committee heard that a key challenge around improving the provision of palliative care in regional, rural and remote New South Wales is the fact that 'consistent data is not available to determine what the need is; what medical practitioners are delivering care, with what training, to what quality; or what the patient experience is'.[465]

5.43 Similarly, the Orange Health Service Medical Staff Council noted that NSW Health does not have an agreed, uniform state-wide platform for the collection of palliative care or end of life care data. Therefore, most community-based teams cannot report clinical key performance

458 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 2.
459 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 5.
460 Submission 686, NSW Farmers' Association, p 9.
461 Submission 254, Australian Association of Social Workers, p 7.
462 Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), p 4.
463 See for example: Submission 627, The Society of Hospital Pharmacists of Australia (SHPA), p 9; Submission 254, Australian Association of Social Workers, p 7; Submission 605, Miss Kristy Burgess, p 1.
464 Evidence, Dr Wenham, 10 September 2021, p 30; see also Submission 470, Murrumbidgee Council, p 3.
465 Evidence, Dr Wenham, 10 September 2021, p 25.

indicator data through the accepted clinical quality tool, which limits the ability to accurately provide clinical benchmarking of regional palliative care services in comparison to metropolitan services.[466]

5.44 Further, in relation to data on staffing specifically, The Australian and New Zealand Society of Palliative Medicine told the committee that:

- there is no data available from the Royal Australian College of Physicians that identifies the number and location of GPs who have completed the Royal Australasian College of Physicians Palliative Medicine Diploma[467]
- the location of GPs that have undertaken the palliative care component of the advanced skills training pathways offered to Rural Generalists by the Royal Australian College of Physicians and the Australian College of Rural and Remote Medicine is also not publicly available.[468]

Staffing

5.45 Following on from the lack of data around staffing, the committee heard about numerous challenges specific to palliative care staffing across the state, including specialists, GPs and allied health staff.

5.46 In relation to specialist palliative care services, the Orange Health Service Medical Staff Council noted that with the exception of Coffs Harbour, Nowra and Broken Hill, the current training programs for specialist recognition in palliative medicine are city-based, limiting the opportunities for regionally-based doctors to obtain the qualification.[469]

5.47 The committee also heard that specialist palliative care services provided by Local Health Districts are inconsistent. In some Local Health Districts full-time staff specialists are employed by and reside in the area, whereas other Local Health Districts such as Murrumbidgee have fractional full-time equivalent staff specialist positions that are filled by fly-in/fly out specialists.[470]

5.48 For those specialists that reside in the Local Heath District in which they work, expectations vary as to the geographical area they are required to cover, as Dr Wenham told the committee:

> I am based in Broken Hill and I cover the whole Far West Local Health District. But, obviously, there is only one of me, and we cover a very large geographical area of up to 300 square kilometres, so that outreach needs to cover the other areas in our district. I know for certain other areas have either not been able to recruit to those positions funded by the ministry or they have got positions that are funded within a particular geographical area within the LHD, but not within other LHDs.[471]

466 Submission 269, Orange Health Service Medical Staff Council, pp 8-9.
467 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 7.
468 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 7.
469 Submission 269, Orange Health Service Medical Staff Council, p 9.
470 Submission 458, The Australian and New Zealand Society of Palliative Medicine (ANZSPM), p 7.
471 Evidence, Dr Wenham, 10 September 2021, p 26.

5.49 Conversely, some Local Health Districts such as Nepean Blue Mountains have no dedicated palliative care units or centres. Rather 10 nominal beds in general medical wards have been allocated to provide palliative care across several hospitals to service approximately 390,000 people.[472]

5.50 In relation to General Practitioners, the Australian Medical Association noted that in rural settings GPs are generally responsible for managing palliative care, both in the community and in the local hospitals with an occasional palliative care nurse available.[473] However, the Association stated that in some communities that have a local GP palliative care specialist available, that GP may not have admitting rights to the local hospital and is therefore unable to care for patients within the hospital setting.[474]

5.51 The committee also heard that the availability of and access to other allied health services that support palliative care can also be problematic, for example:

- Social Workers support the palliated individual and their family through psychological, social, physical, practical and spiritual stressors. The Australian Association of Social Workers told the committee that there are insufficient staff to provide the level of service needed to meet the healthcare needs of residents of regional, rural and remote New South Wales.[475]
- The Pharmaceutical Society of Australia observed that the involvement of a multidisciplinary palliative care team including community pharmacists is paramount to delivering optimal and holistic palliative and end of life care, regardless of setting.[476] The Society commented that its members 'have cited significant rural workforce maldistribution and highlighted concerns about attracting a sufficient rural workforce to adequately support rural and remote Australians in their communities'.[477]

Innovation in service delivery

5.52 Despite the challenges in the provision of palliative care services in rural settings, the committee also heard of examples of innovative service delivery models.

5.53 For example, the Far West Local Health District has successfully developed and expanded a model of delivery that better meets the needs of residents. The model of care and framework for use in low care residential aged care facilities was developed initially by Dr Wenham to support existing staff to develop skills to assist in the palliative process.[478]

472 Submission 368, Ms Trish Doyle MP, Member for Blue Mountains, p 10.
473 Submission 573, Australian Medical Association (NSW), p 15.
474 Submission 573, Australian Medical Association (NSW), p 15.
475 Submission 254, Australian Association of Social Workers, p 7.
476 Submission 250, Pharmaceutical Society of Australia, p 10.
477 Submission 250, Pharmaceutical Society of Australia, p 4.
478 Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), p 19.

5.54 The committee heard that this work led to the development of the Shared Health and Advance care Record for End of life choices project (SHARE) which is funded by the Commonwealth Department of Health. This project in turn resulted in the development and implementation of the electronic Palliative Approach Framework (ePAF).[479]

5.55 Western NSW Primary Health Network explained that ePAF will build capacity and improve the provision of comprehensive, consistent, patient-centred, needs based, high-quality palliative and end of life care for all, irrespective of diagnosis, care location or care provider. The project is currently being trialled across a number of residential aged care facilities and Multipurpose Services in the Western NSW Primary Health Network region, in partnership with the Far West and Western NSW Local Health Districts.[480]

5.56 The National Rural Health Alliance recognised that the Far West NSW Palliative and End-of-Life Model of Care is an excellent model and consideration should be given to expanding the model across other remote settings.[481]

5.57 Additionally, in its submission the Orange Health Service Medical Staff Council noted that the Western NSW Local Health District has made significant steps over the last five years to develop a more comprehensive and contemporary specialist palliative care service; including the transition in 2020 to a Local Health District-wide service model which has already created some efficiencies and service improvements. Additionally, they noted that the Local Health District has established a separate palliative care clinical stream and an after-hours advisory service staffed by local specialist palliative care nursing staff.[482]

5.58 Elsewhere in the state, The Royal Australian College of General Practitioners commented that the palliative care service in Coffs Harbour recognised the need for better integration between generalist and specialist palliative care, and has developed a specialist palliative care program to help train GP registrars on the mid-north coast.[483]

Allied health services

5.59 This section explores the allied health sector including challenges in accessing services as well as potential solutions, and includes a subsection specifically on mental health services.

5.60 It should also be noted in this context that, in addition to doctors, nurses and allied and other health service professionals, other employee categories such as administrative and clerical officers, cooks, ward clerks and security officers also play a critical role in ensuring hospitals run well.

479 Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), p 19.

480 Submission 346, Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN), p 19.

481 Submission 478, National Rural Health Alliance, p 12.

482 Submission 269, Orange Health Service Medical Staff Council, p 8.

483 Submission 629, The Royal Australian College of General Practitioners (RACGP), p 3.

Sector overview

5.61 According to Services for Australian Rural and Remote Allied Health, allied health professionals are 'tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury among all age groups and across all key health and associated service sectors'.[484]

5.62 While there is no universally accepted definition of allied health, Services for Australian Rural and Remote Allied Health identified several relevant criteria:

> The term encompasses a range of professions and evolving areas of specialised therapeutic knowledge, treatment and skills development, based on recognised health-related scientific and associated knowledge and practice capability. Allied Health Professionals hold nationally accredited tertiary qualifications (of at least Australian Qualifications Framework Level 7 or equivalent), enabling eligibility for membership of their national self-regulating professional association or registration with the relevant professional National Board.[485]

5.63 The importance of allied health professionals in regional, rural and remote communities was highlighted by Emeritus Professor Paul Worley, former National Health Commissioner:

> Allied health professionals are essential to the physical, social and psychological wellbeing of people living in rural and remote Australia. They are integral to the care of rural and remote communities, whose capacity to achieve optimal health outcomes is limited by inequitable access to appropriate health services. They are also integral to the economic development of rural and remote populations particularly in relation to workforce participation and educational outcomes.[486]

5.64 While national statistics do not capture self-regulated health professions,[487] the committee heard that nationally, allied health employment statistics reveal that of approximately 195,000 allied health workers, less than 15,000, or approximately 7.7 per cent, work in rural and remote locations.[488]

5.65 NSW Health recognises 23 different professions under the collective banner of allied health. They noted that these professions are heterogeneous with unique scopes of practice and are essential to providing integrated care.[489]

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484 Submission 473, Services for Australian Rural and Remote Allied Health, p 4.

485 Submission 473, Services for Australian Rural and Remote Allied Health, p 4.

486 Submission 456, Exercise and Sports Science Australia (ESSA), p 3.

487 Submission 456, Exercise and Sports Science Australia (ESSA), p 22.

488 National Rural Health Commissioner, *Report for the Minister for Regional Health, Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*, 2020, p 1.

489 Submission, 630, NSW Government, p 48.

5.66 The 23 professions recognised by NSW Health are:

- Art therapy
- Audiology
- Child life therapy
- Counselling
- Diversional therapy
- Exercise Physiology
- Genetic Counselling
- Music therapy
- Nuclear Medicine therapy
- Nutrition & Dietetics
- Occupational therapy
- Radiation therapy
- Orthoptics
- Orthotics & Prosthetics
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Radiography
- Sexual assault
- Social work
- Speech pathology
- Welfare[490]

5.67 NSW Health reported that between 2012 and 2020, the allied health workforce in rural areas increased by 1,146 full-time equivalent positions or 29 per cent to 5,061 full-time equivalent positions. However, it also acknowledged that the workforce is unevenly distributed and can be difficult to maintain in rural areas.[491]

5.68 NSW Health went further to state that it can be challenging to ensure that a sustainable workforce model which includes an appropriate mix and number of professionals from each allied health profession is available in each location.[492] NSW Health also highlighted inconsistent workforce profiles, including the absence of smaller professions in rural Local Health Districts or allied health professionals being employed as a sole practitioner for the whole Local Health District.[493]

5.69 In order to address some of these issues, NSW Health reported that research has been conducted with key partners and stakeholders to develop workforce plans for 14 allied health professions.[494]

5.70 Strategies have also been put in place to provide further support for professional development. This includes the funding of a number of scholarships and grants to create a 'rural pipeline of talent', by supporting rural students to undertake their education and training in rural locations.[495]

490 NSW Government – Health, Allied Health Portfolio – Allied Health Professionals within NSW Health, https://www.health.nsw.gov.au/workforce/alliedhealth/Pages/default.aspx
491 Submission, 630, NSW Government, p 48.
492 Submission, 630, NSW Government, p 48.
493 Submission, 630, NSW Government, p 48.
494 Submission, 630, NSW Government, p 48.
495 Submission, 630, NSW Government, p 48.

Access to services

5.71 The committee heard that despite allied health comprising the second-largest clinical workforce after nursing and midwifery, it is often the forgotten grouping in health care.[496]

5.72 At the hearing in Dubbo, Ms Jessica Brown, General Manager, Strategy and Growth Business Development, Marathon Health Ltd told the committee that while the maldistribution and shortage of community-based allied health professionals is well documented, demand has increased significantly due to the National Disability Insurance Scheme and aged-care reforms.[497]

5.73 Marathon Health Ltd also observed that since the introduction of the National Disability Insurance Scheme, the availability of Medicare-billed allied health services has dramatically decreased. The committee heard that access to community allied health is now almost exclusively limited to children, and there are very few opportunities to obtain funding for early intervention or preventative health.[498]

5.74 Ms Leanne Evans, Senior Policy & Relations Advisor, Exercise & Sports Science Australia highlighted gaps in information sharing, specifically when patients enter the public system and are then referred to the private sector for treatment. Ms Evans explained that there are policies that prevent public practitioners from providing certain referral pathways for patients and that the sharing of patient information between the two systems is often problematic.[499]

5.75 Additionally, Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health noted that because the allied health workforce frequently provides services within primarily health, aged and disability service settings where access to private allied health services is lacking, additional pressure is placed on public health resources.[500]

5.76 Furthermore, Ms Maloney commented that even within Local Health Districts, 'the allied health workforce and capacity to deliver the services is often not available, unsupported or overstretched'.[501] She stated that while there are some governance supports and resources in place within each Local Health District, often there is very little funding made available to allied health professionals to enable adequate access to supervision and support, which the committee heard results in burn out and individuals leaving the profession.[502]

496 Evidence, Ms Leanne Evans, Senior Policy & Relations Advisor, Exercise & Sports Science Australia, 3 December 2021, p 18.

497 Evidence, Ms Jessica Brown, General Manager, Strategy and Growth Business Development, Marathon Health Ltd, 19 May 2021, p 31.

498 Submission 256, Marathon Health, p 1.

499 Evidence, Ms Evans, 3 December 2021, p 21.

500 Evidence, Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health, 3 December 2021, pp 17-18.

501 Evidence, Ms Maloney, 3 December 2021, p 18.

502 Evidence, Ms Maloney, 3 December 2021, p 22.

Sector suggested solutions

5.77 The committee received a number of suggestions from within the allied sector for improving the provision of these services in rural, regional and remote New South Wales. These included:

- Ms Maloney from Services for Australian Rural and Remote Allied Health highlighted the importance of supporting allied health workforce development at every stage of the workforce development pipeline. This could include a greater number of allied health professionals filling operational management positions with responsibility for service delivery and for developing innovative, integrated models of care.[503] Ms Maloney also suggested strengthening and implementing public-private partnerships such as the program that operates in the Murrumbidgee Local Health District and provides allied health services to hospital inpatients, aged-care recipients and outpatients.[504]
- Ms Evans from Sports Science Australia argued that support must be put in place to ensure that early career allied health professionals have successful, supported and positive experiences working rurally, and argued for greater flexibility to enable multidisciplinary and cross-sector models of care that utilise the available workforce capacity to its fullest extent.[505] Ms Evans also advocated for fewer short-term contracts in the sector to ensure consistency of services.[506]
- Numerous stakeholders advocated for the continued operation and expansion of the HealthOne model that brings Commonwealth funded general practice and state-funded primary and community health care services together.[507]

Mental health services

5.78 As previously mentioned, the allied health sector is composed of a significant number of different professions, each contributing to sustain the overall wellbeing of the population. The committee heard from a number of witnesses and received many submissions related to the issues faced by different professions that fall under the 'allied health' umbrella. This section provides a snapshot of the issues raised by psychology and mental health providers specifically.

5.79 According to the 2016 census, approximately two million people live in regional, rural, and remote New South Wales and about one in five, or 400,000 of those a year will have a mental illness.[508]

503 Evidence, Ms Maloney, 3 December 2021, pp 18 and 20.

504 Evidence, Ms Maloney, 3 December 2021, p 18.

505 Evidence, Ms Evans, 3 December 2021, p 20.

506 Evidence, Ms Evans, 3 December 2021, p 18.

507 See for example: Submission 478, National Rural Health Alliance, pp 5-6; Submission 686, NSW Farmers' Association, p 11; Submission 179, Coraki Health Reference Group, pp 1-2; Submission 457, Central NSW Joint Organisation, p 4; Submission 582, Dr Joe McGirr MP, Independent Member for Wagga Wagga, p 7.

508 Evidence, Dr Justine Hoey-Thompson, Member, The Royal Australian and New Zealand College of Psychiatrists, 3 December 2021, p 35.

5.80 In evidence to the committee, Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW highlighted that:

- all rural and remote Local Health Districts have higher than average rates of high or very high psychological distress in adults
- suicide rates tend to increase with remoteness
- intentional self-harm hospitalisations are much higher in regional and remote Local Health Districts compared to metropolitan districts
- most recently, NSW Heath's 2021 data shows an increase in suspected or confirmed suicide deaths, self-harm and suicide ideation presentations in emergency departments in almost all regional and rural Local Health Districts.[509]

5.81 Ms Lourey also observed that the long-term consequences of numerous compounding disasters including drought, bushfires, the 2020 floods and COVID-19 on mental health in regional and remote communities is 'still being explored'.[510]

5.82 In terms of provision of psychological services, the committee heard that the limited services available in regional, rural and remote New South Wales are provided by private, public, Aboriginal, non-government agency and philanthropic staff, supplemented by visiting clinicians and a wide range of mental telehealth programs and services.[511] The primary care component of mental healthcare is provided by GPs and some private practitioners, with the Primary Health Networks also commissioning services that support a stepped care model.[512]

5.83 In regards to the provision of baseline psychological services in New South Wales, NSW Health informed the committee that:

- All rural Local Health Districts have access to the NSW Mental Health Line. This service links callers to the relevant Local Health District's mental health Intake and Triage services to provide a brief assessment and determine risk and urgency of response. Individuals are then referred to the most appropriate service to meet the individual's mental health needs.[513]
- Rural Local Health Districts also have access to Mental Health Emergency Consultation Services, which provide virtual in-reach to Emergency Departments via telehealth.[514]
- Larger emergency departments across rural parts of the state are declared mental health facilities under the *Mental Health Act 2007*, meaning individuals who have been detained under the Act can be taken to these facilities for mental health assessment and immediate

509 Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW, 3 December 2021, pp 34-35.
510 Evidence, Ms Lourey, 3 December 2021, p 35.
511 Evidence, Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health, 3 December 2021, p 37.
512 Submission 630, NSW Government, p 5.
513 Submission 630, NSW Government, p 15.
514 Submission 630, NSW Government, p 15.

care. Individuals who need specialist inpatient care are transferred to an acute mental health inpatient unit.[515]

- NSW Health also provides a number of community mental health and psychiatric clinics in addition to collaborations with non-government organisations in some Local Health Districts.[516]

5.84 However, NSW Health acknowledged that private practitioners within Local Health Districts are not readily available.[517]

5.85 In terms of access challenges, similar to other allied health professions, in New South Wales the distribution of mental health professionals rapidly decreases with remoteness. The committee heard that psychiatrists are six times less prevalent, psychologists five times less prevalent and mental health nurses three times less prevalent in rural areas.[518]

5.86 The Centre for Rural and Remote Mental Health explained that there is considerable structural fragmentation within the mental health system in Australia, including in New South Wales. Services are funded by federal and state bodies, each with different governance, oversight, funding models, and output/outcome measures. There are also provider variations across government (state and federal), non-government agencies and private practitioners, as well as variations between resident and visiting health professionals.[519]

5.87 On the issue of funding, Dr Justine Hoey-Thompson, Member, The Royal Australian and New Zealand College of Psychiatrists stated that there can be a 700 per cent disparity between mental health spending in the city compared to a remote area, and services may be more expensive to run remotely because of the distances travelled by the practitioner.[520]

5.88 In terms of patient experience, Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, noted that in order to access mental health services the standard practice is to see a GP for a referral. The inability to see a GP in a timely manner in some rural areas leads to risk of an escalation in the intensity of the illness, delay in terms of getting treatment and potential lack of continuity of care.[521]

5.89 The committee also heard that even when services can be accessed, the lack of workforce often means that there can be significant delays in obtaining an appointment, with patients having to travel to attend appointments. It was also noted that even with Medicare benefit scheme subsidies, the cost of accessing psychology services can be prohibitive for those in the lower social economic groups.[522]

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515 Submission 630, NSW Government, pp 15-16.

516 Submission 630, NSW Government, pp 16-17.

517 Submission 630, NSW Government, p 15.

518 Evidence, Dr Hoey-Thompson, 3 December 2021, p 36.

519 Submission 454, Centre for Rural and Remote Mental Health, p 6.

520 Evidence, Dr Hoey-Thompson, 3 December 2021, p 36.

521 Evidence, Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, 3 December 2021, p 40.

522 Submission 454, Centre for Rural and Remote Mental Health, p 6.

5.90 One Door Mental Health – Great Lakes Mental Health Carer Support Group stated:

> Currently there are no mental health services in the Great Lakes area other than Community Health which is only available during business hours by referral to a case worker or the Psychiatrist weekly for people on a community treatment order. The closest support service available is Flourish (only for NDIS clients) and Parramatta Mission for those without a NDIS package, located in Taree.[523]

5.91 The Centre for Rural and Remote Mental Health also outlined the issues associated with the 'missing middle'. Due to the general lack of services, those who are experiencing mild to moderate mental health issues have very limited treatment options:

> Patient needs are too serious for General Practitioners (GPs) and PHN-funded services to address but not serious enough for state mental health service care and so these patients do not receive adequate care. [524]

5.92 At the other end of the spectrum of care, Dr Hoey-Thompson told the committee that there is frequently a lack of 24-hour support and care for acute presentations at night at state-run facilities.[525]

5.93 Further, Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health commented that some rural residents are 'excluded from many of the teleservices by poor internet access, poor skills or capability to use those services, and sometimes they are trying to use services from a place that is not safe'.[526]

5.94 Bringing together themes common to many allied health professions and indeed the health workforce more broadly, Ms Lourey stated that ease of navigation though referral pathways, short-term funding cycles for provision of services, workforce shortages in terms of peer support, professional development, recruitment and social considerations such as the availability of housing also pose significant challenges for individuals seeking services and the professionals delivering them.[527]

5.95 Looking beyond the challenges, Professor Perkins acknowledged that as rural communities are highly variable and one service model will not fit all, the most effective services are those that are designed by local communities working with input from community members and service providers.[528]

5.96 In its submission, The Centre for Rural and Remote Mental Health drew attention to models in place that successfully support resident services and health professionals. These include the visiting psychiatrist model in Broken Hill, the Mental Health Rural Access Program via the mental health line, and digital models such as This Way Up which provide effective tools to

523 Submission 249, One Door Mental Health, p 2.
524 Submission 454, Centre for Rural and Remote Mental Health, p 5.
525 Evidence, Dr Hoey-Thompson, 3 December 2021, p 37.
526 Evidence, Professor Perkins, 3 December 2021, p 37.
527 Evidence, Ms Lourey, 3 December 2021, p 35.
528 Evidence, Professor Perkins, 3 December 2021, p 37.

support resident health professionals such as GPs, allied health and social workers to provide evidence-based therapeutic support for their patients/clients.[529]

5.97 The Centre also drew attention to the paucity of data when it comes to mental health outcomes in rural New South Wales, stating that the last national mental health and wellbeing survey was conducted in 2007 and did not adequately sample rural areas. Furthermore, they noted that the 'landmark Australian Rural Mental Health Study, delved much deeper into the social, environmental, economic and rural determinants of mental health' but that that data is now ten years old. The Centre therefore highlighted the 'great and pressing need for comprehensive data on the mental health of rural and remote New South Wales residents and the factors that impact this'.[530]

Other health services

5.98 This section explores a number of other health services, including drug and alcohol rehabilitation services, preventative health, care for the elderly in nursing homes, dental care and maternity services and care.

Drug and alcohol rehabilitation services

5.99 In its submission, NSW Health stated that a range of alcohol and other drug services are available in regional areas. These services are provided through the Local Health Districts and NSW Health-funded non-government organisations, and include withdrawal management, drug counselling and case management, medicated-assisted treatment, opioid agonist treatment, hospital-based drug and alcohol consultation liaison services, substance use in pregnancy and parenting programs, outpatient programs, criminal justice diversion programs, outreach, ongoing care services and residential rehabilitation treatment programs. The committee was told that the Local Health Districts also provide drug and alcohol intake telephone lines, which are a key access point for people seeking treatment services in their communities.[531]

5.100 However, despite the 17,848 consumers from regional Local Health Districts that accessed New South Wales funded alcohol and drug treatment services in 2018-2019,[532] the committee heard from numerous community members and organisations who reported that the availability and accessibility of services are inadequate to meet community need.[533]

529 Submission 454, Centre for Rural and Remote Mental Health, p 5.

530 Submission 454, Centre for Rural and Remote Mental Health, p 4.

531 Submission 630, NSW Government, p 18.

532 Submission 630, NSW Government, p 19.

533 See for example: Submission 106, Network of Alcohol and other Drugs Agencies (NADA), p 1; Submission 272, The Royal Australian and New Zealand College of Psychiatrists (RANZCP), p 10; Submission 263, Riverina Murray Regional Alliance, p 3; Submission 258, New South Wales Nurses and Midwives' Association, p 9; Submission 181, Deniliquin Mental Health Awareness Group (Deni MHAG), p 5; Submission 257, Health Services Union NSW ACT QLD, p 6; Submission 445, Country Women's Association of NSW (CWA of NSW), p 4; Submission 706, Just Reinvest NSW, p 6; Submission 172, Temora Shire Council, p 2; Submission 397, Warren Shire Council, pp 2 and 3; Submission 633, Leeton Shire Council, p 5; Submission 460, Ms Kate Stewart, p 18; Submission 83, Name suppressed, p 1.

5.101 The most common concerns in this regard included:

- the inability to access mental health and drug and alcohol treatments simultaneously[534]
- timeliness of access to services and lack of early intervention[535]
- the location of services and the need to travel long distances to access them[536]
- the absence of culturally safe treatment options for First Nations people.[537]

5.102 These issues were explored in detail in the committee's 2018 report entitled *Provision of drug rehabilitation services in regional, rural and remote New South Wales.*[538]

Preventative health

5.103 Broadly speaking, preventative health refers to creating systems and environments that keep people healthy and well and to avoid the start of illness, disease or injury. Examples of preventative health measures include:

- early detection programs such as cancer screening
- immunisation
- strategies to prevent and reduce overweight and obesity, drug use, smoking and alcohol-related harm
- education and awareness campaigns to promote a healthy lifestyle.[539]

534 See for example: Evidence, Dr Amy Perron, General Practitioner, Dubbo Regional Aboriginal Medical Service, 19 May 2021, p 13; Evidence, Aunty Monica Kerwin, Private individual, 2 December 2021, p 41; Submission 272, The Royal Australian and New Zealand College of Psychiatrists (RANZCP), p 10.

535 See for example: Evidence, Ms Jenny Lovric, Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest NSW, 3 December 2021, p 3 and 9; Evidence, Dr Hoey-Thompson, 3 December 2021, p 35; Evidence, Cr Darriea Turley AM, Mayor, Broken Hill City Council, 2 December 2021, p 7; Submission 106, Network of Alcohol and other Drugs Agencies (NADA), p 1.

536 See for example: Evidence, Ms Betty Kennedy Williams, Enrolled Nurse, New South Wales Nurses and Midwives' Association, 2 December 2021, p 30; Evidence, Ms Lovric, 3 December 2021, pp 3 and 7; Evidence, Ms Monica Whelan, Member, Can Assist Coleambally, 29 April 2021, p 21; Evidence, Mr John Fernando , Chairperson, Riverina Murray Regional Alliance, 6 October 2021, p 29; Evidence, Cr Turley AM, 2 December 2021, p 6; Submission 106, Network of Alcohol and other Drugs Agencies (NADA), p 1

537 See for example: Evidence, Dr Perron, 19 May 2021, p 13; Evidence, Mr Fernando, 6 October 2021, p 29; Submission 258, New South Wales Nurses and Midwives' Association, p 9; Submission 263, Riverina Murray Regional Alliance, p 3.

538 Portfolio Committee No. 2 – Health, NSW Legislative Council, *Provision of drug rehabilitation services in regional, rural and remote New South Wales* (2018).

539 Department of Health, *About preventive health in Australia* (14 December 2021), https://www.health.gov.au/health-topics/preventive-health/about.

5.104 As touched on in Chapter 1, the committee heard that healthy behaviours have a significant impact on an individual's life expectancy and quality of life.[540]

5.105 Cancer Council NSW highlighted the importance of public health and preventative health measures, noting that one in three cancers are preventable. The Council noted that many cancer risk factors, such as excess alcohol consumption, smoking, overweight and obesity, inadequate fruit and vegetable intake, and inadequate exercise, are more prevalent in regional areas.[541] The Council also emphasised the importance of cancer screening and early detection,[542] and argued that prevention campaigns at both the State and Commonwealth level have been underfunded for a lengthy period of time.[543]

5.106 Exercise and Sports Science Australia advised that in 2017, Australia spent only 1.9 per cent of its total health budget on preventative care, which was significantly lower than expenditure in comparable countries.[544] Similarly, Professor Andrew Searles, Associate Director – Health Research Economics at the Hunter Medical Research Institute told the committee that Australia has tended to under-invest in preventative care, in comparison to other countries with similar health systems.[545]

Care for the elderly in nursing homes

5.107 In rural, regional and remote locations, aged care services are primarily provided by Multipurpose Services run by NSW Health and by private and community operated aged care facilities.

5.108 According to NSW Health, Multipurpose Services bring together health and aged care services under one management structure to provide a more flexible, cost-effective, and coordinated approach to service delivery.[546] To date more than $400 million in capital funding has been provided for the redevelopment of 63 facilities across New South Wales. The purpose of this investment is to increase access to and provide sustainable health services in small, rural communities to better meet local needs.[547]

5.109 Despite being lauded as a best practice model for assisting citizens to remain in their local community, the committee heard numerous accounts of nursing staff allocated to the aged care section of a Multipurpose Service being required to assist their colleagues in the emergency section of the facility and at times leaving the aged care residents unattended.[548]

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540 Submission 456, Exercise and Sports Science Australia, p 8; Evidence, Mr John Scarce, General Manager, Murrumbidgee Council, 29 April 2021, p 3.

541 Submission 173, Cancer Council NSW, p 26.

542 Submission 173, Cancer Council NSW, pp 26-27; Evidence, Mr Mitchell, 5 October 2021, p 6.

543 Evidence, Mr Mitchell, 5 October 2021, p 6.

544 Submission 456, Exercise and Sports Science Australia, p 9.

545 Evidence, Professor Andrew Searles, Associate Director – Health Research Economics, Hunter Medical Research Institute, 5 October 2021, p 30.

546 Submission 630, NSW Government, p 5.

547 Submission 630, NSW Government, p 5.

548 See for example: Evidence, Mrs Kristyn Paton, Registered Nurse & Branch President, New South Wales Nurses and Midwives' Association, 19 March 2021, p 37; Evidence, Ms Sheree Staggs,

5.110 In addition to privately owned and operated facilities, the committee heard that local councils and small not for profit community groups are also supporting or in some cases operating aged care facilities in rural locations to allow ageing residents to be cared for in their home towns.[549]

5.111 According to evidence given by Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health to the Select Committee on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, many of these smaller facilities in rural towns are struggling and some have sought assistance and support from NSW Health.[550] While these issues are often financial in nature,[551] this committee heard that they also extend to the availability of GPs to treat residents,[552] and the availability of appropriately trained nursing and other aged care workers.[553]

5.112 Dr Lyons characterised the challenges in this way:

> We are ageing. Our people are living longer but living with chronic conditions, so the likelihood of somebody who goes into residential aged care having significant health problems is very high. It is not just about aged care and providing a residence and a home for them; it is about ensuring they have access to all of those healthcare services. The need has never been greater.[554]

5.113 The issues faced by aged care services have recently been explored in depth during the Royal Commission into Aged Care Quality and Safety and the NSW Legislative Council's Select Committee inquiry into the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020.

Dental care

5.114 Traditionally, oral health has been separated from general health in terms of delivery of services, health policy and funding, and education programs. The Australian Institute of Health and Welfare reported that in 2018-2019, $5.1 billion was spent on managing and treating tooth decay in Australia and that tooth decay was the most common chronic disease worldwide.[555]

5.115 At its hearing in Sydney, Dr Michael Jonas, President, Australian Dental Association – NSW Branch told the committee that there are over 85,000 adults on the public dental waiting list in New South Wales, with approximately 30,000 of those located in regional, rural and remote

Registered Nurse, New South Wales Nurses and Midwives' Association, 18 May 2021, p 13 and 19; Submission 268, Quality Aged Care Action Group Incorporated (QACAG), p 3.

549 Submission 345, Local Government NSW, p 18.

550 Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, Select Committee on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, 22 February 2021, p 21.

551 Evidence, Dr Lyons, Select Committee on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, 22 February 2021, p 21.

552 Evidence, Dr Kerrie Stewart, General Practitioner, Ochre Medical Centre, 19 May 2021, p 2-3.

553 Submission 604, Aged and Community Services Australia (ACSA), p 3 and 6-7.

554 Evidence, Dr Lyons, Select Committee on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, 22 February 2021, p 25.

555 Submission 714, Australian Dental Association – NSW Branch, pp 1-2.

areas.[556] The Association also advised that the wait list for a standard check-up is currently three years,[557] and that Medicare does not cover dentistry.[558]

5.116 The committee heard that, as with other health services, rural communities struggle with the lack of specialist oral health services, long public oral health waiting lists, the cost of treatment as well as longer travel times and limited transport options.[559]

5.117 Furthermore, Dr Jonas explained that the challenges are compounded as rurality increases, and that poor oral health has negative consequences for a range of chronic conditions:

> The more remote you get, the less chance you have to access clean, fluoridated drinking water, fresh healthy foods and oral hygiene products; and the patient-to-dentist ratio nearly triples. Good oral health is fundamental to overall health and wellbeing. Tooth decay and gum disease cost of billions of health dollars each year and this is without accounting for the wider health consequences of poor oral health on chronic diseases including diabetes, cardiovascular disease, lung conditions, adverse pregnancy outcomes—and the list goes on.[560]

5.118 The Australian Dental Association – NSW Branch also highlighted the maldistribution of dental practitioners in rural, regional and remote locations, noting that early intervention and preventative actions are less therefore likely to occur in these communities.[561]

5.119 The Australian Dental Association – NSW Branch suggested that the following measures would improve access to dental services in rural, regional and remote areas:

- recognition of tele-dentistry by private health funds[562]
- greater collaboration between private and public services[563]
- the promotion of schemes such as the Child Dental Benefits Schedule.[564]

Maternity services and care

5.120 A number of stakeholders expressed concern about the lack of midwives and maternity services to support women having children in their home location.[565] In fact, Dr Simon Holliday, a GP

556 Evidence, Dr Michael Jonas, President, Australian Dental Association – NSW Branch, 3 December 2021, p 24.

557 Evidence, Dr Sarah Raphael, Advisory Services Manager, Australian Dental Association – NSW Branch, 3 December 2021, pp 25-26.

558 Evidence, Dr Raphael, 3 December 2021, p 32.

559 Evidence, Dr Jonas, President, 3 December 2021, p 24.

560 Evidence, Dr Jonas, President, 3 December 2021, p 24.

561 Submission 714, Australian Dental Association – NSW Branch, p 3.

562 Submission 714, Australian Dental Association – NSW Branch, p 5.

563 Evidence, Dr Raphael, 3 December 2021, pp 26-27.

564 Evidence, Dr Jonas, President, 3 December 2021, p 24.

565 See for example Submission 33, Mr John Round, p 1; Submission 43, Name suppressed, p 1; Submission 126, Name suppressed, p 1; Submission 128; Name suppressed, p 1; Submission 308; Name suppressed, p 1.

based in Taree, stated in his submission that, according to the Rural Doctors Association of Australia, 50 per cent of all rural maternity units have closed around the nation over the last decade.[566] Mission Australia said that in West and Far West New South Wales, Dubbo and Moree are the only hospitals with a maternity ward, which is made more inaccessible by the long distances people have to travel, the costs of travel as well as the lack of public transport options.[567]

5.121 One expectant mother explained the impact of a lack of midwifery services on her. She said that for the birth of her first two children there was a midwife clinic that visited the Wee Waa Hospital fortnightly. She said that she is currently pregnant with her third child and the clinic has been 'shut down', and that it is unreasonable for pregnant women to have to 'make an 80 kilometre round trip to Narrabri' to attend the clinic there, particularly when they may work and have other parenting responsibilities.[568] This stakeholder was not alone in raising concerns about midwifery services being taken away from their community.[569]

5.122 The NSW Nurses and Midwives' Association echoed these concerns in its submission, noting as well the lack of support for the midwives who do work in rural settings:

> It seems unreasonable and unfair to us that women living in rural, regional and remote areas of NSW do not have access to the same standard of maternity care that their counterparts in the city receive. Nor is it acceptable to us that midwives are constantly working in isolation and have limited access to routine education opportunities. Maternity services in these areas are grossly insufficient as is staffing. The Association remains concerned about inappropriate skill mix and many new midwives working in these areas without adequate support.[570]

5.123 Poorer outcomes for women and their babies was also identified as a problem resulting from the lack of services available in rural locations. The New Yass Hospital with Maternity Working Group explained this issue:

> [W]omen in areas like Yass might feel pressured to travel to hospital earlier to prevent issues, but in the process increase the risks associated with early intervention. Because they are so far from home, we intervene and we speed their labour up. Women that need to travel further distances for births have poorer outcomes for them and their babies than women that are in larger cities.[571]

5.124 Mrs Shirlee Burge spoke of her serious concerns regarding midwifery services in Deniliquin. She said that there have been failings in recruiting which have led to '5 young energetic new midwives' leaving Deniliquin because the Local Health District would not award them permanency. According to Mrs Burge, midwifery services have suffered as a result, pointing to

566 Submission 379, Dr Simon Holliday, p 3.
567 Submission 385, Mission Australia, pp 3-4.
568 Submission 126; Name suppressed, p 1.
569 See for example: Submission 33, Mr John Round, p 1; Submission 43, Name suppressed, p 1; Submission 126, Name suppressed, p 1; Submission 128; Name suppressed, p 1; Submission 308; Name suppressed, p 1.
570 Submission 258a, NSW Nurses and Midwives' Association, p 2.
571 Submission 349, New Yass Hospital with Maternity Working Group, p 2; see also Submission 393, Clr Nina Digiglio, p 2.

the inability to maintain a reliable service over peak periods as well as poor working conditions for midwives.[572]

5.125 Similarly, a nurse from Cootamundra said that women choosing to give birth locally are often transferred to Young or Wagga Wagga at the last minute due to little or no midwifery coverage, which increases their levels of stress and does not accord with 'woman centred care'.[573] Another submission highlighted that even if there is a midwife on an evening shift in her rural area, they are often also looking after a ward full of patients at the same time so they are not able to give their full attention to a woman presenting in labour.[574]

5.126 Charles Sturt University agreed that there is a shortage of specialist maternity and midwifery practitioners in regional areas and suggested ways to address this shortage:

> The shortage can be addressed in part by increasing the number of specialist training places for midwifery in regional areas, though Charles Sturt suggests there is also scope for more innovative solutions such as providing midwifery training for registered nurses, for example through the NSW Rural Generalist Medical Training Program.[575]

5.127 A number of stakeholders argued that the 'midwifery continuity of care model' should be implemented across rural, regional and remote New South Wales, to ensure women receive consistent support throughout their pregnancy and birth from a known midwife.[576]

5.128 NSW Health advised that there is a current investment of $35.3 million to fund extra midwives and child and family health nurses, including in rural and regional areas.[577]

Ambulance services

5.129 This section examines issues facing the ambulance sector, including response times, staffing levels, skill level distribution and the use of ambulance vehicles and resources. The issues covered come both from the perspective of community members, and key sector stakeholders.

Community perspective

5.130 Overall, community members expressed concern that the current level of ambulance services in regional, rural and remote New South Wales leaves their communities exposed to an unacceptable level of risk. This risk was expressed in terms of response times when a call is made to the Emergency Services via the Triple Zero phone number, and the subsequent time it takes for an ambulance to arrive and render assistance.[578]

572 Submission 484, Ms Shirlee Burge, p 6.

573 Submission 557, Name suppressed, p 1.

574 Submission 587, Mrs Renee Murphy, p 2.

575 Submission 401, Charles Sturt University, p 4.

576 See for example: Submission 349, New Yass Hospital with Maternity Working Group, p 1; Evidence, Ms Garemyn, 6 October 2021, p 10.

577 Submission 630a, NSW Government, p 13.

578 See for example: Evidence, Cr Paul Maytom, Mayor, Leeton Shire Council, 6 October 2021, p 3; Submission 179, Coraki Health Reference Group, p 2; Submission 186, Mrs Jillian Davidson, p 1;

5.131 In this regard, the NSW Government noted that the Service Agreement between NSW Health and NSW Ambulance sets a median emergency response time for Priority 1A (highest priority) incidents of within 10 minutes. NSW Health informed the committee that this target was achieved in regional areas in 2018-2019 and 2019-2020, with the median response time for such incidents being 8.05 minutes and 7.98 minutes respectively.[579]

5.132 However, the committee heard and received numerous submissions describing what community members consider to be excessive response times, including the following examples:

- Leeton – 'A teenage boy with a head concussion at a local school waited 45 minutes for an ambulance … We provide the story of a 77-year-old man who passed away after an ambulance took 41 minutes to reach him even though his home was less than five minutes from the ambulance station'.[580]
- Grafton – 'My mother suffered what was assessed as being a serious stroke … A person from NSW emergency services telephoned my mother to confirm her situation and informed her that an ambulance had been dispatched but may take a little while to arrive. The Grafton ambulance station is less than five minutes' drive from my mother's home in Alice Street and the Grafton Base Hospital is less than two minutes' drive around the corner in Arthur Street … It took more than an hour for the ambulance to arrive at her address … The ambulance was called from Coffs Harbour to attend to my mother's needs, a drive of approximately one hour'.[581]
- Fitzroy Falls – 'I fell off my horse … in a riding lesson … It took over 1.5 hours to arrive, coming from the Shoalhaven area as the Bowral ones were too busy. It was a patient transport van and not an ambulance'.[582]

5.133 Cr Neville Kschenka, Mayor, Narrandera Shire Council, told the committee that some of the delays that have been experienced are as a result of paramedics being required to undertake non-urgent patient transports which then requires other crews to travel out of their area to respond:

> When ambulances are used for the purpose of transporting patients, there is a risk that a local ambulance will not be available for an emergency and one will have to travel from another town, causing a delay in attending incidents, with potentially fatal outcomes.[583]

5.134 This was further supported by Mrs Daphne Calvert, who lives in Warren and who described getting an emergency vehicle to attend to a call as a 'lottery':

Submission 231a, Mrs Carol Richard, p 1; Submission 301, Name suppressed, p 1; Submission 678, Manning Great Lakes Community Health Action Group Inc., p 10; Submission 682, Mr Geoffrey Langford, p 3; Submission 694, Australian Lawyers Alliance, p 23.

579 Submission 630, NSW Government, p 54.

580 Evidence, Cr Maytom, 6 October 2021, p 3.

581 Submission 434, Mr Andrew Johnson, p 1.

582 Submission 114, Name suppressed, p 1.

583 Evidence, Cr Neville Kschenka, Mayor, Narrandera Shire Council, 6 October 2021, p 4.

> The standard of the Ambulance services consists of two paramedics on duty and on call for eight days at a time and it is a lottery if you can get an emergency vehicle as it may have been called to a neighbouring town because they have been left without an ambulance or simply out on another job.[584]

5.135 Furthermore, as Mrs Patricia David, Secretary, Unions Shoalhaven told the committee, concerns about wait times are compounded when the closest ambulance station is located over 30 minutes away and there is no guarantee they will be able to respond if required:

> If you live in, let's say, the Milton Ulladulla area of the South Coast, that is an hour's drive to Shoalhaven hospital depending on traffic … If it is during peak holiday season, you could be stuck for up to two hours or more. … And then you have got the outlying villages that do not have an ambulance or anything like that. They are relying on them to come from Vincentia or St Georges Basin …. That impact can be quite huge. If you are having a heart attack or a stroke or something like that, we all know how important it is for the reaction time to get people to their emergency care in a best practice time ... One of the main concerns that people have when you are living in such a vast LGA like the Shoalhaven is the response times for emergency situations.[585]

Sector perspective

5.136 Stakeholders from within the ambulance sector raised a number of issues impacting the sector in regional, rural and remote New South Wales. Of significant concern was staffing levels, resource availability and the lack of career progression opportunities.

Staffing

5.137 The Health Services Union NSW ACT QLD commented that the combination of increased need for ambulance services and understaffing has led to a situation where staff are increasingly subjected to excessive workloads and workplace stress.[586]

5.138 The committee heard evidence from the Australian Paramedics Association (NSW) that despite increases in paramedic staffing levels in recent years,[587] more positions are required.[588]

5.139 The Australian Paramedics Association (NSW) advised that the increase in staff numbers did not necessarily increase the capacity of ambulance services; rather additional paramedics were utilised to move stations from 'on call' models of operation to a '24/7' model, which does not increase coverage but simply changed the type of coverage from on-call to on-duty staff.[589]

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584 Submission 622, Mrs Daphne Calvert, p 1

585 Evidence, Mrs Patricia David, Secretary, Unions Shoalhaven, 6 October 2021, p 20.

586 Submission 257, Health Services Union NSW ACT QLD, p 1.

587 Submission 664, Australian Paramedics Association (NSW), p 4; Submission 630, NSW Government, p 52.

588 Evidence, Mr Scott Beaton, Vice President and Intensive Care Paramedic, Station Officer, Gilgandra Station, Australian Paramedics Association (NSW), 10 September 2021, p 14.

589 Submission 664, Australian Paramedics Association (NSW), p 5.

5.140 The committee also heard evidence of the increasing demand for ambulance services across the state,[590] including data which shows that calls for an ambulance are 2.5 times higher in remote communities when compared to metropolitan or inner regional areas.[591]

5.141 Furthermore, the Health Services Union NSW ACT QLD reported that two thirds of its members working at non-metropolitan stations indicated that there are not enough staff to meet demand in their area, and as a result there can be extended wait times for a crew to arrive at an incident, directly echoing the concern of community members:

> Due to the few crews on duty, and the distances traversed to transport patients to hospital, there are frequently times where the nearest paramedics available may be 100 kilometres away. When crews are not immediately available to respond to a case, wait times for an ambulance to arrive can extend beyond an hour. This frequently occurs where crews are taken out of their response area and are not backfilled.[592]

5.142 Along similar lines, in a survey conducted by the Australian Paramedics Association (NSW), one in three paramedics consistently or usually felt too fatigued to drive, one in five were consistently or usually asked to complete a job even after stating that they were too fatigued, and one in two consistently or usually worked overtime due to long-distance transfers.[593]

5.143 Mr Scott Beaton, Vice President, Intensive Care Paramedic, Australian Paramedics Association (NSW) and Station Officer at Gilgandra station, told the committee that he and his paramedic colleagues are exhausted.[594]

Task appropriateness

5.144 Echoing the concerns of community members, Mr Beaton told the committee that paramedics have begun to feel like a taxi service and in doing so take resources away from communities:

> We spend a lot of our time acting as a taxi service for NSW Health. This is not to say that patients do not need to be transported—they absolutely need to be in the right healthcare facility for their injury or illness—but much of the time we are transporting patients who do not require our level of clinical care. When we transport these patients we are taking the only resource away from a small community.[595]

5.145 The Australian Paramedics Association (NSW) reported that the limited resourcing, coverage and operating hours of patient transport services has led to reports that one in two regional paramedics have been consistently or usually called out to undertake frequent, and sometimes unnecessary, long distance transfers at night, diverting limited emergency resources to low-acuity cases for which they are not required.[596]

590 Submission 664, Australian Paramedics Association (NSW), p 3.
591 Submission 275, Australasian College of Paramedicine, p 1.
592 Submission 257, Health Services Union NSW ACT QLD, p 9.
593 Submission 664, Australian Paramedics Association (NSW), p 6.
594 Evidence, Mr Beaton, 10 September 2021, p 9.
595 Evidence, Mr Beaton, 10 September 2021, p 9.
596 Submission 664, Australian Paramedics Association (NSW), pp 6-7.

5.146 Ms Liu Bianchi, Delegate and Intensive Care Paramedic, Extended Care Paramedic, Tuncurry Station, Australian Paramedics Association (NSW), informed the committee that this situation is exacerbated by the current practice of '000' operators assigning any ambulance to a call as soon as it comes in.[597]

5.147 Ms Bianchi went on to explain that the issue with this approach is that the wrong type of paramedic is sent to the call-out, and when they are unable to address the issue at hand it results in more hospital presentations:

> The flow-on effect is that you then have this ripple effect of ECPs attending high-acuity jobs needing backup and then you get P1s and ICPs attending really low-acuity jobs that are ECP but then have to transport them because they cannot fix that low-acuity case. Then you get all of this ramping at hospitals and presentations at hospitals that do not need to be there.[598]

5.148 Furthermore, the result of having crews traveling long distances away from their communities at night has led to a reliance on off-duty paramedics to attend call-outs in place of the rostered crews who are engaged elsewhere.[599]

5.149 Mr Ryan Lovett, College Chairperson, Australasian College of Paramedicine, suggested that in order to address this issue and ensure that community needs are met appropriately, a detailed community and modelling profiling program such as that undertaken in South Australia could assist the NSW Government and NSW Health in identifying the holistic needs of the community, including the appropriate ambulance response and skill sets required by a community or target area.[600]

5.150 A further issue raised with the committee was around the fact that in addition to their core responsibilities, where hospitals are understaffed, paramedics can be called on to render assistance as part of the Clinical Emergency Response Systems (CERS) Assist program.[601]

5.151 According to the Health Services Union NSW ACT QLD, more than 80 per cent of the regional and rural paramedics they surveyed have been called on to assist patients in hospital as the highest qualified clinician available in the area.[602] The Union pointed out that, while undoubtedly very valuable for communities that do not have doctors available to them, undertaking these tasks takes time and resources away from core ambulance tasks.[603]

5.152 Moreover, Mr Beaton stressed to the committee that the reliance on paramedics to provide services that have traditionally been the responsibility of primary and preventative care is increasing:

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597 Evidence, Ms Liu Bianchi, Delegate and Intensive Care Paramedic, Extended Care Paramedic, Tuncurry Station, Australian Paramedics Association (NSW), 10 September 2021, p 11.

598 Evidence, Ms Bianchi, 10 September 2021, p 14.

599 Evidence, Mr Beaton, 10 September 2021, p 12.

600 Evidence, Mr Ryan Lovett, College Chairperson, Australasian College of Paramedicine, 10 September 2021, p 14.

601 Evidence, Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council, 5 October 2021, p 13.

602 Submission 257, Health Services Union NSW ACT QLD, p 12.

603 Submission 257, Health Services Union NSW ACT QLD, p 13.

> … rural paramedics attend to a wide variety of patient presentations ranging from critical, traumatic injury to chronic, complex geriatric syndromes in aged-care facilities. They respond to mental health illnesses, substance abuse and they are often there during the final days of a person's life, providing palliative and end-of-life presentations. Most of these attendances have traditionally fallen within the domain of primary and preventative care; however, due to the prolonged shortages of rural doctors and limited availability of community nursing, patients are increasingly being managed by the paramedic workforce in these areas. This is exacerbated by the lack of options for out-of-hours care and the geographical distribution of health services. Communities are increasingly relying on paramedics in the delivery of routine health care, particularly when primary healthcare services are difficult to access or not available at all.[604]

Career progression

5.153 Despite the growing reliance on paramedics to provide or contribute to the delivery of routine health care, the committee heard that career progression remains a significant issue for those based in regional, rural and remote New South Wales. In this context, the Health Services Union NSW ACT QLD[605], the Australian Paramedics Association (NSW)[606] and the Australasian College of Paramedicine[607] all reported that there is a lack of specialist paramedics employed in regional areas.

5.154 In this regard, Ms Bianchi informed the committee that there are 83 funded positions for Extended Care Paramedics in metropolitan Sydney, but no funded positions in regional areas beyond Wollongong and Newcastle.[608]

5.155 Ms Bianchi explained that specialist training is required to become an Extended Care Paramedic and their primary role is to treat low acuity patients and if suitable refer them to non-emergency department pathways. Extended Care Paramedics are able to provide initial wound management, suturing, reset dislocations, apply plaster and fiberglass splints, replace urinary catheters and gastronomy feeding tubes as well as antibiotic treatment for skin conditions and for community-acquired pneumonia.[609]

5.156 Further, Ms Bianchi explained that when Extended Care Paramedics are sent to the right patients, the recognition and management of minor illnesses and minor injury can occur without the need for presentation at an emergency department and subsequent hospitalisation.[610]

5.157 At the other end of the spectrum, the committee heard that Intensive Care Paramedics develop specialised skills such as airway management, intubation, pain management and can administer drugs, such as ketamine, fentanyl, and midazolam, at high doses over extended periods.[611] The Health Services Union NSW ACT QLD explained that these skills can be essential during patient transport and that this expanded scope of practice allows Intensive Care Paramedics to

604 Evidence, Mr Beaton, 10 September 2021, p 10.
605 Submission 257, Health Services Union NSW ACT QLD, pp 10-11.
606 Submission 664, Australian Paramedics Association (NSW), p 9.
607 Submission 275, Australasian College of Paramedicine, p 2.
608 Evidence, Ms Bianchi, 10 September 2021, p 11.
609 Evidence, Ms Bianchi, 10 September 2021, p 11.
610 Evidence, Ms Bianchi, 10 September 2021, p 11.
611 Submission 257, Health Services Union NSW ACT QLD, p 12.

take on higher level clinical decision making, helping to fill some of the gaps for smaller communities.[612]

5.158 However, the Union highlighted significant barriers for those wishing to work as Intensive Care Paramedics in non-metropolitan areas, including barriers to accessing the specialised two-year training which takes place in Sydney, and that those that attain the qualification are prevented from transferring to non-metropolitan stations unless they accept a position in a less qualified role.[613]

5.159 While acknowledging the NSW Government's June 2021 announcement of 203 Intensive Care Paramedics over four years for regional locations, Mr Beaton expressed concern that it is not a large enough increase and that the majority of the newly trained Intensive Care Paramedics will be placed in larger coastal emergency department centres, not in smaller communities.[614]

5.160 Looking to solutions, in addition to increased utilisation of Extended Care Paramedics and Intensive Care Paramedics, the Australasian College of Paramedicine suggested that in order to make the most of the oversupply of paramedicine graduates, consideration should be given to employing paramedics outside of the scope of ambulance services and utilising their skills in community settings.[615]

5.161 As described by Mr Lovett in evidence, a community paramedic's scope of practice could be focused on providing holistic, evidence-informed primary and preventative health care, as well as urgent and emergent care.[616] Mr Lovett went further to describe how this model could work in practice by supporting Local Health Districts, GPs and other health practitioners to deliver patient centred care:

> Community paramedics could be employed in the community by ambulance services, by local health districts, by private health clinics, all contributing and supporting the activities of other health professionals in delivering quality, patient-centred care. We propose that community paramedics would work as part of a multidisciplinary team, delivering team-based care in partnership with general practitioners, specialist community nurses, hospitals and local health districts.[617]

5.162 In response to this situation NSW Health confirmed in its supplementary submission that under the NSW Ambulance 2021-2026 strategic plan, community paramedics will assist the service to become a mobile integrated health service, and there is potential for paramedics to be utilised proactively to fill critical gaps and work alongside other health professionals.[618]

612 Submission 257, Health Services Union NSW ACT QLD, pp 12-13.

613 Submission 257, Health Services Union NSW ACT QLD, p 11; Evidence, Mr Beaton, 10 September 2021, p 9.

614 Evidence, Mr Beaton, 10 September 2021, p 9.

615 Evidence, Mr Lovett, 10 September 2021, p 10.

616 Evidence, Mr Lovett, 10 September 2021, p 10.

617 Evidence, Mr Lovett, 10 September 2021, p 10.

618 Submission 630a, NSW Government, p 11.

Virtual care

5.163 A notable issue explored throughout the inquiry was the use of virtual models of care, specifically telehealth, in place of in-person services. In New South Wales virtual care includes telehealth, telemedicine, eHealth technologies, artificial intelligence and digital health.[619]

5.164 The terms virtual care and telehealth were used synonymously throughout the inquiry.

5.165 This section of the report explores the views of members of the community, unions, clinicians and NSW Health.

Community perspective

5.166 While acknowledging that virtual care can play a positive role in the provision of health services as demonstrated most recently during the COVID-19 pandemic,[620] inquiry participants also expressed concerns about the way virtual care systems are utilised in New South Wales with the potential to substitute telehealth for face-to-face care. These concerns primarily focused on a perceived overreliance on telehealth for primary and emergency care, poor experiences eroding confidence in the system, a lack of communication from the Local Health Districts and the limited infrastructure available in some communities to support this technology.

5.167 Numerous community members expressed unease about the perceived overuse of virtual care and telehealth as a substitute for GP and/or emergency services. For example, the committee heard that:

- 'Telehealth and remote monitoring are increasingly being touted as the cure all solution. These service models can be very useful and compliment improved care but cannot ever replace a lack of basic on-site specialist services at all major regional hospitals'.[621]
- 'What we need is doctors on the front line to actually diagnose that to see whether they need to be going to those specialists and whatnot. We do not have that. … We have got a doctor on telehealth for the most basic things'.[622]
- '[Telehealth] has a role to play for rural and remote patients but it cannot be the only Doctor service source. Great in an emergency situation to have a medical specialist guide the GP if the situation requires in trauma situations but it cannot be the main medical source'.[623]

619 Submission 630, NSW Government, p 27.

620 See for example: Submission 107, Family Planning NSW, p 5; Submission 173, Cancer Council NSW, p 23; Submission 181, Deniliquin Mental Health Awareness Group, p 4; Evidence, Mrs Tanya Forster, Psychologist and Director, Macquarie Health Collective, 19 May 20021, p 32; Submission 385, Mission Australia, p 10.

621 Submission 508, Name suppressed, p 1.

622 Evidence, Ms Jenny Tyack, Chair, Doctor Crisis Condobolin, 30 April 2021, p 32.

623 Submission 549, Name suppressed, p 1.

- 'I think the overwhelming feeling that the deployment of this service is leaving people with is that they now feel that the health service deems them not worthy of physical face-to-face health care'.[624]
- 'Council is concerned that Telehealth, while is a great initiative to support local GP's, is being used to replace doctors in rural communities as a cost saving measure'.[625]

5.168 In addition, several inquiry participants expressed concern about the increased reliance on nurses to go beyond their scope of practice as a consequence of the provision of virtual care with no doctor onsite.[626]

5.169 In terms of individual experiences of telehealth, the committee heard numerous accounts of poor experiences, eroding confidence in the system. For example, at its hearing in Cobar, Mrs Annie Ryan, Deputy Chair, Doctor Crisis Condobolin provided an account of a misdiagnosis at Condobolin District Hospital:

> The Telehealth doctor told me I had gastro when I actually had appendicitis. I believe the nurse thought it was a serious stomach issue however was over ruled by the tele health doctor. Unhappy with this diagnosis I travelled to Forbes hospital (100km away) where a doctor assessed me in person then admitted me and commenced treatment for an infection. Further testing found it was to be appendicitis. My appendix were then removed 5 days later. This potentially fatal mistake I believe could have been averted if there was a doctor in person at Condobolin emergency department.[627]

5.170 Inquiry participants also told the committee of telehealth practitioners requesting diagnostic procedures for patients such as x-rays that are then unavailable at the facility at which the patient is located, highlighting a lack of local knowledge.[628]

5.171 There was also a sense of frustration expressed about the seeming lack of transparency from Local Health Districts, and in some cases, local General Practitioners, regarding when virtual care is the sole means of medical assistance in a community:

> We are just not clear of when the doctor will be available in the hospital and when there will be telehealth. It is all part of this commercial-in-confidence nonsense that goes on. We need to know in our town what services are available and when they are available, and not to know is really stupid.[629]

624 Evidence, Dr Neil McCarthy, Private individual, 19 May 2021, p 26.
625 Submission 632, Hay Shire Council, p 1.
626 Evidence, Mrs Kristyn Paton, 19 March 2021, p 32, see also Evidence, Ms Tyack, 30 April 2021, p 29.
627 Evidence, Mrs Annie Ryan, Deputy Chair, Doctor Crisis Condobolin, 30 April 2021, p 31.
628 Evidence, Mrs Sharelle Fellows, Private individual, 18 May 2021, pp 30-31.
629 Evidence, Dr Kitty Eggerking, Member, Gulgong Petitioners, 18 May 2021, p 29.

5.172 The effectiveness of telehealth was also called into question in light of concerns about technological limitations such an internet connectivity,[630] electricity supply[631] and lack of infrastructure[632] in rural, regional and remote areas.

5.173 Despite these concerns, the overwhelming consensus among individual inquiry participants was that telehealth and virtual care plays a valuable role when used to support primary or emergency health care, as opposed to replacing face-to-face roles.[633]

Clinician perspective

5.174 The committee heard from clinicians across a variety of fields who expressed support for telehealth and virtual care, provided it is used appropriately.

5.175 For example, The Royal Australian College of General Practitioners,[634] the Australian College of Rural and Remote Medicine[635], the Australian Medical Association[636] and the National Rural Health Alliance[637] all indicated that telehealth and virtual care have an important role to play in the health system.

5.176 As well as allowing for specialist care to be delivered remotely, the committee heard that virtual care models also allow complementary services to be delivered to those who may not be able to access these services face-to-face or during business hours,[638] and support practitioners to continue to practice in regional, rural and remote locations.[639]

5.177 However, echoing the concerns heard from community members, stakeholders from the medical profession emphasised that the benefits of virtual care can only be realised when that care supplements medical practitioners who are present on the ground.

5.178 For example, Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council expressed the view that while virtual care can be a very powerful tool, technology cannot replace the bedside clinician. Rather, its strength lies in creating links between specialists and onsite practitioners who maintain continuity of care for the patient:

630 Evidence, Dr Culbert, 29 April 2021, p 52, see also, Evidence, Mr George Thompson, Member, Coraki Health Reference Group, 17 June 2021, p 8.

631 Submission 537, Name suppressed, p 2.

632 Submission 571, Regional Medical Specialists Association, p 8.

633 See for example: Submission 549, Name suppressed, p 1; Submission 479, Isolated Children's Parents' Association of New South Wales Inc., p 3.

634 Evidence, Dr Michael Clements, Chair – Rural, The Royal Australian College of General Practitioners, 19 March 2021, p 16.

635 Evidence, Dr Rod Martin, Rural Generalist, Australian College of Rural and Remote Medicine, 19 March 2021, p 26

636 Answers to questions on notice, Dr Danielle McMullen, President, Australian Medical Association, 19 April 2021, p 1.

637 Evidence, Ms Colette Colman, Director, Policy and Strategy Development, National Rural Health Alliance, 19 March 2021, p 7.

638 Evidence, Mrs Forster, 19 May 2021, p 32.

639 Evidence, Professor Pat Giddings, Chief Executive Officer, Remote Vocational Training Scheme, 10 September 2021, p 47.

> These are all powerful tools and excellent programs that can achieve big gains, but those programs link with local clinicians. They do not replace them; they are bringing a specialist to the bedside. They are bringing specialist care over the top of basic healthcare services. You have still got doctors and nurses and paramedics caring for those patients. You are bringing additional assistance to those clinicians and helping them care for patients.
>
> … Where telehealth can be quite rightly criticised is, you cannot replace always a hands-on approach and there are certain things telehealth cannot do. Telehealth must link with local clinicians. It has got to provide structure for ongoing care and ongoing assessment.[640]

5.179 Along similar lines, Dr Tony Sara, President, Australian Salaried Medical Officers' Federation NSW argued that while telehealth offers opportunities for the flexible delivery of health care, the quality of the staff at either end of the technology is essential:

> Telehealth can deliver better flexible modes of health services, but it must be staffed adequately. We underline that and put it in bold letters, Chair. The equipment is there in many rural places but the networked system of providing comprehensive, stable, senior clinician support is very often lacking. Let us be clear: Telehealth does not deliver quality care; the staff do, the doctors and the nurses. You need staff at the sending end who are trained in what telehealth is and how you use it, and you need senior doctors at the other end to interpret, assist and coach the doctor and the nurses at the sending end. Those models are not yet stable and well supported enough to be a system you can always rely on.[641]

5.180 On a related note, the committee heard that where workforce shortages have led to no doctors on site, the increased use of telehealth and virtual care technologies has placed greater responsibility on nurses,[642] as Mr Brett Holmes, General Secretary, New South Wales Nurses and Midwives' Association, explained:

> The shift to an increasing reliance on virtual doctors or telehealth does not acknowledge the fact that this has removed the very important pair of hands that doctors were once able to provide when they responded to calls for emergencies. And there has been no recognition that nurses are now forced to try and replace the hands of the doctors during these virtual referrals, as well as doing their own nursing role. It becomes an increasingly impossible task when you have an emergency such as a cardiac arrest.[643]

5.181 Dr Justin Bowra, Founder & Medical Doctor, My Emergency Doctors, an organisation that provides virtual care services, confirmed that the use of telemedicine in such a manner is contrary to best practice:

> I think there is a belief, and it is very understandable, that the tele-emergency, when people are talking about it in rural and regional communities, is talking to a doctor

640 Evidence, Dr Arnold, 5 October 2021, p 16.

641 Evidence, Dr Tony Sara, Australian Salaried Medical Officers' Federation NSW, 19 March 2021, p 43.

642 Evidence, Dr Sara, 19 March 2021, p 43, see also Evidence, Mrs Paton, 19 March 2021, p 32; Evidence, Ms Staggs, 18 May 2021, p 14.

643 Evidence, Mr Brett Holmes, General Secretary, New South Wales Nurses and Midwives' Association, 19 March 2021, p 30.

> through an app instead of an onsite doctor. It is not about that. The onsite doctor is there and the patient is there and their family is there and they are all there and the specialist is beamed in and they are by their side and they are making it better. They are improving patient care.[644]

5.182 In terms of improving the patient experience, Professor Brigid Heywood, Vice-Chancellor and CEO, University of New England, highlighted the need for patients to be educated about how virtual care operates and the best way to engage with it effectively, observing that this could be 'as simple as just having a checklist in front of you so that you, the patient, knew how to conduct yourself in that situation and were not overwhelmed with the anxiety of … engaging with technology'.[645]

NSW Health perspective

5.183 In its submission to the inquiry, NSW Health stated that virtual care 'is considered a safe, effective and reliable alternative to many conventional methods of delivering health care',[646] explaining that:

> Patient-centred, clinician-led virtual care provides an efficient and effective model of care that may complement, or supplement face-to face consultation. Alternatively, it may increase access to care by providing patients the option to have care delivered at a distance, where it is clinically appropriate.[647]

5.184 In evidence to the inquiry, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health told the committee that NSW Health's approach to the use of telehealth is one of collaboration not substitution:

> The first thing I want to say is that we do not see telehealth or virtual care as being a substitute for having face-to-face, on-the-ground clinicians. Our primary focus is to have those health professionals available in the communities to provide face-to-face care. The virtual care and telehealth is actually used to support those on-the-ground clinicians. That is the focus, to enable them to have access to information, to have backup from people who have got expertise and capability to help them deliver optimal care to their patients in the environment in which they work.[648]

5.185 When asked about the concerns expressed about the apparent over-use of virtual care technologies in rural settings, Dr Lyons reflected that this may be due to the lack of face-to-face practitioners in some communities:

> This over-reliance would be a perception because there is not a face-to-face clinician available. As I have said, our efforts are focused first and foremost in making sure that

644 Evidence, Dr Justin Bowra, Founder & Medical Doctor, My Emergency Doctors, 19 May 2021, p 40.

645 Evidence, Professor Brigid Heywood, Vice-Chancellor and Chief Executive Officer, University of New England, 10 September 2021, p 47.

646 Submission 630, NSW Government, p 27.

647 Submission 630, NSW Government, p 27.

648 Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 19 March 2021, p 61.

> we have got health professionals available in the communities, but if they are not available then having the telehealth and virtual care as a backup to support the clinicians who are there. My sense would be that this is reflecting the concern that rural communities have about not having a doctor in their town or not having somebody who is available for after-hours call at the MPS or the small rural hospital.[649]

5.186 In this regard, NSW Health confirmed that where doctors are not available at a hospital or Multipurpose Service, nurses are supported using virtual care systems[650] and that the use of virtual care is being expanded across metropolitan, rural and regional areas.[651]

5.187 At a subsequent hearing, Mr Scott McLachlan, then Chief Executive, Western NSW Local Health District, acknowledged that this significant change in the way medical services are delivered can cause unease:

> We absolutely understand the concern of rural communities. Things have changed over the last 15 and 20 years and that does create fear and concern for the communities. We have done a lot of things to try and return services to country towns that have changed over recent years. Some of that is in face-to-face services and some of it is in virtual services. I said before things are going to continue to change, probably at a greater rate of knots into the future. We know that does create concern and fear in communities.[652]

5.188 At the committee's final hearing, Dr Lyons informed the committee that, in order to start to change this perception, NSW Health has encouraged individual patients to share positive stories of their experiences with telehealth and has committed to providing the community with evidence about clinical outcomes to 'give people confidence that this is actually delivering better care than they would otherwise be able to receive'.[653]

5.189 Additionally, NSW Health reported that a recent survey conducted by The Bureau of Health Information found that of 4,500 adults who were admitted to 98 small rural public hospitals from July 2019 to June 2020, 13 per cent of these patients has received subsequent care via telehealth. 92 per cent of these patients said they had benefited from these services and 89 per cent rated telehealth as a good or a very good way of receiving care.[654]

5.190 Furthermore, Dr Lyons confirmed that virtual care/telehealth is a service that NSW Health will continue to provide, in recognition of:

- the fact that '[t]here would be no way that we would be able to provide that level of specialist knowledge and input into the care without the support of telehealth'[655]

649 Evidence, Dr Lyons, 19 March 2021, p 62.
650 Evidence, Dr Lyons, 19 March 2021, p 58.
651 Submission 630, NSW Government, p 27.
652 Evidence, Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, 30 April 2021, p 44.
653 Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, 2 February 2022, p 18.
654 Evidence, Dr Lyons, 2 February 2022, pp 16-17.
655 Evidence, Dr Lyons, 2 February 2022, p 17.

- the financial and social benefits to the patient, including the fact that it reduces the requirement for patients to travel[656] and can reduce professional isolation and foster multi-disciplinary teamwork between primary and hospital-based care.[657]

Committee comment

5.191 In rural, regional and remote New South Wales, access to the specific health services discussed in this chapter does not always accord with community need. We acknowledge that it is challenging to provide equitable access to residents living across such a large geographical area. However overall, more must be done to ensure that regardless of postcode, residents can seek, access and receive treatment in a timely and cost-effective manner.

5.192 Once again, the theme of staffing issues dominated the discussion about the challenges faced by oncology, palliative care and allied and other health service providers. The committee is extremely concerned about the disproportionately low numbers of many of these health professionals working in rural, regional and remote areas, and the resulting barriers for patients to access these important services.

5.193 The exact same challenges that are encountered when attempting to recruit GPs and nurses to rural areas are replicated, and perhaps amplified, when recruiting for specialist positions and services. The impact of these workforce challenges on individuals – the stories of individuals having to wait weeks, months and sometimes years, or having to travel many thousands of kilometres to access critical services, are troubling and need to be addressed. The committee also acknowledges the significant stress this situation places on the dedicated practitioners that continue to operate under these circumstances.

5.194 The committee recognises that while there are a number of unique challenges faced by the oncology, palliative care and allied and other health services sectors, at the heart of the problem is the fact that there are simply not enough health professionals to meet community need in rural areas.

5.195 Consequently, the committee finds: that there is a critical shortage of health professionals across rural, regional and remote communities resulting in staffing deficiencies in hospitals and health services; that health and hospital staff are strongly committed to improving health outcomes for their patients, but they are constrained by a lack of resourcing from the NSW and Australian governments; and that that there has been a historic failure by various NSW and Australian governments to attract, support and retain health professionals especially doctors and nurses in rural, regional and remote areas.

Finding 9

That there is a critical shortage of health professionals across rural, regional and remote communities resulting in staffing deficiencies in hospitals and health services.

656 Evidence, Dr Lyons, 2 February 2022, p 17.

657 Submission 630a, NSW Government, p 14.

Finding 10

That health and hospital staff are strongly committed to improving health outcomes for their patients, but they are constrained by a lack of resourcing from the NSW and Australian governments.

Finding 11

That there has been a historic failure by various NSW and Australian governments to attract, support and retain health professionals especially doctors and nurses in rural, regional and remote areas.

5.196 In this regard, we refer to the more general workforce recommendations made in Chapter 3 and 4, such as increasing staffing numbers; rolling out a single employer model; a review of working conditions, contracts and incentives; the provision of training opportunities in rural and regional locations; and formalising professional development opportunities. While the implementation of these reforms cannot be done overnight, the committee is hopeful that such a holistic strategy will ultimately improve the current workforce challenges experienced across the oncology, palliative and allied health sectors.

5.197 The evidence presented to the committee regarding out of pocket costs was alarming. In particular, evidence that a significant proportion of cancer patients are experiencing severe financial distress as a result of accessing cancer treatment and stories of patients choosing to forego life-saving treatments entirely because they simply cannot afford to pay for them.

5.198 The committee acknowledges evidence that public-private partnerships could contribute to the increased cost burden for cancer patients. As such the committee recommends that NSW Health investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services while reducing out-of-pocket costs.

Finding 12

That cancer patients in New South Wales face significant out of pocket costs which is resulting in patients experiencing severe financial distress and/or choosing to skip life-saving cancer treatments.

Recommendation 21

That NSW Health working with the Commonwealth and all relevant service providers investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services while reducing out-of-pocket costs.

5.199 A common theme emerging from the evidence across the oncology, palliative and allied health sectors was that communication between the various providers that support an individual's progress through treatment was very limited, often leading to poorer outcomes for patients. The nature of oncology, palliative care and allied and other health services supported care and treatment is necessarily multidisciplinary and fragmented. The committee was disappointed to hear repeated accounts of breakdowns in communication that meant patients were lost in the system, experiencing inconsistency of care and additional costs. Good communication between providers, especially for individuals undergoing significant treatment and moving through systems with different jurisdictional responsibilities, is essential.

5.200 As such, the committee recommends that NSW Health and the Local Health Districts work with the Primary Health Networks and other partners to promote improved communication between service providers, including through the use of shared medical record systems.

Recommendation 22

That NSW Health and the rural and regional Local Health Districts work with the Primary Health Networks and other partners to promote improved communication between service providers, including through the use of shared medical record systems, in order to ensure continuity of care for patients.

5.201 In relation to palliative care specifically, the committee finds that there is a lack of palliative care and palliative care services in rural, regional and remote New South Wales.

Finding 13

That there is a lack of palliative care and palliative care services in rural, regional and remote New South Wales.

5.202 Further to the issue of sector knowledge and communication, the committee was disturbed to hear that the palliative care sector cannot actually quantify how many practitioners deliver care, what level of training these practitioners have, what is the specialist nursing workforce, what is the size of the volunteer network and what the clinical outcomes are. There is also a clear need for an agreed, uniform state-wide platform for the collection of palliative care and end of life care data to allow for clinical benchmarking of regional palliative care services.

5.203 Therefore, the committee recommends that NSW Health, in conjunction with The Australian and New Zealand Society of Palliative Medicine, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians and the Aboriginal Health and Medical Research Council of NSW urgently establish a taskforce to: plan palliative care access and services of equivalence to those living in metropolitan areas; map who is currently providing palliative care services and their level of training as well as where these services are offered; establish an agreed, uniform state-wide platform for the collection of palliative and end of life care data; investigate and promote innovative models of palliative care services; and ensure culturally appropriate palliative care services are available to First Nations peoples.

Recommendation 23

That NSW Health, in conjunction with The Australian and New Zealand Society of Palliative Medicine, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians and the Aboriginal Health and Medical Research Council of NSW urgently establish a palliative care taskforce to:

- plan palliative care access and services of equivalence to those living in metropolitan areas
- map who is currently providing palliative care services and their level of training, as well as where these services are offered
- establish an agreed, uniform state-wide platform for the collection of palliative care and end of life care data to allow for clinical benchmarking of regional palliative care services
- investigate and promote innovative models of palliative care services
- ensure culturally appropriate palliative care services are available to First Nations peoples.

5.204 The committee acknowledges and welcomes the innovative service delivery methods being trialled and introduced across a number of the disciplines. Example such as the Remote Video Assisted Chemotherapy Service, the palliative model of care and framework known as ePAF, and the increased adoption of HealthOne facilities are prime examples of patient-centred care that actively address the real challenges of operating across wide geographical areas with limited resources. The committee commends these initiatives and encourages each of the sectors to critically review their operations to continue to look for ways to improve and expand service delivery.

5.205 In relation to palliative care specifically, we recommend the expansion of the Far West NSW Palliative and End-of-Life Model of Care across other rural and remote settings.

Recommendation 24

That NSW Health and the rural and regional Local Health Districts expand the Far West NSW Palliative and End-of-Life Model of Care to other rural and remote settings across New South Wales.

5.206 In relation to allied health, we urge NSW Health to finalise the workforce plans currently being developed across 14 allied health professions as quickly as possible.

5.207 The committee was very concerned by the number of stakeholders who raised the issue of the lack of adequate mental health services in rural, regional and remote New South Wales. The committee believes it is unacceptable that this unmet demand for mental health services contributes to greater than average rates of high or very high psychological distress in adults and higher suicide and intentional self-harm hospitalisation rates. However, as mental health services in rural, regional and remote New South Wales were not within the Terms of Reference for this inquiry, the committee was unable to explore the issue with the thoroughness it deserves. Hence, the committee recommends that Portfolio Committee No. 2 - Health consider undertaking an inquiry into mental health, including into mental health services in rural, regional and remote New South Wales in the future.

Recommendation 25

That Portfolio Committee No. 2 – Health consider undertaking an inquiry into mental health, including into mental health services in rural, regional and remote New South Wales in the future.

5.208 In relation to maternity services, the support and care given to women before, during and after birth must be a key priority, and be of the highest possible standard across all areas of the state. That women living in rural, regional and remote areas do not have access to the same standard of maternity care than their counterparts in metropolitan cities is unacceptable. One way to overcome some of these barriers would be to implement the midwifery continuity of care model in regional, rural and remote communities.

5.209 Accordingly, the committee recommends that the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales. Further, the committee recommends that the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.

Recommendation 26

That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.

Recommendation 27

That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.

5.210 When exploring the issue of ambulance services, the committee was concerned to hear how entire rural and remote communities are left exposed and without support while paramedics are required to undertake patient transfers. That is not to say that some of these transfers are not absolutely necessary for the health and wellbeing of the patient, however the associated service gaps appear to have reached critical levels in some areas.

5.211 The committee is further troubled by the number of accounts provided by the community and paramedics themselves documenting the time it takes for an ambulance to attend an incident and the distances many of the crews had to travel to provide that care. The community knows that paramedics have their best interests at heart however they are losing faith that they will be there in their hour of need.

5.212 Accordingly, the committee finds that a lack of regional Patient Transport Services is being supplemented by Ambulance NSW, resulting in paramedics frequently attending patients who

do not require emergency care and reducing Ambulance NSW's capacity to respond to emergencies, and that this comes at great cost to patient and paramedic safety. The committee therefore recommends that NSW Health in conjunction with NSW Ambulance and unions review the use of ambulance vehicles for patient transfers, and in partnership with the Local Health Districts explore extending the hours of operations of patient transfer vehicles to provide 24-hour coverage and minimise the number of low-acuity jobs that paramedics attend to, to relieve pressure on ambulance crews.

Finding 14

That a lack of regional Patient Transport Services is being supplemented by Ambulance NSW, resulting in paramedics frequently attending patients who do not require emergency care and reducing Ambulance NSW's capacity to respond to emergencies, and that this comes at great cost to patient and paramedic safety.

Recommendation 28

That NSW Health in conjunction with NSW Ambulance and unions review the use of ambulance vehicles for patient transfers, and in partnership with the rural and regional Local Health Districts explore extending the hours of operations of patient transfer vehicles to provide 24-hour coverage and minimise the number of low-acuity jobs that paramedics attend to, to relieve pressure on ambulance crews.

5.213 The committee acknowledges that the lack of health care practitioners in some rural communities has led to an increased reliance on paramedics to provide primary care services. This, in conjunction with excessive overtime due to lack of staff, an overreliance on off-duty colleagues to fill staffing gaps and being required to undertake other non-core ambulance tasks is leading to increased dissatisfaction and burn out.

5.214 Additionally, the committee was surprised to hear that paramedics in regional, rural and remote locations were not, until recently, being provided with the opportunity to further their careers as Intensive Care Paramedics. We welcome recent announcements around support for a community paramedic program and the placement of Intensive Care Paramedics in regional locations, however we find that there are significant barriers to the training and deployment of Extended Care and Intensive Care Paramedics in rural, regional and remote New South Wales despite the fact that these roles would provide significant health benefits in those communities.

5.215 In order to address under-staffing issues more broadly, the committee recommends that NSW Health in conjunction with NSW Ambulance: undertake a community profiling program across rural, regional and remote New South Wales to identify the paramedic needs of communities; ensure the equitable distribution of paramedics at all levels, including Extended Care and Intensive Care Paramedics and update ambulance deployment modelling to reflect present day demand, ensuring that ambulances are deployed as rostered; expand the Intensive Care and Extended Care Paramedics program across rural, regional and remote New South Wales and allow paramedics outside metropolitan areas to undertake training, skills consolidation and skills maintenance locally; explore innovative models of care utilising the skill sets of paramedics to

better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor; and undertake a review of the efficacy of the current call triaging system and referral services.

Finding 15

That there are significant barriers to the training and deployment of Extended Care and Intensive Care Paramedics in rural, regional and remote New South Wales despite the fact that these roles would provide significant health benefits in those communities.

Recommendation 29

That NSW Health in conjunction with NSW Ambulance:

- undertake a community profiling program across rural, regional and remote New South Wales to identify the paramedic needs of communities
- ensure the equitable distribution of paramedics at all levels, including Extended Care and Intensive Care Paramedics and update ambulance deployment modelling to reflect present day demand, ensuring that ambulances are deployed as rostered
- expand the Intensive Care and Extended Care Paramedics program across rural, regional and remote New South Wales and allow paramedics outside metropolitan areas to undertake training, skills consolidation and skills maintenance locally
- explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor
- undertake a review of the efficacy of the current call triaging system and referral services.

5.216 On the issue of virtual care, there was clear consensus from communities, clinicians and NSW Health that virtual care has an increasingly important role to play in the health system, and delivers clear benefits for rural communities, including giving some communities access to specialised care that may otherwise not be available, and providing a level of convenience to patients who can access care at their own doorstep, rather than having to travel long distances.

5.217 However, the committee heard again and again – both from members of the community and health professions – that virtual care in the first instance should only be used to support and supplement onsite practitioners, rather than replacing face-to-face services.

5.218 Indeed, while there was no evidence to the inquiry suggesting that virtual care should replace in-person care, the fact remains that cost pressures will naturally drive consideration regarding how it can be deployed to make savings where possible. There is an inherent tension that is not easily reconciled.

5.219 Accordingly, the committee finds that the introduction and use of virtual care is an important new innovation. However, it must not be used as a basis to reduce or substitute for face-to-face health services and care, but rather complement and enhance them.

Finding 16

That the introduction and use of virtual care is an important new innovation. However, it must not be used as a basis to reduce or substitute for face-to-face health services and care, but rather complement and enhance them.

5.220 It was also disappointing to hear that the use of virtual care technology does not always follow best practice. Nurses have been pressured to make judgements and decisions beyond their training and competency , the technology and infrastructure used to support virtual care can be unreliable or not available in some locations, and poor experiences are eroding confidence in a system that has the potential, when used appropriately, to provide timely care to those who may not be able to access services via other means.

5.221 The committee recognises and indeed supports the fact that virtual care will be an ongoing service delivery method in the future, particularly in rural and remote areas. However, in order to ensure that it is used to best effect, the committee recommends that NSW Health: commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities; commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services; roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer; ensure that staff are provided with training to effectively use telehealth and other virtual models of care; create a public information campaign specifically targeted to rural, regional and remote communities to assist patients to effectively engage with virtual care; ensure that the use of virtual care if required is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas; and investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.

Recommendation 30

That NSW Health:

- commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities
- commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services
- where virtual models of medical care are operating, roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer
- provide staff members with training on how to effectively use telehealth and other virtual models of care
- create a public information campaign specifically targeted to rural, regional and remote communities in order to assist patients to effectively engage with virtual care, including factsheets and checklists to set expectations and support positive interactions
- ensure that the use of virtual care, if required, is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas
- investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.

Chapter 6 Health services for First Nations people

This chapter examines the impact of health and hospital services in rural, regional and remote New South Wales on First Nations people, including their ability to access services in a culturally safe way, workforce and training issues, service delivery models, and partnerships with Aboriginal Community Controlled Health Services.

Overview

6.1 In its submission to the inquiry, the Aboriginal Health and Medical Research Council of NSW stated that approximately one third of the national total of First Nations people live in New South Wales, with 145,000 people residing outside of Greater Sydney.[658]

6.2 As touched on in Chapter 1, the committee heard that Aboriginal Australians generally experience poorer health outcomes and have a lower life expectancy than non-Aboriginal Australians.[659] In addition, Aboriginal people experience a higher level of burden of disease which may require a higher number of episodes of care.[660]

6.3 In terms of accessing health and hospital services, while the same challenges that were explored in Chapter 2 also apply to Aboriginal and Torres Strait Islander people living in regional, rural and remote communities, Mr Bob Davis, Chief Executive Officer, Maari Ma Health elaborated on additional social and cultural barriers:

> There are also a range of issues relating to both social and cultural in terms of health that hamper Aboriginal people accessing care, including experiences of discrimination, racism and poor communication with healthcare professionals, a lack of affordable transport and healthcare services, the perceived lack of confidentiality, a lack of culturally appropriate services and information on available services, and different perceptions and understanding of health, illness and treatment. Together, these difficulties make the navigation of a fractured and complex health system that is poorly suited to remote communities and smaller populations a very big ask, indeed.[661]

6.4 Some of these challenges were also highlighted by Ms Stacey O'Hara, Committee Member, Murrumbidgee Aboriginal Health Consortium, who nevertheless identified the biggest barrier to accessing care as being a lack of local services:

> Accessing health services in the bush has always been a challenge for Aboriginal people. Where mainstream services are available, a lot of our community are reluctant to access them due to a past history of being excluded and marginalised. But perhaps the biggest obstacle is the actual lack of local services, particularly in our more remote communities. A lot of communities need travel to access services and, in some cases, do not have the means to travel the 200 or 300 kilometres, particularly those who rely on Centrelink payments. Even those in paid employment often have exorbitant living costs and must

658 Submission 265, Aboriginal Health and Medical Research Council of NSW, pp 3-4.

659 Evidence, Ms Stacey O'Hara, Committee Member, Murrumbidgee Aboriginal Health Consortium, 6 October 2021, p 25.

660 Submission 265, Aboriginal Health and Medical Research Council of NSW, p 2.

661 Evidence, Mr Bob Davis, Chief Executive Officer, Maari Ma Health, 2 December 2021, p 44.

prioritise whether or not accessing medical treatment is more important than feeding the family or registering the car.[662]

6.5 In terms of the services available, in addition to mainstream public and private services, First Nations people in regional, rural and remote New South Wales can also access healthcare through Aboriginal Community Controlled Health Services (also known as Aboriginal Community Controlled Health Organisations).[663] These organisations provide culturally safe primary health care programs and services including health checks, as well as addressing social and welfare needs.[664]

6.6 Approximately 70 per cent of the core funding for Aboriginal Community Controlled Health Services comes from the Australian Government, with approximately 15 per cent from NSW Health and the remainder from self-generated money.[665]

6.7 Despite the availability of multiple services in some locations, the committee heard from Wilcannia community members Aunty Monica Kerwin and Mr Michael Kennedy, who expressed their frustration and disappointment with the availability of, and lack of communication between, the health services in their area.

Case study: Aunty Monica Kerwin

I was born and raised in Wilcannia. I grew up there, lived there all my life and never moved away … I am a Maari Ma client. They get funding because I am a statistic. But they have not been doing what they supposed to do in our community regarding mental health, and not only mental health but a lot of the other underlying health issues—chronic disease. We have a lot of things around. A lot of our people have got chronic disease, diabetes, heart troubles and all of this. Then we got hit with a virus. Not one of them came to the table to even do a little simple welfare check on people.

We see a lot of the assets in our community—their pools of cars, their houses—but we do not see what they are supposed to be servicing us with. We do not see the clinics on the ground, the home visits … we need a lot of mental health on the ground building relationships with people …. We like to talk face to face.

But I think we need to know that you actually genuinely care as opposed to somebody who will dial in and we say they are only in the job for pay packet. So I am angry with Health. I am. And it is not just with the mental health side; it is right across the board … People are dying. People are dying, and not from COVID, not from a disease but from all the other things that they have been denied.

The Government needs to listen a lot more to grassroots people on the ground—not an employee in an organisation that is government funded but actual grassroots people living in the daily conditions that we do live in. And we need changes in our health structure. According to statistics that they have, chronic disease—statistics with diabetes. All these areas need to be properly addressed by our health

662 Evidence, Ms Stacey O'Hara, Committee member, Murrumbidgee Aboriginal Health Consortium, 6 October 2021, pp 25-26.

663 Submission 265, Aboriginal Health and Medical Research Council of NSW, p 2.

664 Evidence, Associate Professor Malouf, 5 October 2021, pp 23-24.

665 Evidence, Associate Professor Malouf, 5 October 2021, p 24.

services and the health system under government. The funding needs to be spent properly, according to our community and the people's health issues.

Health plays a vital role, if not the leading role, in our wellbeing and our survival … you go to meetings in your community and you are dictated to by health professionals or people employed in service providers. We do not need dictators. We need the proper health care.

With the three health providers we do have, all of them have a duty of care to the people. You go in there and they palm you off to Maari Ma. You go into Maari Ma; they will palm you off to RFDS [Rural Flying Doctor Service]. We do not know who is supposed to be actually servicing us or providing the service to our community in health—but more, you know, 'Oh, you need to see this one.' But when you question them, you are spoken down to. It is like you throw your hands in the air and walk away and say, 'I don't want to even bother with talking to any one of you.' So a lot of our people are, you know, sick of being mistreated and dictated to, or spoken down to, or like they are goats or cattle.[666]

Case study: Mr Michael Kennedy

What frustrates me the most is, we have got three different health organisations running our community and we are going backwards. Our people die. On average, a male in Wilcannia only lives to 37 years of age; a female, 41, 42 years of age. It is quite alarming that we have three health organisations in Wilcannia and in the year 2021 this is our statistics.

The nearest dialysis machine from Wilcannia is 200 kilometres away. Travel three days a week for dialysis. That is a 1,200-kilometre-a-week trip for them. That is 5,000 kilometres a month that they have to do. We have another lady in Wilcannia, an elder, that is well into her eighties. She has to do the same thing—travel near 5,000 kilometres a month for dialysis.

Us as Aboriginal people, for us to move off our country where we are originally from, that is one of the biggest heartbreaking things that could ever happen to us. We cannot leave our country. We are too spiritually connected to our country, where we are from and which tribe in the country. For Elders like that to move 200 kilometres or 400 or 600 kilometres away for dialysis, that is probably killing them just as much as the actual disease is. Because mentally and spiritually they are disconnected from their country and it breaks our Elders down massively because of that.

It is very frustrating around health out here, with a lot of issues—with suicide, with the amount of travelling that people have to do, and just all of the other underlying health issues that we have in our community.

I think we should be a lot further ahead with three health organisations. But I think one of the main problems is they just simply do not work together. The three organisations are run by different departments. They really do not communicate to one another.

Everyone that is either in our situation or has more serious illnesses and stuff like that, if they cannot deal with them in Broken Hill, then they go down to Adelaide. The only time they'll send them to Dubbo or Sydney is if there's no room or beds or stuff available in Adelaide.

666 Evidence, Aunty Monica Kerwin, Private individual, 2 December 2021, pp 37-41.

> When you drop Wilcannia, it is about a 7½-hour drive. On the bus I think it is closer to eight or nine hours because the bus has to do its stops along the way. To fly down, it is about a 45-minute flight from Broken Hill.[667]

NSW Health perspective

6.8 In its submission to the inquiry, NSW Health stated that it is committed to improving health outcomes for all Aboriginal people, and to continuing to support health service reform through the *NSW Aboriginal Health Plan 2013-2023*.[668]

6.9 Developed in partnership with the Aboriginal Health and Medical Research Council of NSW, the *Aboriginal Health Plan* sets forth the strategic direction for health services in New South Wales to achieve health equity and deliver culturally respectful and responsive services to better meet the needs of Aboriginal people.[669]

6.10 Initiatives contained within the plan include:

- increasing the Aboriginal health workforce with a minimum target of 3 per cent across occupations and salary bands
- strengthening Local Health District performance with Service Agreements incorporating new KPIs to measure cultural safety and experiences of racism
- implementing mandatory cultural respect training
- implementing enhanced accountability mechanisms.[670]

6.11 In relation to accountability mechanisms, NSW Health reported that the Aboriginal Cultural Engagement Self-Assessment (Audit) Tool has been specifically designed to improve Aboriginal health outcomes. The engagement tool supports accreditation of facilities across NSW Health organisations and embeds cultural safety within existing reporting mechanisms across Local Health Districts and Networks.[671]

6.12 Likewise, the *Respecting the Difference: Aboriginal Cultural Training Framework* that commenced in 2011 mandates staff training to support the development of cultural safety and highlights local community and service needs.[672]

6.13 NSW Health acknowledged that the Aboriginal health workforce directly contributes to cultural safety across the health system and is essential to Aboriginal patients achieving improved health and wellbeing outcomes.[673] As at June 2017, NSW Health had employed 3,103 Aboriginal

667 Evidence, Mr Michael Kennedy, Private individual, 2 December 2021, pp 38-43.
668 Submission 630, NSW Government, p 34.
669 Submission 630, NSW Government, p 34.
670 Submission 630a, NSW Government, p 14.
671 Submission 630, NSW Government, p 35.
672 Submission 630, NSW Government, p 50.
673 Submission 630, NSW Government, p 34.

employees which includes 93 doctors, 793 nurses and 376 Aboriginal health workers, including seven Aboriginal health practitioners.[674]

6.14 In order to help boost the Aboriginal workforce, the committee was told that a $21 million investment will fund the recruitment of 18 full time equivalent Aboriginal Care Navigators and 18 full time equivalent Aboriginal Peer Workers to improve the cultural safety of services and promote accessibility for Aboriginal people.[675]

6.15 Additionally, cadetships and scholarships are available to Aboriginal students through the following programs:

- Aboriginal Nursing and Midwifery Strategy
- Aboriginal Allied Health Cadetships
- NSW Rural Medical Officer Cadetship Program
- Aboriginal Medical Pathways Program.[676]

6.16 Furthermore, NSW Health supports Aboriginal Community Controlled Health Services to provide culturally safe and holistic care for Aboriginal people. In 2020-2021, $28 million was provided to 41 organisations.[677] NSW Health has also committed to developing partnerships between Local Health Districts and Aboriginal Community Controlled Health Services in response to an action item in the *2020-2021 NSW Implementation Plan for Closing the Gap*.[678]

Key issues

6.17 This section explores the key issues raised by Indigenous stakeholders namely, the importance of providing culturally safe services, workforce and training issues, different service delivery models, and enhancing partnerships with Aboriginal Community Controlled Health Services.

Cultural safety

6.18 Many submission authors and witnesses stressed to the committee the importance of cultural safety to First Nations people and the detrimental impacts of not providing healthcare in a culturally safe way.[679]

674 Submission 630, NSW Government, p 49.

675 Submission 630a, NSW Government, p 12.

676 Submission 630, NSW Government, pp 47-49.

677 Submission 630, NSW Government, p 34.

678 Submission 630a, NSW Government, p 14.

679 For example, see: Submission 173, Cancer Council NSW, p 10; Submission 254, Australian Association of Social Workers, p 8; Submission 261, The Royal Australasian College of Medical Administrators, p 3; Submission 263, Riverina Murray Regional Alliance, p 2; Submission 391, Office of the National Rural Health Commissioner, pp 14-15; Submission 476, Mental Health Commission of NSW, p 11; Submission 478, National Rural Health Alliance, p 13; Submission 604, Aged and Community Services Australia (ACSA), p 10; Submission 628, National Justice Project, pp 17-18; Submission 706, Just Reinvest, p 4.

6.19 The committee heard that a lack of understanding of Aboriginal history, discrimination and intergenerational trauma have contributed to a sense of reluctance by some First Nations people to seek medical assistance.[680]

6.20 Numerous witnesses described to the committee the impact of discrimination on an individual's choice to seek treatment, for example:

- 'They will not go to the hospital because of the way they are treated because of the colour of their skin. They will not go to the hospital because they are left in their beds for days without even having their sheets changed. No-one has visited them, as in Aboriginal health workers'.[681]
- 'I actually had a client of mine a couple of days ago say to me that she would not go back to the hospital because she is sure if she turned up unconscious they would think she had overdosed. She has not used in eight years, and she has actually had a missed heart attack because she was put in the waiting room as a malingerer'.[682]
- ' … some Aboriginal people sometimes feel that some of the staff in the hospital and emergency do not treat them well. Some people feel uncomfortable and judged, and that they are discriminated against. There is a feeling that people's medical problems are regarded as self-inflicted, due to addiction issues and the like. Some Aboriginal people in Moree feel staff at the hospital are dismissive and do not take their concerns seriously. There are too many stories of people being sent home with very serious conditions and some of the people get very, very sick at home with their very serious conditions, and some people, in fact, have died'.[683]

6.21 In its submission to the inquiry, the National Justice Project echoed these sentiments, observing that the 'continued experiences of racism and lack of adequate care can lead to an expectation of discrimination and avoidance of certain situations and institutions altogether'.[684] The National Justice Project further highlighted that this avoidance can impact on health outcomes, especially when it prevents essential follow up treatment, a situation which is exacerbated by the limited availability of services and the associated lack of choice in rural, remote and regional areas.[685]

6.22 In order to avert this situation, Ms Jenny Lovric, Manager, Community Engagement & Partnerships – Aboriginal Legal Service, Just Reinvest told the committee that in addition to 'supporting the Aboriginal community controlled sector, cultural safety needs to be implemented across the whole spectrum of mainstream services as well'.[686]

680 For example, see: Evidence, Associate Professor Peter Malouf, Executive Director – Operations, Aboriginal Health and Medical Research Council of NSW, 5 October 2021, p 19; Evidence, Ms Jenny Lovric, Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest, 3 December 2021, p 3; Evidence, Ms Ann-Maree Chandler, Owner, Indidg Connect, 19 May 2021, p 14.

681 Evidence, Ms Jamie Keed, Practice Manager, Dubbo Regional Aboriginal Medical Service, 19 May 2021, p 17.

682 Evidence, Dr Amy Perron, General Practitioner, Dubbo Regional Aboriginal Medical Service, 19 May 2021, p 17.

683 Evidence, Ms Lovric, 3 December 2021, p 3.

684 Submission 628, National Justice Project, p 14.

685 Submission 628, National Justice Project, p 14.

686 Evidence, Ms Lovric, 3 December 2021, p 9.

6.23 As noted above, NSW Health has attempted to address this issue through the use of Aboriginal Cultural Engagement Self-Assessment (Audit) Tool and delivering *Respecting the Difference: Aboriginal Cultural Training* to staff.[687]

6.24 When asked about the Aboriginal Cultural Engagement Self-Assessment Tool, Associate Professor Peter Malouf, Executive Director – Operations, Aboriginal Health and Medical Research Council of NSW, explained that cultural safety was about much more than 'ticking a box':

> [Y]ou can have tools to tick off about whether or not a health service is being culturally appropriate, but at the end of the day it is about people and services working closely with community on the ground. When we have people that develop checklists, it really becomes a tokenistic kind of gesture to say that, yes, we have ticked all these boxes to say, yes, we are culturally safe. But are you really? The only way to measure cultural safety is by actually yarning with Elders and community members about their experience of the healthcare system and also seeking their advice and the guidance around what strategies should be applied within the healthcare system.[688]

6.25 With reference to the *Respecting the Difference* cultural awareness training, Associate Professor Malouf noted that the standardised material is not necessarily applicable or suitable for all traditional language groups.[689]

6.26 This point was reiterated by Dr Amy Perron, General Practitioner, Dubbo Regional Aboriginal Medical Service, who emphasised that cultural training must be appropriate for the local community:

> It needs to be local. I know when we did the cultural training for GP training we learned a lot of, 'Don't make eye contact, don't name the dead,' blah, blah, blah. That is okay for the Northern Territory but that is not Wiradjuri. That is not how we do things here. If you are behaving in that way towards an Indigenous person they are going to think you are a goose.[690]

6.27 In evidence, Associate Professor Malouf expanded on the many ways that cultural safety and culturally appropriate care can be provided:

> When we talk about cultural safe care or culturally appropriate care, we are talking about systems and services that acknowledge the history of Aboriginal people as well as their culture. That could be through acknowledging the lands which the building is built upon. It could be staff entering into understanding cultural histories through cultural awareness training or cultural immersion programs. It could be allocating spaces for Aboriginal people, such as a healing garden or spaces where they are connecting to country. That is when we talk about culturally appropriate care. On top of that, it is also about the health system acknowledging cultural-based practices. For mob, we still practise our traditional healing practices. So that needs to be incorporated into whatever

687 Submission 630, NSW Government, pp 35 and 50.
688 Evidence, Associate Professor Malouf, 5 October 2021, p 24.
689 Evidence, Associate Professor Malouf, 5 October 2021, p 24.
690 Evidence, Dr Perron, 19 May 2021, p 19.

care that is given to an Aboriginal patient in the health system. It is acknowledging that they have a right to cultural-based care.[691]

6.28 Specific suggestions for improving the delivery of culturally safe healthcare included:

- Local Health Districts and/or the local facilities engaging with Elders and community members about their experiences and seeking their advice and guidance about what strategies need to be put in place, as well as incorporating local content into their training programs. A positive example of this is the Waminda cultural immersion program for staff from the Illawarra Shoalhaven Local Health District.[692]
- To support First Nations people to feel more comfortable in healthcare facilities, employing Aboriginal people in front of house roles like reception staff,[693] and including Aboriginal artwork[694] and acknowledgements and welcome to country protocols.[695]

6.29 The committee heard that building rapport and cultural safety into the operation and functioning of a service has the added benefit of First Nations people willingly choosing to travel to seek medical attention, as Dr Perron observed: 'Quite often once you build a rapport with a patient, they will make that effort to travel further to come and see you in an area where they feel comfortable and supported'.[696]

6.30 This was further supported by Mr Carl Grant, Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service, who noted that 'our mob will go and visit services that they are comfortable with. If they are comfortable with those services then they will go and get the care'.[697]

Workforce and training

6.31 One of the key criticisms highlighted by inquiry participants was the lack of First Nations people employed in client facing roles, whether as medical practitioners or in service positions.[698]

6.32 The levels of employment of Aboriginal people across NSW Health varies. For instance, various Local Health Districts reported the following Aboriginal employment rates:

691 Evidence, Associate Professor Malouf, 5 October 2021, p 24.
692 Evidence, Associate Professor Malouf, 5 October 2021, p 24.
693 Evidence, Dr Perron, 19 May 2021, p 19.
694 Evidence, Mr Greg Packer, Delegate for Wagga Wagga, Riverina Murray Regional Alliance, 6 October 2021, p 32.
695 Submission 476, Mental Health Commission of NSW, p 11.
696 Evidence, Dr Perron, 19 May 2021, p 12.
697 Evidence, Mr Carl Grant, Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service, 2 December 2021, p 46.
698 For example, see: Evidence, Ms O'Hara, 6 October 2021, p 28; Evidence, Mr Packer, 6 October 2021, p 26; Evidence, Mr John Fernando, Chairperson, Riverina Murray Regional Alliance, 6 October 2021, p 28; Submission 276, New South Wales Medical Staff Executive Council, pp 10-11.

- Mid North Coast – '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'.[699]
- Western NSW – 'We have an extensive network of Aboriginal health workers right across our region, including over 20 in our northwest rural and remote towns … We have grown to over 5.7 per cent of our workforce is now Aboriginal—an increase of over 80 staff in the last 12 months. It is something that we are committed to growing to 9.4 per cent over the next three years'.[700]
- Murrumbidgee – '93 Aboriginal people employed in MLHD making up 2.8% of the total workforce, Oct 2020 (increased from 79 staff Oct 2019). MLHD target for employment of Aboriginal people is 3% of the total by 2020'.[701]

6.33 The Mental Health Commission of NSW acknowledged that Aboriginal staff face the extra challenge of working with cultural expectations and responsibilities to community, as well as to their employer and as part of a team.[702]

6.34 However, as Ms O'Hara told the committee at its Sydney hearing, 'if we see more black faces in these jobs, you would see more Aboriginal people accessing these services'.[703]

6.35 The Orange Health Service Medical Staff Council,[704] the NSW Medical Staff Executive Council[705] and the NSW Nurses & Midwives' Association[706] also highlighted in their submissions that there is a greater need for Aboriginal Liaison Officers and the targeted creation of Aboriginal caseworkers or care coordinators who are specifically trained to support patients as they navigate the health system.

6.36 Additionally, Mr John Fernando, Chairperson, Riverina Murray Regional Alliance argued that the more visible First Nations employees are within the health system, the more likely it is that First Nation children will have role models and careers to aspire to:

> The best way for us is to support our medical people and give them some shining lights, give them some role models. We need to see Aboriginal faces and bodies in our health service so these kids can aspire to be nurses, doctors, counsellors, because at the moment when they go to a mainstream hospital, all they see is a lot of non-Indigenous people—doctors—and they also see a lot of overseas doctors there who are working when the opportunity is there for Aboriginal people. We definitely need to increase the

699 Evidence, Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District, 1 February 2022, p 7.

700 Evidence, Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, 30 April 2021, pp 23-24.

701 NSW Health – Murrumbidgee Local Health District: Population Data and Health Statistics – Report: Murrumbidgee Aboriginal Health Profile – December 2020 - https://www.mlhd.health.nsw.gov.au/getmedia/d68bacb2-42fe-4c6f-b587-8139ba926ec6/Aboriginal-Health-Profile-MLHD-December-2020

702 Submission 476, Mental Health Commission of NSW, p 11.

703 Evidence, Ms O'Hara, 6 October 2021, p 32.

704 Submission 269, Orange Health Service Medical Staff Council, p 10.

705 Submission 276, New South Wales Medical Staff Executive Council, p 10.

706 Submission 258, New South Wales Nurses and Midwives' Association, p 2.

numbers of health workers within our AMSs to give these young kids a goal to say, "I can do that".[707]

6.37 In addition to more First Nations people undertaking roles with the Local Health Districts and other health services, the committee also heard calls for more targeted education and training to be made available in regional locations, for example:

- an undergraduate program for medicine in Dubbo[708]
- a nurse and allied health training on country proposal from the Walgett Aboriginal Medical Service in partnership with the University of Newcastle[709]
- additional Commonwealth-supported places for Aboriginal people to undertake medical or health degrees[710]
- additional funded programs to support the education and training of Aboriginal Liaison Officers, Aboriginal Care Coordinator positions and Indigenous health care workers[711]
- support for Aboriginal and Torres Strait Islander registered training organisations.[712]

6.38 In this regard, stakeholders suggested that where possible, training should be facilitated on country in order to maintain connection to the land, allow students to stay close to family and reduce the associated costs of having to travel to obtain a qualification.[713]

Service delivery models

6.39 Overall, while numerous initiatives and strategies have been designed to improve the way that health services are delivered to First Nations communities, NSW Rural Primary Health Networks emphasised that Aboriginal-led health service planning, design and commissioning is vital to ensuring their success.[714]

6.40 In terms of service delivery models, telehealth services were highlighted by numerous witnesses as being less than optimal for First Nations people.[715] Associate Professor Malouf told the committee that Aboriginal patients need face-to-face interaction, and that where telehealth is used it should be followed up by a face-to-face visit:

707 Evidence, Mr Fernando, 6 October 2021, p 31.
708 Evidence, Dr Perron, 19 May 2021, p 18.
709 Evidence, Ms Christine Corby OAM, Chief Executive Officer, Walgett Aboriginal Medical Service, 2 December 2021, p 47.
710 Evidence, Associate Professor Malouf, 5 October 2021, p 23.
711 Submission 276, New South Wales Medical Staff Executive Council, p 11.
712 Evidence, Associate Professor Malouf, 5 October 2021, p 23.
713 Evidence, Ms Betty Kennedy Williams, Enrolled Nurse, New South Wales Nurses and Midwives' Association, 2 December 2021, p 26; Evidence, Ms Katrina Ward, Operations Manager, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service, 2 December 2021, p 50.
714 Submission 452, NSW Rural Primary Health Networks, p 14.
715 For example, see: Evidence, Associate Professor Malouf, 5 October 2021, p 21; Evidence, Dr Perron, 19 May 2021, p 12; Evidence, Ms O'Hara, 6 October 2021, p 27.

> … Aboriginal patients require … face-to-face interaction. The telehealth has created a barrier for mob in terms of their care management and compliance. Our Aboriginal Community Controlled Health Services do utilise telehealth, but they also have the second component, that face-to-face interaction. So if a patient is home sick, they can utilise the telehealth function—but then our services also provide the welfare check. They actually go to the home to check on the individual and how they are travelling. Telehealth and face-to-face need to be working hand in hand, particularly in Aboriginal health.[716]

6.41 In her testimony to the committee, Dr Perron remarked that at the start of the COVID-19 pandemic the Dubbo Regional Aboriginal Medical Service noticed a very large drop in patients that were accessing GP appointments as only telehealth was available.[717] Similarly, Mr Fernando told the committee that Aboriginal people prefer to speak to a practitioner one-on-one and that there has been a significant drop in people seeking medical advice when they can only access a doctor via phone call or webcam.[718]

6.42 In this regard, Ms Katrina Ward, Operations Manager, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service, noted that in many areas internet connectivity is questionable and drop-outs can lead an individual to feel like they are not being heard properly, causing frustration.[719]

6.43 In addition to a very strong preference for face-to-face consultations, the committee heard that treatment on country is important to maintaining the wellbeing of First Nations people. For example, in is submission to the inquiry, Tresillian described a service model that includes taking services directly to small communities by using a purpose-designed van.[720]

6.44 In addition, Associate Professor Malouf argued that if specialist services are made available in regional or remote communities, health outcomes particularly for Aboriginal people are optimised, because they are being treated on country and therefore not being removed to metropolitan Sydney or other locations for treatment.[721]

6.45 Specifically in relation to palliative care, Associate Professor Malouf highlighted the importance of giving Aboriginal people the option to die on country, explaining that the issue is not just about choice, but also about recognising and supporting cultural protocols and practices:

> It is about acknowledging cultural protocols and practices in terms of their end-of-life journey and having the system to support those cultural practices. The system needs to understand and appreciate that the patient has a right to decide on where they would like to end their end of life. The majority of our Aboriginal communities want to be back home on country.[722]

716 Evidence, Associate Professor Malouf, 5 October 2021, p 21.
717 Evidence, Dr Perron, 19 May 2021, p 12.
718 Evidence, Mr Fernando, 6 October 2021, p 27.
719 Evidence, Ms Ward, 2 December 2021, p 54.
720 Submission 174, Tresillian, p 20.
721 Evidence, Associate Professor Malouf, 5 October 2021, p 20.
722 Evidence, Associate Professor Malouf, 5 October 2021, p 21.

Partnerships with Aboriginal Community Controlled Health Services

6.46 As noted above, in many regional, rural and remote locations Aboriginal Community Controlled Health Services provide primary care and in some cases allied care services.[723]

6.47 The committee heard that Aboriginal Community Controlled Health Services are supposed to work in partnership with their respective Local Health District to access acute and tertiary care for their patients, but that there are significant disparities in how these partnerships fundamentally operate.[724]

6.48 For example, Associate Professor Malouf told the committee that the national accreditation of hospitals dictates that Local Health Districts must work in partnership with their local Aboriginal Community Controlled Health Services, however many of these partnerships have not been formalised.[725]

6.49 Further to this point, Ms Margaret Cashman, Director of Ethics, Policy and Research, Aboriginal Health and Medical Research Council of NSW told the committee about the relative inconsistency of partnerships that currently exist:

> … in some areas we see very strong partnerships between the LHDs and the ACCHOs. Those partnerships are often linked to resourcing, and they involve clear outlines around the service delivery for the ACCHOs and how that works with the hospitals. In other regions, we do not see any partnerships or we see very surface-level partnerships that relate to just documentation. What we see in particular in some areas is where the LHD might have a partnership with a regional body and the regional body may represent some of the ACCHOs in that region—but there needs to be an onus on the LHD to ensure that they have some form of partnership with every ACCHO because we do not want to see any ACCHOs left behind in that system of care.[726]

6.50 Likewise, Mr Davis noted that the Local Health Districts and Primary Health Networks have not recognised the clinical and cultural knowledge and authority of Aboriginal health institutions in regional areas with reciprocal partnerships, investment or advocacy.[727]

6.51 Further, the committee also heard that fragmented or unstable partnerships can impact the quality of care given to Aboriginal people,[728] because of potential gaps and confusion in a patient's health journey between Aboriginal Community Controlled Health Services and the Local Health District. According to Associate Professor Malouf, clear communication and information sharing as a person moves from one service to another and through the discharge process is essential in ensuring the individual's engagement with the health system is as seamless as possible.[729]

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723 Evidence, Ms Corby OAM, 2 December 2021, p 51.

724 Evidence, Ms Margaret Cashman, Director of Ethics, Policy and Research, Aboriginal Health and Medical Research Council of NSW, 5 October 2021, pp 21-22.

725 Evidence, Associate Professor Malouf, 5 October 2021, pp 22-23.

726 Evidence, Ms Cashman, 5 October 2021, pp 21-22.

727 Evidence, Mr Davis, 2 December 2021, p 45.

728 Evidence, Associate Professor Malouf, 5 October 2021, p 19.

729 Evidence, Associate Professor Malouf, 5 October 2021, pp 20-21.

6.52 On the other hand, where these partnerships are fully developed and implemented, positive outcomes can be seen by the community, as Ms O'Hara told the committee:

> Working in partnership with our local health district, Primary Health Network and the NSW Rural Doctors Network has allowed us to make some real progress in addressing health issues for our Aboriginal communities.[730]

6.53 Associate Professor Malouf went further to explain that in order to ensure that First Nations people receive the highest levels of care and consideration, genuine partnerships must be formalised between Aboriginal Community Controlled Health Services and the Local Health Districts,[731] including formal Service Level Agreements that are linked to an agreed set of performance indicators that ensure accountability of both parties.[732]

6.54 This could include a First Nations representative on regional, rural or remote Local Health District Boards[733] and the engagement of Aboriginal Community Controlled Health Services Chief Executive Officers in hospital or facility health service planning.[734]

Committee comment

6.55 The committee acknowledges that the issues faced by First Nations people in seeking out and accessing health services not only in regional, rural and remote areas but across the entire state, are influenced by a myriad of historical, cultural and social factors. The interplay of discrimination, racism, poor experiences with healthcare professionals, lack of transport, and the lack of affordable and culturally appropriate healthcare services all contribute to a sense of reluctance by some First Nations people to seek medical assistance.

6.56 In particular, it was disturbing to hear accounts of First Nations individuals choosing not to seek medical assistance in hospitals because they are treated like second-class citizens – neglected, not taken seriously and discriminated against because of the colour of their skin. That any Aboriginal person should be treated in this way in our public health system is completely unacceptable.

Finding 17

That it is unacceptable that some First Nations people still experience discrimination when seeking medical assistance in some rural, regional and remote hospitals in New South Wales.

6.57 Evidence to this committee has highlighted the correlation between First Nations people feeling culturally safe, and actively choosing to seek health care services.

730 Evidence, Ms O'Hara, 6 October 2021, p 26.
731 Evidence, Associate Professor Malouf, 5 October 2021, p 19.
732 Submission 265, Aboriginal Health and Medical Research Council of NSW, p 6.
733 Submission 466, ONE - One New Eurobodalla hospital, p 11.
734 Evidence, Associate Professor Malouf, 5 October 2021, p 25.

6.58 The committee notes with concern the evidence received from First Nations witnesses regarding the significant challenge that telehealth services pose for their communities. Consequently, the committee finds that telehealth has created another barrier for First Nations people in terms of accessing culturally appropriate health services. Further, the committee recommends that NSW Health acknowledge the significant cultural barriers that telehealth poses for First Nations communities and work to ensure face-to-face consultations are prioritised.

Finding 18

That telehealth has created another barrier for First Nations people in terms of accessing culturally appropriate health services.

Recommendation 31

That NSW Health acknowledge the significant cultural barriers that telehealth poses for First Nations communities and work to ensure face-to-face consultations are prioritised.

6.59 Further on the issue of cultural safety, while the committee acknowledges that some steps have been taken by NSW Health to roll-out audit tools and standardised training, further ongoing work is required. As the committee heard, cultural safety is about more than 'ticking a box' against a generic set of criteria; it is about having systems and services that acknowledge the history and culture of Aboriginal people. Moreover, despite efforts by individual Local Health Districts, such as the Waminda cultural immersion program for staff from the Illawarra Shoalhaven Local Health District, progress overall appears to be ad hoc.

6.60 In order to make health services, particularly those in rural, regional and remote New South Wales more culturally safe for First Nations people, the committee recommends that NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Elders and local communities to revise and incorporate local content into staff cultural awareness training, to listen to their experiences of the healthcare system and seek the guidance around what cultural safety strategies should be applied in their areas, and to include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.

Recommendation 32

That NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Aboriginal Elders and local communities to:

- revise and incorporate local content into cultural awareness training such as *Respecting the Difference: Aboriginal Cultural Training*
- listen to their experiences of the healthcare system and seek guidance around what cultural safety strategies should be applied in their areas
- include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.

6.61 The committee commends the efforts of some Local Health Districts to increase the size of their First Nations workforce, however more needs to be done across the entire LHD network. We know that First Nations people benefit from receiving care from, and interacting with, staff that are First Nations, be that as medical professionals or in service roles.

6.62 Therefore, the committee recommends that NSW Health and the Local Health Districts prioritise building their Indigenous workforce across all disciplines, job types and locations. In doing so, additional funding should be targeted to increasing the number of Aboriginal Care Navigators and Aboriginal Peer Workers to improve the cultural safety of services and promote accessibility for Aboriginal people.

Recommendation 33

That NSW Health and the Local Health Districts, particularly those located in rural, regional and remote areas, prioritise building their Indigenous workforce across all disciplines, job types and locations. This should include additional funding targeted at increasing the number of Aboriginal Care Navigators and Aboriginal Peer Workers.

6.63 In regards to service delivery, the committee notes that among First Nations people there is a very strong preference for healthcare related interactions to be conducted face to face. This approach helps to build rapport and trust. Accordingly, we urge the Local Health Districts to provide every opportunity, where possible, for First Nations people to access face to face consultations and where this is not possible, to be aided by visual virtual care technology.

6.64 Finally, the committee was surprised to hear evidence regarding the failure of some Local Health Districts and Primary Health Networks to formalise partnerships with their local Aboriginal Community Controlled Health Services.

6.65 Evidence to the committee has shown that where these partnerships are formalised and implemented, benefits flow to the community. Therefore, the committee recommends that NSW Health and the Local Health Districts prioritise the formalisation of functional partnerships with the Aboriginal Community Controlled Health Services as a matter of priority to support the delivery of health services and improve the health outcomes of First Nations people in New South Wales. These partnerships should include formal documentation of service delivery responsibilities and expected outcomes.

Recommendation 34

That NSW Health and the Local Health Districts prioritise formalising partnerships with all Aboriginal Community Controlled Health Services to support the delivery of health services and improve the health outcomes of First Nations people in New South Wales. These partnerships should include formal documentation of service delivery responsibilities and expected outcomes.

6.66 In addition, in order to ensure Indigenous representation at the highest level within the Local Health Districts, the committee recommends that the NSW Government mandate the requirement for each Local Health District to have at least one Indigenous community representative on the governing board.

Recommendation 35

That the NSW Government mandate the requirement for each Local Health District to have at least one Indigenous community representative on the governing board.

Chapter 7 Governance

This chapter explores governance at the NSW Health and Local Health District level. Firstly, it discusses various governance issues that have been highlighted during the course of the inquiry, including around accountability and transparency. It then explores partnerships with the Primary Health Networks and cross border arrangements, before focusing on the culture of the Local Health Districts and communication with the community.

The health bureaucracy in New South Wales

7.1 The New South Wales public health system is the biggest and busiest public health system in Australia, with 228 public hospitals and 170,000 (127,156 full-time equivalent) staff.[735] As outlined in Chapter 1, the health bureaucracy in New South Wales is essentially comprised of:

- the NSW Ministry of Health (otherwise referred to as NSW Health), the overall system manager for the state's public health system
- the Local Health Districts, which are responsible for operating public hospitals and institutions and providing health services to communities within their geographical area, governed by a Chief Executive who reports to the Ministry for Health, and a governing board.[736]

7.2 A common theme emerging from the evidence received in submissions and at the hearings throughout the inquiry was the lack of transparency and accountability from NSW Health and the Local Health Districts in terms of governance.

7.3 The committee heard from numerous organisations, peak bodies and private individuals about a range of issues on this front. On the theme of transparency, particularly around budgets and health expenditure, the committee heard:

- '[G]aining access to hospital budgets and expenditure is very difficult. Rural and remote residents have expressed uncertainty about whether funds allocated to rural and remote hospitals are being fully acquitted against the budget … detailed budgets should continue to be published for each hospital annually and be accessible from the web page of each hospital. In addition, monthly reports should also be published online of expenditure against budget to enable communities to review progress in achieving funded goals'.[737]
- 'There is little transparency and spurious reasons provided for these investment / service decisions which drives the … view that there is serious inequity in the health planning system and a lack of regard for the demographics and risks faced in the community'.[738]
- '[The LHD] keeps to itself matters of significant community interest such as infrastructure plans and budget proposals. Despite repeated attempts by Council and others to seek change, improvement is elusive'.[739]

735 NSW Health, *Annual Report 2020-2021*, p 2.
736 Submission 630, NSW Government, p 4.
737 Submission 705, Rural and Remote Medical Services Ltd, p 42.
738 Submission 633, Leeton Shire Council, p 7.
739 Submission 245a, Bathurst Regional Council, p 2.

- 'It is difficult (arguably impossible) to find the information to undertake meaningful analysis and provide an informed opinion about investment at the local level'.[740]
- 'A widely held impression is that the LHD Executive and Ministry "manage upward" and prioritize budget over health outcomes, particularly in the remote and regional health settings. There appears to be no recognition at Ministry of Health level of the systemic risks arising from incompetent and budget driven decisions made at LHD Executive and Ministerial level'.[741]

7.4 On the theme of accountability and governance more broadly, concerns were expressed around agreed and measureable health outcomes, consistency of operation, verification of reporting and data sources, and complaints management systems and culture. Comments from stakeholders included:

- 'How can we effectively compare the health outcomes of Local Health Districts if we are sometimes including data about all of them, sometimes including data about some of them and generally cherry picking what we are prepared to make public and not?'[742]
- '… If primary health care is so important to the future of rural and remote health in New South Wales, why do we not have a New South Wales primary healthcare strategy, a rural health plan that sets out measurable health outcomes against which governments will be held accountable, or clear and accessible framework that tells rural and remote people exactly what services they can expect in their local hospital and the minimum workforce it will receive? Sustainable primary health care is the key to the future of rural health, and this can only be delivered if there is a clear strategic and accountability framework, and the resourcing, to support primary healthcare-led service delivery in rural and remote communities'.[743]
- 'The rigorous oversight, regulation, adherence to performance indicators, and accountability that are feature of our excellent public health system in metropolitan teaching hospitals in NSW, have not been replicated in the 'bush', where mismanagement and misbehaviour is tolerated 'out of sight and mind' in a system that at best hides, and at the worst can attract, practitioners with less than competent practice'.[744]
- 'Where is the accountability from the Department of Health in how health districts operate, how boards operate, the accountability of boards and how people in regional areas will get their fair equity?'[745]
- 'The LHDs report to NSW Health through the Chief Executive and this lacks transparency as part of the service agreement. There is no verification of clinical governance structures and the accuracy of reporting'.[746]

740 Submission 633, Leeton Shire Council, p 8.
741 Submission 74, Name suppressed, p 2.
742 Submission 460, Ms Kate Stewart, p 6.
743 Evidence, Mr Richard Anicich AM, Chair, Rural and Remote Medical Services Ltd, 2 December 2021, p 10.
744 Submission 678, Manning Great Lakes Community Health Action Group Inc., p 7.
745 Evidence, Mr Alan Tickle, Private individual, 16 June 2021, p 25.
746 Submission 276, New South Wales Medical Staff Executive Council (NSW MSEC), p 11.

- 'The NSW Government must develop a properly funded, data-based strategy to improve RRR healthcare, with data made public to monitor performance and enhance accountability'.[747]
- '… in NSW there needs to be accountability measures through the transparent, publicly available reporting of complaints and any responses received'.[748]
- 'I think you need to look beyond the LHDs and look at NSW Health as an organisation—its top-down approach, its poor culture, it's very managerial style, its inflexibility. If you can address those problems then you will give the LHDs the ability to do things and to be more flexible and more agile and, therefore, get the job done. As things stand at the moment, I cannot see any way of moving forward to improve these problems whilst NSW Health remains so apart and so unaccountable'.[749]

7.5 As a result of these and the other systemic issues highlighted in the inquiry, in December 2021, the NSW Government announced the appointment of the Hon. Bronnie Taylor MLC as Minister of the newly created Regional Health portfolio.[750]

7.6 The portfolio sits within the Health cluster under the leadership of the Minister for Health, the Hon. Brad Hazzard MP. The Regional Health portfolio is responsible for the rural Local Health Districts, with the organisation and structure of budgetary and governance considerations to be announced at a later date.[751]

7.7 Further, at the March 2022 supplementary Budget Estimate hearings, Minister Taylor confirmed that one of the first priorities of the portfolio will include the development of a new rural health plan.[752]

7.8 By way of background, the previous rural health plan, *NSW Rural Health Plan: Towards 2021* was implemented in 2014 under the direction of the then Minister for Health and Medical Research, the Hon. Jillian Skinner MP. It was developed to strengthen and improve the delivery of health services to rural and regional communities and included a focus on collaboration with Commonwealth and private health providers in order to deliver 'the right care, in the right place, at the right time'.[753] According to evidence given at the March 2022 supplementary Budget Estimate hearing, the development of the next regional health plan is currently in progress, with the intention that it be finalised by December 2022.[754] Two progress reviews of the *NSW Rural Health Plan: Towards 2021* are available on the NSW Health website, dated 2015 and 2017-2018 respectively.

747 Submission 453, Australian Salaried Medical Officers' Federation (NSW) (ASMOF), p 3.

748 Submission 628, National Justice Project, p 23.

749 Evidence, Dr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Shire Council, 18 May 2021, p 4.

750 Evidence, Hon Bronnie Taylor MLC, Minister for Women, Minister for Regional Health and Minister for Mental Health, Budget Estimates 2021-2022, 3 March 2022, pp 7-8.

751 Evidence, Hon Bronnie Taylor MLC, 3 March 2022, pp 7-8.

752 Evidence, Hon Bronnie Taylor MLC, 3 March 2022, pp 10-11.

753 NSW Government – NSW Health, NSW Rural Health Plan: Towards 2021, https://www.health.nsw.gov.au/rural/Pages/rural-health-plan.aspx

754 Evidence, Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, NSW Health, Budget Estimates 2021-2022, 3 March 2022, p 10.

7.9 At the same Budget Estimates hearing, Minister Taylor also advised that the Minister's rural and regional advisory group would be re-established and will be made up of clinicians, chief executives and people who are influential in rural and regional health.[755] At the time of writing, the expression of interest process had commenced, with panel members to advise the Minister on:

- the development and implementation of a Regional Health Plan for NSW
- the design of innovative workforce and service delivery models
- identifying barriers and incentives to attracting healthcare workers to regional areas
- helping create strategies to improve access to health and social services.

7.10 Following selection by the Minister for Regional Health and approval by Cabinet, the inaugural appointments will be appointed for a period of up to three years. The newly named Regional Health Ministerial Advisory Panel will meet at least every three months.[756]

7.11 Additionally, in April 2022, just prior to the tabling of this report, Minister Taylor announced the establishment of a new Regional Health Division in NSW Health. The Division will be led by a Coordinator-General who will report directly to the Secretary of NSW Health. The Regional Health Division will support the Regional Health Minister to:

- support the swift delivery of the NSW Government's regional health election commitments and the response to the recommendations of the NSW Rural Health Inquiry
- support and coordinate the development and implementation of a new Regional Health Plan
- provide a single point of contact and advocacy for issues that are common across the Regional Health environment, including matters of long term concern such as workforce attraction and retention, cross border issues and communication and engagement with communities, clinicians and stakeholders
- identify opportunities to enhance local access to health and other social services that support quality health outcomes, including IPTAAS policy and reporting and strengthening pathways to other social services
- integrate health, social and economic data, business intelligence tools, and stakeholder feedback.[757]

7.12 However, Rural and Remote Health Medical Services noted that 'rural and remote communities share no similarities with inner regional and metropolitan cities in terms of the availability of health infrastructure, workforce or models of care', and that the 'differences in the way in which health systems operate in urban and regional cities, and in rural and remote communities, are

[755] Evidence, Hon Bronnie Taylor MLC, 3 March 2022, pp 10-11.

[756] NSW Government – NSW Health, Expressions of interest open for Regional Health Ministerial Advisory Panel, 14 April 2022, https://www.health.nsw.gov.au/news/Pages/20220414_00.aspx

[757] NSW Government – NSW Health, NSW Government to deliver a strengthened focus on regional health, 8 April 2022, https://www.health.nsw.gov.au/news/Pages/20220408_02.aspx

poorly articulated in NSW health planning and policy'. Further, in its submission the organisation was critical of the *Rural Health Plan: Towards 2021*, arguing:

> While the document identifies the importance of community engagement, integrated primary health and hospital care and the application of new technologies, it is principally designed to set the direction of hospital services in regional NSW and does not contain any specific actions or measures to address improvements to health outcomes in rural and remote communities.[758]

7.13 Further, Rural and Remote Health Medical Services said it was not clear whether people living in rural and remote communities had been consulted in the development of the Plan and whether it addressed their priorities. Finally, they stated:

> The lack of a clear definition of 'what success looks like', the absence of specific targets for rural and remote health access and outcomes, and the lack of measurable performance indicators limits the capacity of the NSW Rural Health Plan to drive the broader health system reform to bridge the gap in health access and outcomes and makes it difficult for health services (hospitals, GPs, NGOs) to collaborate towards common goals.[759]

Partnerships

7.14 In order to function effectively as the key provider of tertiary health services, NSW Health and the Local Health Districts partner with other sector participants in regional, rural and remote areas to ensure the sustainable delivery of these services.[760] In its submission, NSW Health noted that the benefits of such partnerships include the ability to provide a greater range of services, avoiding duplication in resource allocation, sustaining the health workforce and ensuring the ongoing delivery of patient care.[761]

7.15 However, the committee heard that the ability of NSW Health and the respective Local Health Districts to develop strong, consistent and effective partnerships varies significantly.[762]

7.16 The provision of health services to First Nations people and inconsistencies in the partnerships between the Local Health Districts and Aboriginal Community Controlled Health Organisations was explored in Chapter 6. This section focuses on partnerships with the Primary Health Networks and on cross border arrangements for the six rural and regional Local Health Districts that share borders with other states or territories.

Relationships with the Primary Health Networks

7.17 The *NSW Primary Health Network - NSW Health Joint Statement*, signed by NSW Health, the Local Health Districts and the 10 Primary Health Networks in NSW in September 2021, affirms that as the primary providers of health care services for New South Wales residents, strong

758 Submission 705, Rural and Remote Medical Services Ltd, pp 23-24.
759 Submission 705, Rural and Remote Medical Services Ltd, p 25.
760 Submission 630, NSW Government, pp 50-51.
761 Submission 630, NSW Government, p 51.
762 Evidence, Mr Anicich AM, 2 December 2021, p 10.

partnerships between the Primary Health Networks and Local Health Districts are essential to ensure that high quality services are cooperatively planned and successfully delivered.[763]

7.18 However, the committee heard that despite this commitment to working in partnership to deliver patient centred health care, and the best intentions of staff in both organisations, this has not been universally or consistently delivered upon.[764]

7.19 Further, as noted by Rural & Remote Medical Services Ltd, while the *NSW Rural Health Plan – Towards 2021* acknowledges the importance of integrating primary and hospital care, there is very little consistency in the approach to the delivery of services across New South Wales to support the sustainability of primary health care and general practice.[765] This is discussed in detail in Chapter 3.

7.20 Looking at individual partnerships, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network, representing the NSW Rural Primary Health Networks told the committee that there are many excellent examples of Primary Health Networks and Local Health Districts working together to achieve better care in the community such as the Health Pathways portal. However, Ms Kitcher commented that 'in practice, implementing health reform is patchy across the regions as both LHDs and PHNs are generally under-resourced and faced with many competing priorities'.[766]

7.21 In its submission to the committee, the NSW Rural Primary Health Networks stated that:

- while a 'one-size fits-all' solution is not appropriate, some of the simplest improvements can be achieved through linking digital systems and mapping referral pathways[767]
- without appropriate resourcing and concerted efforts by the Primary Health Networks, NSW Health and the Local Health Districts, integration and coordination across the multiple health care settings will be limited.[768]

7.22 Furthermore, providing a community focused perspective, Dr Kristin Bell, Chair, Specialist Training Program Committee and Chair, QEC Regional Training Network, The Royal Australian and New Zealand College of Ophthalmologists highlighted the importance of coordination in improving service delivery, telling the committee that a good starting point would be a centralised process that takes into account geography, demographics and community engagement:

> What we need is a central process and wider engagement. Let us work out what should be delivered in each area. Let us calibrate it for geography and calibrate it for

763 NSW Government – NSW Health, The NSW Primary Health network – NSW Health Joint Statement, 17 September 2021, https://www.health.nsw.gov.au/integratedcare/Pages/joint-statement.aspx

764 Evidence, Ms Dianne Kitcher, Chief Executive Officer, South Eastern NSW Primary Health Network, on behalf of the NSW Rural Primary Health Network, 19 March 2021, pp 10-11.

765 Submission 705, Rural & Remote Medical Services Ltd, p 28.

766 Evidence, Ms Kitcher, 19 March 2021, pp 10-11.

767 Submission 452, NSW Rural Primary Health Networks, pp 19-20.

768 Submission 452, NSW Rural Primary Health Networks, pp 19-20.

demographics, provide LHDs with a detailed map of outpatient and inpatient services which should be delivered in the area.[769]

7.23 As suggested by the NSW Rural Primary Health Networks, improvement in health care outcomes in New South Wales will only be achieved if the NSW Ministry of Health and Local Health Districts, the primary care sector, the Primary Health Networks, other organisations, and the community work together.[770]

Cross border arrangements

7.24 For residents living in cross border regions, the committee heard that NSW Health, in partnership with the six relevant Local Health Districts, navigates jurisdictional arrangements to secure cross-border access to complex services, expand care networks and support natural patient flow to tertiary services. This includes 'South Australia to Broken Hill Hospital, NSW patient flows to the Australian Capital Territory for elective surgery, critical care in Victoria, and patient flow patterns from NSW to Queensland'.[771]

7.25 In regards to how these partnerships with other jurisdictions work, the key features are that they are:

- governed by formal and informal agreements that vary between jurisdictions
- designed to reduce risk of fragmented care for cross border communities, including provisions for data sharing, measures to manage activity and funding variation, and ways to acknowledge service and retrieval capacity
- overseen by the NSW Cross-Border Commissioner who also advocates on behalf of cross border communities and works with jurisdictions to raise issues and establish common understanding.[772]

7.26 Additionally, NSW Health noted that some Local Health Districts have established cross border committees to improve continuity of care and have implemented innovative models of collaboration to improve access to health services for cross border residents.[773]

7.27 However, NSW Health acknowledged that access and provision of health services in cross border regions is a complex and challenging issue, with the COVID-19 pandemic highlighting the problematic nature of these arrangements in relation to interruptions in service delivery, lack of data sharing and restrictions on workforce movement.[774]

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769 Evidence, Dr Kristin Bell, Chair, Specialist Training Program Committee and Chair, QEC Regional Training Network, The Royal Australian and New Zealand College of Ophthalmologists, 3 December 2021, p 29.

770 Submission 452, NSW Rural Primary Health Networks, p 20.

771 Submission 630, NSW Government, p 56.

772 Submission 630, NSW Government, p 56.

773 Submission 630, NSW Government, p 56.

774 Submission 630, NSW Government, p 55.

7.28 Indeed, stakeholders highlighted that despite agreements with other jurisdictions, the pandemic emphasised the reliance on access to cross border health services for residents who live in border adjacent areas, and the difficulties that arise when these arrangements are interrupted, both for these residents and for employees who reside or work in other jurisdictions. For example:

- 'Tenterfield and Broken Hill were stark examples of communities which all but lost access to health services'.[775]
- 'NSW Health needs to work better with other jurisdictions to build effective cross border partnerships. ASMOF Members at Queanbeyan hospital identified trans-border networking deficits, primarily because patients who live outside of the Australian Capital Territory (ACT) are unable to be supported within ACT Health. Additionally, as has been widely reported, there have been serious networking disruptions at Tweed Hospital throughout 2020-2021 due to border closures between Queensland and NSW'.[776]
- 'Border residents had access cut from Victorian services and were unable to access the NSW system either due to transportation issues or Albury services unable to cope with the overload. Those cross border services later made accessible due to public backlash also included a stipulation whereby consumers then had to isolate 14 days on return. A trip to an ENT specialist normally taking 3-6 weeks in the Victorian system became a 5-month waiting list on the NSW side'.[777]
- 'Council has also been made aware of significant health issues arising from the closure of the South Australian border during COVID-19 and advocate for a Memorandum of Understanding to be established with the South Australian Government for cross border communities to ensure residents requiring medical treatment are not locked out of the State again. As a result of several serious cases being denied access to medical treatment in South Australia, it is unknown what long-term consequences there will be for those patients because of their healthcare being postponed'.[778]

The Local Health Districts

7.29 The committee heard from a range of peak bodies, organisations and community stakeholders who raised concerns in relation to the performance of the Local Health Districts.

7.30 These concerns primarily revolved around:

- investment and allocation of budget to individual facilities[779]

775 Submission 460, Ms Kate Stewart, p 15.

776 Submission 453, Australian Salaried Medical Officers' Federation (NSW) (ASMOF), p 18.

777 Submission 484, Ms Shirlee Burge, p 5.

778 Submission 398, Broken Hill City Council, p 2.

779 See for example: Submission 168, Manning Base Hospital Taree (Department of Medicine), p 6; Submission 262, Australasian College for Emergency Medicine (ACEM), p 2; Submission 571, Regional Medical Specialists Association, p 10; Evidence, Ms Sheree Staggs, Registered Nurse, New South Wales Nurses and Midwives' Association, 18 May 2021, p 14; Evidence, Cr Warren Aubin, Councillor, Bathurst Regional Council, 18 May 2021, p 2; Evidence, Mr Tickle, 16 June 2021, p 24; Submission 258, New South Wales Nurses and Midwives' Association, p 16; Submission 705, Rural & Remote Medical Services Ltd, p 4; Submission 633, Leeton Shire Council, p 7; Submission 181,

- ensuring a sustainable workforce of doctors, nurses and allied health practitioners[780] (discussed in Chapters 3, 4 and 5 respectively)
- the time taken to fill vacancies and the speed of on-boarding processes[781]
- a focus on performance reporting over patient centred care[782]
- work, health and safety concerns.[783]

7.31 In addition to the aforementioned issues, stakeholders also raised serious concerns about workplace culture, communication and community engagement.

Deniliquin Mental Health Awareness Group (Deni MHAG), p 6; Submission 271, The Royal Australian and New Zealand College of Ophthalmologists (RANZCO), p 7; Submission 379, Dr Simon Halliday, p 9; Submission 413, Mr James Burns, p 2; Submission 111, Name suppressed, p 3; Submission 496, Name suppressed, p 1.

780 See for example: Evidence, Dr Charlotte Hespe, Chair NSW and ACT, Royal Australian College of General Practitioners, 19 March 2021, p 11; Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 19 March 2021, pp 34-35; Submission 465, Remote Vocational Training Scheme, p 4; Submission 276, NSW Medical Staff Executive Council, p 5; Submission 259, Australian College of Nurse Practitioners, p 3; Submission 269, Orange Health Service Medical Staff Council, p 5; Evidence, Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health, 3 December 2021, p 3; Submission 456, Exercise and Sports Science Australia, p 28; Submission 316, Name suppressed, p 1; Submission 531, Name suppressed, p 1.

781 See for example: Evidence, Ms Leonie Brown, Manager Corporate Services, Bourke Shire Council, 30 April 2021, p 8; Evidence, Ms Sarah Thompson, Member, NSW Farmers' Rural Affairs Policy Committee, NSW Farmers' Association, 3 December 2021, p 10; Submission 88, Name suppressed, p 1; Submission 95, Deniliquin Health Action Group, p 1; Submission 111, Name suppressed, p 2; Submission 245, Bathurst Regional Council, p 11; Submission 258b, New South Wales Nurses and Midwives' Association, p 3; Submission 262, Australasian College for Emergency Medicine (ACEM), p 3; Submission 492, Dr Claire Cupitt, pp 1-4.

782 See for example: Evidence, Associate Professor Peter Malouf, Executive Director – Operations, Aboriginal Health and Medical Research Council of NSW , 5 October 2021, p 23; Submission 247, The Australasian College of Dermatologists, p 12; Submission 276, New South Wales Medical Staff Executive Council (NSW MSEC), pp 4, 9, 11; Submission 38, Name suppressed, p 1; Submission 80, Name suppressed, p 1; Submission 222, Mr Alan Tickle, p 1; Submission 245, Bathurst Regional Council, p 5; Submission 269, Orange Health Service Medical Staff Council, pp 3, 14; Submission 628, National Justice Project, pp 23-24.

783 See for example: Evidence, Mr Holmes, 19 March 2021, p 30; Submission 258, NSW Nurses and Midwives' Association, p 20; Evidence, Dr Shehnarz Salindera, Councillor, Australian Medical Association, 19 March 2021, pp 3-5; Evidence, Dr Marion Magee, Chair, Deniliquin Health Action Group, 29 April 2021, pp 15-17; Submission 65, Mr Liam Minogue, p 1; Submission 158, Name suppressed, p 1; Submission 453, Australian Salaried Medical Officers' Federation (NSW) (ASMOF), pp 3, 8, 11-14, 22.

Workplace culture

7.32 During the hearings[784] and repeatedly highlighted in submissions,[785] the committee heard about the negative workplace culture that has developed in facilities and the wider Local Health District network.

7.33 As already noted in Chapter 4, Ms Liz Hayes told the committee that a number of health professionals had contacted her, in her role as a journalist, to raise concerns about substandard care because they themselves were scared about potential retribution:

> I have spoken to many doctors, nurses and health care workers who have felt fearful for their patients, because of a substandard health system, but have been too afraid to speak out. There is a very real belief that punishment awaits those who go public with their concerns. They're deemed troublemakers.[786]

7.34 This sentiment was also echoed by Ms Jamelle Wells, who told the committee that transparency and a reduction in defensiveness and 'spin' was required.[787]

7.35 In addition to the accounts discussed in Chapter 4 regarding the treatment of nurses, the committee heard of the reluctance of staff at all levels to alert senior management to issues, for fear of jeopardising their employment. For example:

- '… employees are often reluctant to "rock the boat" and will often tolerate things more than metropolitan colleagues for fear of jeopardising their job whereas their metropolitan counterparts can change employers more easily'.[788]
- 'It must also be noted that for healthcare workers living in closed and close communities, there is a fear of reprisal, targeted bullying and intimidation, the threat of job loss, where there are few immediate job prospects, or an adverse report or reference that would compromise future employment particularly within NSW Health'.[789]
- 'Many expressed fears that raising their concerns would result in a punitive response from their management'.[790]
- 'The local health bureaucracy in my electorate - Murrumbidgee Local Health District - gags their staff from sharing their ideas on improving their health services. Medical staff

784 See for example: Evidence, Ms Liz Hayes, Private individual, 10 September 2021, p 4; Evidence, Ms Jamelle Wells, Private individual, 10 September 2021, p 4; Evidence, Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council, 5 October 2021, p 12; Evidence, Mr Eddie Wood, President, Manning Great Lakes Community Health Action Group, 16 June 2021, p 2.

785 See for example: Submission 257, Health Services Union NSW ACT QLD, p 2; Submission 258, New South Wales Nurses and Midwives' Association, p 10; Submission 2, Name suppressed, p 1; Submission 74, Name suppressed, p 2; Submission 660, Name suppressed, p 1; Submission 356, Miss Vicki Morrison, p 6; Submission 449, The Office of Helen Dalton MP, Member for Murray, p 7; Submission 515, Name suppressed, 3; Submission 620, Mr Roy Butler MP, Member for Barwon, pp 13-14.

786 Submission 613, Ms Liz Hayes, p 3.

787 Evidence, Ms Wells, 10 September 2021, p 4.

788 Submission 111, Name suppressed, p 2.

789 Submission 660, Name suppressed, p 1.

790 Submission 258, New South Wales Nurses and Midwives' Association, p 10.

often make anonymous complaints to me, refusing to give their names for fear of repercussions'.[791]

- 'Staff have voiced their concerns regarding being fearful of the ramifications of speaking out, also adding comments regarding the lack of trust in the leadership and their decisions made without consultation'.[792]
- '… clinicians feel alienated in regional NSW Health decision making and fear raising their head above the parapet concerned they'll be branded a troublemaker'.[793]

7.36 These accounts, while anecdotal, were not isolated to one facility or one Local Health District. Additionally, the committee heard that where staff have chosen to raise issues with management, common responses were silence and inaction,[794] or bullying and intimidation.[795]

7.37 These concerns were echoed by Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council, who told the committee that the automatic response of some administrators is to assume a defensive position when issues are raised, and in the process the focus on ensuring quality care for the patient is compromised:

> The problems are that there is a tendency for staff to raise concerns, administrators to defend their position because they do not want to admit that they are wrong or that there is blame. That situation needs to be diffused so that the focus can be on patient care and on quality and on sifting through what are genuine concerns about how the systems are running, and getting away from the self-defending stance of some administrators. … If you do not have the correct audit structures and the correct accountability, you create these problems. So yes, staff fear retribution and it is a problem.[796]

7.38 Dr Arnold further argued that, while there are individuals within the Local Health District network who address issues systematically and are supported by appropriate resources, formal avenues must be put in place to ensure issues are addressed in a timely manner without fear of retribution or intimidation.[797]

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791 Submission 449, The Office of Helen Dalton MP, Member for Murray, p 2.

792 Submission 557, Name suppressed, p 2.

793 Submission 620, Mr Roy Butler MP, Member for Barwon, p 14.

794 See for example: Submission 453, Australian Salaried Medical Officers' Federation (NSW) (ASMOF), p 18; Submission 258, New South Wales Nurses and Midwives' Association, p 14; Submission 356, Miss Vicki Morrison, p 4; Submission 449, The Office of Helen Dalton MP, Member for Murray, p 7; Submission 660, Name suppressed, p 1, Submission 515, Name suppressed, p 3; Submission 625, Mr Timothy Burge, p 3; Submission 280, Name suppressed, p 1.

795 See for example: Evidence, Mr Wood, 16 June 2021, p 2; Submission 257, Health Services Union NSW ACT QLD, p 2; Submission 356, Mrs Vicki Morrison, p 6; Submission 449, The Office of Helen Dalton MP, Member for Murray, p 7; Submission 484, Mrs Shirlee Burge, p 6; Submission 2, Name suppressed, p 1; Submission 74, Name suppressed, p 3.

796 Evidence, Dr Arnold, 5 October 2021, p 12.

797 Evidence, Dr Arnold, 5 October 2021, p 12.

7.39 Similarly, as noted in Chapter 4, the New South Wales Nurses and Midwives' Association emphasised that safety and quality in healthcare relies on individuals feeling empowered to raise concerns and issues that impact patient safety.[798]

Community communication and engagement

7.40 In its submission, NSW Health acknowledged that while rural health systems tend to serve smaller populations, their communities generally have a strong sense of identity and members are often highly engaged in health service delivery and governance.[799]

7.41 In order to provide formal opportunities for the community to provide input in local health services, the Local Health Districts offer the following avenues of participation:

- local health councils/ advisory committees
- health infrastructure partnerships
- engagement of consumers to co-design mental health models of care.[800]

7.42 Additionally, Local Health Districts are encouraged to design partnerships in consultation with the wider community and deliver care that meets the needs, expectations and preferences of patients, families and carers.[801]

7.43 However, as Mr Scott McLachlan, then Chief Executive, Western NSW Local Health District reflected, the efforts to date have not always met community expectations:

> I would be first to admit that we can improve our communication and engagement with all the people across country towns in the region. We know how crucial and important health services are to a community. There is no question that we want to maintain the confidence of the town that they can come and access services at their local hospital when they are crook … I would love to commit that we will step into further communication and engagement with our communities to help appreciate what services are available.[802]

7.44 Consistent with this observation, a common criticism raised with the committee was around the lack of information about what services are available in local communities, and where:

- 'We are just not clear of when the doctor will be available in the hospital and when there will be telehealth. It is all part of this commercial-in-confidence nonsense that goes on. We need to know in our town what services are available and when they are available, and not to know is really stupid'.[803]

798 Submission 258, New South Wales Nurses and Midwives' Association, p 10.
799 Submission 630, NSW Government, p 56.
800 Submission 630, NSW Government, p 57.
801 Submission 630, NSW Government, p 57.
802 Evidence, Mr Scott McLachlan, Chief Executive, Western NSW Local Health District, 30 April 2021, p 46.
803 Evidence, Dr Kitty Eggerking, Member, Gulgong Petitioners, 18 May 2021, p 29.

- '… what I do see is that the community sees these things happening and it adds to their level of anxiety and the debate around what services are available. We get lots of cross information from the community speculating about what we do or do not have and what services have been cut and have not been'.[804]
- 'Community consultation from the local health district is almost non-existent … The community is entitled to be advised what services will be provided'.[805]
- 'If we look at what services are available in, for example, community health, where do you go to get access about that? Finding that accurately presented on websites I think is problematic'.[806]

7.45 Furthermore, the *2019 Review of the Governance of Local Health Districts* undertaken by the NSW Auditor General found that the Local Health Districts currently do not have a method of effectively measuring community engagement within their governance framework:

> Despite the importance of community and consumer engagement, it remains underdeveloped in existing governance arrangements, including the accountability mechanisms. It is difficult for boards or the Ministry to know with confidence that community and consumer engagement is being done effectively. If devolution was intended to bring the management of health services closer to local communities, then there is little way to know whether this is being achieved.[807]

7.46 Consistent with this conclusion, Leeton Shire Council noted that the purpose of Local Health Advisory Committees has significantly changed. According to the Council, members of advisory committees are no longer privy to local health and hospital service outcomes, nor are they invited to participate in health service planning. Instead they are increasingly steered towards health and wellbeing programs, which means that the advisory committees 'are no longer serving as meaningful conduits between local communities and local health services for health planning and health reporting purposes'.[808]

7.47 In this regard, the Australian College of Rural and Remote Medicine stated that rural communities should be meaningfully involved in all planning and decision-making.[809]

7.48 In relation to access to information, Rural & Remote Medical Services Ltd reported that 'Rural and remote people have told us they cannot easily obtain access to information and data about health services and outcomes in their communities'.[810] Rural & Remote Medical Services Ltd further suggested that the kinds of information communities want ready access to includes:

- what are the minimum service standards for my local hospital (e.g. opening hours, access to emergency care) and was this achieved?

804 Evidence, Mr Phil Stone, General Manager, Edward River Council, 29 April 2021, p 5.
805 Evidence, Ms Brown, 30 April 2021, p 3.
806 Evidence, Ms Thompson, NSW Farmers' Association, 3 December 2021, p 14.
807 Submission 705, Rural & Remote Medical Services Ltd, p 51.
808 Submission 633, Leeton Shire Council, p 7.
809 Submission 403, Australian College of Rural and Remote Medicine, p 8.
810 Submission 705, Rural & Remote Medical Services Ltd, p 25.

- how many people in my town require dialysis compared to other towns, and do we have the same access to dialysis as other towns based on population need?
- how many residents in my town died by Triage Category compared to other towns?
- how many people in my town died prematurely and how many died from preventable causes?[811]

7.49 The committee heard that this incomplete picture of what services an individual can access in a location and the lack of meaningful community consultation causes potential delays when seeking treatment,[812] and also diminishes the confidence of the community in the health service.[813]

Health as a whole-of-government priority

7.50 The submission by Rural and Remote Medical Services stressed the importance of health being considered in all government decision-making. They used the example of the South Australian government which has adopted a Health in All Policies (HiAP) approach. Rural and Remote Medical Services' submission states:

> The HiAP approach aims to systematically account for the health implications of all public policy decisions and promote horizontal collaboration across multiple policy domains to reduce harmful health impacts in order to improve population health and health equity. The website of the program states:
>
> > 'Health in All Policies is about promoting healthy public policy, based on the understanding that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. Actions to address complex, multi-faceted 'wicked problems' such as preventable chronic disease and health care expenditure require joined-up policy responses.
> >
> > The South Australian Health in All Policies initiative is an approach to working across government to better achieve public policy outcomes and deliver co-benefits for agencies involved including to improve population health and wellbeing.
> >
> > Established in 2007, the successful implementation of Health in All Policies in South Australia has been supported by a high-level mandate from central government, an overarching framework which is supportive of a diverse

811 Submission 705, Rural & Remote Medical Services Ltd, p 25.

812 See for example: Evidence, Cr Jamie Chaffey, Mayor, Gunnedah Shire Council, 16 June 2021, p 4; Evidence, Mr Jeff Mitchell, Chief Executive Officer, Cancer Council, 5 October 2021, pp 4-5; Evidence, Ms Margaret Cashman, Director of Ethics, Policy and Research, Aboriginal Health and Medical Research Council of NSW, 5 October 2021, p 22; Submission 382, Warrumbungle Shire Council, p 4; Submission 464, Blue Mountains City Council, p 7; Submission 549, Name suppressed, p 2; Submission 568, Name suppressed, p 2.

813 Evidence, Mr Stone, 29 April 2021, p 5.

program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process'.[814]

Committee comment

7.51 Many of the issues raised in this chapter and elsewhere in the report are not new. In a media release issued on 25 November 2011 by the then Minister for Health, the Hon. Jillian Skinner MP, commenting on the final progress report on the implementation of the Special Commission of Inquiry into acute care services in NSW public hospitals she said:

> A series of organisational reforms are being implemented across the health system to empower local decision-making and provide greater clinician engagement, so that decisions are made based on what is best for patients.
>
> We are also committed to improving workplace culture and building a stronger public health system that is supported by collaboration, openness, respect and empowerment. We want our health professionals to work in environments that are supportive, and free of bullying and harassment, so that they really can work together to provide the best possible care to patients.[815]

7.52 The committee acknowledges that the health bureaucracy in New South Wales manages the largest public health system in Australia and with this comes significant organisational complexity and challenges. By its very nature, NSW Health is a large, multifaceted public organisation so the questions regarding accountability and transparency are continuously under scrutiny and judgement. However, despite the challenge of size, the committee was concerned to hear about the gaps and breakdowns in governance that were highlighted during the course of the inquiry. Consequently, the committee finds that there is a lack of transparency and accountability of NSW Health and the rural and regional Local Health Districts in terms of governance.

Finding 19

That there is a lack of transparency and accountability of NSW Health and the rural and regional Local Health Districts in terms of governance.

7.53 There can be no question that in regard to this inquiry the combination of submissions, public and virtual hearings, site visits and the associated publicity has, as it sought to do, brought to the attention of the NSW Government and indeed the Parliament, a swathe of issues impacting both directly and indirectly on health outcomes and access to health and hospital services in rural, regional and remote parts of the state. For those living in these parts of New South Wales, this inquiry and what it has uncovered will no doubt be seen as coming rather late in the day. Nevertheless, it has now been done and it is up to the NSW Government to, without delay, address the issues that have been raised.

814 Submission 705, Rural and Remote Medical Services Ltd, p 46.

815 Media release, Hon Jillian Skinner MP, Minister for Health and Minister for Medical Research, 'Final Garling Report welcomed', 25 November 2011.

7.54 The committee welcomes the appointment of a Regional Health Minister in December last year and the establishment of a new Regional Health Division in NSW Health and urges the NSW Government to ensure this Minister has the appropriate authority to address issues raised in the inquiry and future issues that affect the rural, regional and remote health system and its communities.

Recommendation 36

That the NSW Government maintain a Regional Health Minister in cabinet and provide that Minister with appropriate authority to address issues raised in the inquiry and future issues that affect the rural, regional and remote health system and its communities.

7.55 The committee also wishes to stress the importance of there being an informed and comprehensive evaluation of *NSW Rural Health Plan: Towards 2021* being undertaken before finalising the new health plan. The committee therefore recommends that NSW Health complete and publish the final evaluation of the *NSW Rural Health Plan: Towards 2021* before finalising the new rural health plan.

7.56 The committee urges the new Regional Health Minister to ensure that the development of the new rural health plan includes genuine consultation with rural and remote communities and acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems. Further, the committee was convinced by evidence that without realistic, measurable and quantifiable goals in terms of health outcomes in rural, regional and remote communities it is impossible to ensure accountability for decisions made by the government, including NSW Health and the Local Health Districts.

Recommendation 37

That NSW Health complete and publish the final evaluation of the *NSW Rural Health Plan: Towards 2021* before finalising the next rural health plan for New South Wales.

Recommendation 38

That the NSW Government ensure that the development of the next Rural Health Plan:

- acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems
- includes genuine consultation with rural and remote communities
- contains realistic, measurable and quantifiable goals in terms of tangible health outcomes
- provides the funding and support required to deliver against those goals.

7.57 In relation to partnerships, it is clear that despite the importance of having strong partnerships in place between NSW Health, the Local Health Districts and the Primary Health Networks to coordinate and deliver high quality health services in rural areas, this is not always occurring. We acknowledge that this is not necessarily reflective of a lack of will, given the evidence about

the LHDs and PHNs being under-resourced and faced with many competing priorities. However, the variability of these partnerships has a direct impact on the delivery of health services to communities across New South Wales.

7.58 The NSW and Australian Governments through the Local Health Districts and Primary Health Networks have repeatedly affirmed their commitment to ensuring that high quality services are cooperatively planned and successfully delivered. After everything we have heard in this inquiry, now is the time to deliver on this commitment.

7.59 Therefore, the committee recommends that NSW Health and the rural and regional Local Health Districts upgrade and enhance their collaborative work with the Primary Health Networks to ensure that high quality services are cooperatively planned and successfully delivered, and to drive innovative models of service delivery, including those recommended elsewhere in this report.

Recommendation 39

That NSW Health and the rural and regional Local Health Districts upgrade and enhance their collaborative work with the Primary Health Networks to:

- ensure that high quality health services for rural, regional and remote New South Wales are cooperatively planned and successfully delivered
- drive innovative models of service delivery, including those recommended elsewhere in this report.

7.60 In regards to cross border arrangements, the committee acknowledges the complexity associated with ensuring that residents who live in border adjacent areas can access cross border health services, and encourages the NSW Cross Border Commissioner to take a strong role in ensuring timely access to health services across the border.

7.61 On the issue of workplace culture, the committee was concerned to hear accounts of unsatisfactory workplace cultures across the Local Health District network. While acknowledging this is not universal, it is nonetheless troubling to hear the number of negative reports that were brought to the committee's attention over the course of the inquiry. Fear should not and must not be a part of any workplace culture.

7.62 Accordingly, the committee finds that there is a culture of fear operating within NSW Health in relation to employees speaking out and raising concerns and issues about patient safety, staff welfare and inadequate resources.

Finding 20

That there is a culture of fear operating within NSW Health in relation to employees speaking out and raising concerns and issues about patient safety, staff welfare and inadequate resources.

7.63 The committee recognises that cultural change cannot happen overnight, however the quality of the health care system relies first and foremost on individuals feeling empowered to draw attention to issues that impact on patient and staff safety and wellbeing. As touched on in

Chapter 4, management within the Local Health Districts must move away from a culture of blame and distrust, towards a culture in which feedback from staff is encouraged and viewed as an invaluable source of intelligence to identify pressure points early, based on values of openness, continuous improvement and respect.

7.64 The committee therefore recommends that NSW Health and the rural and regional Local Health Districts: commission an independent review of workplace culture including complaints management mechanisms and processes to align with a culture in which feedback from staff is encouraged, based on values of openness, continuous improvement and respect; implement complaints management training for staff, particularly those in management positions; commission the conduct of independent and confidential staff satisfaction surveys to measure progress and cultural improvements over time; review and enhance whistle blower protections to ensure staff feel comfortable in speaking up, with training material to be developed and implemented across the Local Health Districts to support this change; and develop and fund a plan to eliminate bullying and harassment within the rural and regional Local Health Districts.

7.65 Furthermore, the committee is of the view that the seriousness of the issues raised regarding the failure of the complaints management system and associated governance warrant the establishment of a new, independent body to investigate the administrative conduct of NSW Health and the Local Health Districts. As such, the committee recommends that the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of the Local Health Districts and NSW Health from staff, doctors, patients, carers and the public. The Ombudsman is to be empowered to review administrative decisions of NSW Health and Local Health District management, including but not limited to, alleged cover-ups of medical errors or deaths, false or misleading data, inaccurate communications and/or media reporting, Visiting Medical Officer accreditation decisions, staff blacklisting, and bullying or harassment of whistle-blowers. Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.

Recommendation 40

That NSW Health and the rural and regional Local Health Districts:

- commission an independent review of workplace culture including complaints management mechanisms and processes to align with a culture in which feedback from staff is encouraged, based on values of openness, continuous improvement and respect
- implement complaints management training for staff, particularly those in management positions
- commission the conduct of independent and confidential staff satisfaction surveys to measure progress and cultural improvements over time
- review and enhance whistle blower protections to ensure staff feel comfortable in speaking up, with training material to be developed and implemented across the Local Health Districtss to support this change
- develop and fund a plan to eliminate bullying and harassment within the rural and regional Local Health Districts.

Recommendation 41

That the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of Local Health Districts and NSW Health from staff, doctors, patients, carers and the public. The Health Administration Ombudsman is to be empowered to review administrative decisions of NSW Health and Local Health District management, including but not limited to, alleged cover-ups of medical errors or deaths, false or misleading data, inaccurate communications and/or media reporting, Visiting Medical Officer accreditation decisions, staff blacklisting, and bullying or harassment of whistle-blowers. Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.

7.66 Finally, the committee was disappointed to hear how little attention the Local Health Districts appear to give to effectively communicating with their most important stakeholder – the general public. The incomplete picture of the services available to residents and the lack of truly meaningful consultation has diminished the confidence of the community. As echoed in Chapter 2, the community desperately wants this engagement to take place. They want to know more about the services available in their community, and to be provided with a genuine avenue to consult with the facilities and Local Health Districts in regards to local health and hospital services.

7.67 Consequently, the committee finds that there is a lack of communication and genuine consultation between boards and management of Local Health Districts and communities when changes are proposed and made to hospitals and health services.

Finding 21

That there is a lack of communication and genuine consultation between boards and management of Local Health Districts and communities when changes are proposed and made to hospitals and health services.

7.68 The committee also finds that there is a lack of information and support for patients in rural, regional and remote areas when they leave the hospital system – especially those discharged in remote communities – resulting in poor health outcomes.

Finding 22

That there is a lack of information and support for patients in rural, regional and remote areas when they leave the hospital system – especially those discharged in remote communities – resulting in poor health outcomes.

7.69 In order to provide better community engagement and participation, the committee recommends that the Local Health Districts review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning. The committee also recommends that the Local Health Districts investigate methods of better informing communities about the

services that are available to them, and publish additional data such as wait times for services and the minimum service standards of the facilities within their remit.

7.70 Furthermore, the committee recommends that the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population

Recommendation 42

That the rural and regional Local Health Districts:

- review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning
- investigate methods of better informing communities about the services that are available to them, and publish additional data such as wait times and minimum service standards for the facilities within their remit.

Recommendation 43

That the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.

7.71 Finally, the committee agrees with the views put forward that the health of the people of New South Wales should be central to government decision making. Indeed, the pandemic has brought the importance of this to the fore. Therefore the committee believes that the NSW Government should adopt a policy similar to the South Australian Government's Health in All Policies framework to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. The framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.

Recommendation 44

That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.

Appendix 1 Submissions

No.	Author
1	Name suppressed
2	Name suppressed
3	Name suppressed
4	Confidential
5	Confidential
6	Dr Nigel Roberts
7	Mrs Christine Thomas
8	Name suppressed
9	Confidential
10	Confidential
11	Name suppressed
12	Name suppressed
13	Name suppressed
14	Name suppressed
14a	Name suppressed
15	Name suppressed
16	Mrs Winsome Rowbotham
17	ONE - One New Eurobodalla hospital
18	Name suppressed
19	Name suppressed
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24	Name suppressed
25	Name suppressed
26	Ms Elizabeth McCall
27	Name suppressed
28	Name suppressed
29	Mr Ross Haldeman
30	Mr Robert Whiter

No.	Author
31	Mrs Marg Haley
32	Ms Marion R Hosking OAM
33	Mr John Round
34	Can Assist (Cancer Assistance Network)
35	Name suppressed
36	Name suppressed
37	Name suppressed
38	Name suppressed
38a	Name suppressed
39	Name suppressed
40	Confidential
41	Confidential
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43	Name suppressed
44	Name suppressed
45	Name suppressed
46	Name suppressed
47	Mr Timothy Metcraft
48	Miss Sharon Horton
49	Mrs Belinda Perrett
50	Mrs Fiona Simson
51	Save Our Sons, Duchenne Foundation
52	Name suppressed
53	Mr Andrew Kemeny
54	Ms Elizabeth Kelly
55	Mr Wiliam Jones
56	Medical Error Action Group
57	Mrs Ellen Spencer
58	Name suppressed
59	Name suppressed
60	Name suppressed
61	Name suppressed
62	Mr Thornton Brown
63	Gunnedah Shire Council
64	Mrs Ashlea Mosley

No.	Author
65	Mr Liam Minogue
66	Ms Britt Vikstrand-Richards
67	Ms Tayla Kennedy
68	Mrs Rebecca Flett
69	Professor Richard Day
70	Name suppressed
71	Name suppressed
72	Name suppressed
73	Name suppressed
74	Name suppressed
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90	Confidential
91	Confidential
92	Confidential
93	Confidential
94	Name suppressed
95	Deniliquin Health Action Group
96	Ms Margaret Morgan
97	Rotary Club of Warren
98	Confidential
99	Confidential

No.	Author
100	Western NSW Local Health District, Medical Staff Executive Council
101	Name suppressed
102	Ms Leigh Adnum
103	Name suppressed
104	Name suppressed
105	Name suppressed
106	Network of Alcohol and other Drugs Agencies (NADA)
107	Family Planning NSW
108	NSW Council of Social Service (NCOSS)
109	Name suppressed
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163	Name suppressed
164	Blue Mountains Hospital Auxiliary
165	Narrandera Shire Council
166	Mid Coast 4 Kids

No.	Author
167	Manning Valley Push for Palliative
168	Manning Base Hospital Taree (Department of Medicine)
169	Bay Medical Group
170	Carers NSW Australia
171	Indidg Connect
172	Temora Shire Council
173	Cancer Council NSW
174	Tresillian
175	Cr Carol Sparks, Mayor, Glen Innes Severn Council
176	Council on the Ageing (COTA) NSW
177	Medical Council of NSW
178	ALP Tweed Heads Branch
179	Coraki Health Reference Group
180	MEN Talking With MEN
181	Deniliquin Mental Health Awareness Group (Deni MHAG)
182	NSW Rural Health Research Alliance
183	Gulgong Petitioners
184	Ballina Cancer Advocacy Network
185	Save Murwillumbah Hospital Action Group
186	Mrs Jillian Davidson
187	Mrs Sheryl Rowlands
188	Mrs Marlene Wynd
189	Mrs Christie Germon
190	Mrs Kathryn Pearson
191	Miss Alison Pearson
192	Miss Jaymee Manns
193	Mrs Annette McAndrew
194	Mr David Wynn
195	Mr Allan Small
196	Mrs Rhonda Hetherington
197	Mrs Crystal Dwyer
198	Ms Carole Jenkins
199	Mrs Sally Empringham
200	Mr Stephen Taverner
201	Confidential

No.	Author
202	Miss Jessie Day
203	Miss Lisa Cole
204	Mrs Carmelina Leotta
205	Mr Peter Leotta
206	Mr Andre Othenin-Girard
207	Mrs Karen Border
208	Ms Lisa Urquhart
209	Mr Derek Hayden
210	Mr Garry Baker
211	Mrs Joan Staggs
212	Ms Jennifer Apps
213	Confidential
214	Mr Christopher Pearson
215	Ms Sue Newbery
216	Mrs Sally Blinkhorne
217	Mrs Jennifer Kooloos
218	Dr Florian Roeber
219	Mrs Danielle Bickford
220	Mr Karle Duke
221	Carmel Kentwell
222	Mr Alan Tickle
223	Mr Robert McCallum
224	Name suppressed
225	Ms Sharelle Fellows
226	Dr Phillip Jolly
227	Mr Graeme (Mick) McLeod
227a	Mr Graeme (Mick) McLeod
228	Mrs Kate Mildner
229	Ms Sarah Pringle
230	Miss Samantha Bayley
231	Mrs Carol Richard
231a	Mrs Carol Richard
231b	Confidential
232	Ms Kate Halliwell
233	Mrs Annette Piper

No.	Author
234	Mr Scott Cartwright
235	Miss Ann McLachlan
236	Mrs Samantha Mcleod
237	Mrs Lois Biti
238	Mr Robert Dickson
239	Mrs Kate Ryan
240	Mr Bill Hancock
241	Mrs Karen Samuels
242	Mrs Judith Bond
243	Mrs Francis Bond
244	Shine Lawyers
245	Bathurst Regional Council
245a	Bathurst Regional Council
246	Mr Ryan Park MP
247	The Australasian College of Dermatologists
248	Edward River Council
249	One Door Mental Health - Great Lakes Mental Health Carer Support Group
250	Pharmaceutical Society of Australia
251	Mrs Courtney Dawson
252	Wee Waa Chamber of Commerce
253	Wollondilly Shire Council
254	Australian Association of Social Workers
255	The Heart Foundation
256	Marathon Health Ltd
257	Health Services Union NSW ACT QLD
258	New South Wales Nurses and Midwives' Association
258a	New South Wales Nurses and Midwives' Association
258b	New South Wales Nurses and Midwives' Association
258c	New South Wales Nurses and Midwives' Association
258d	New South Wales Nurses and Midwives' Association
259	Australian College of Nurse Practitioners
260	Royal Far West
261	The Royal Australasian College of Medical Administrators
262	Australasian College for Emergency Medicine (ACEM)
263	Riverina Murray Regional Alliance

No.	Author
264	Mid-Western Regional Council
265	Aboriginal Health and Medical Research Council of NSW
266	Australian Nuclear Science and Technology Organisation (ANSTO)
267	Project Sprouts
268	Quality Aged Care Action Group Incorporated (QACAG)
269	Orange Health Service Medical Staff Council
270	Gunnedah Early Childhood Network
271	The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
272	The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
273	Mr Greg Piper
274	Unions Shoalhaven
275	Australasian College of Paramedicine
276	New South Wales Medical Staff Executive Council (NSW MSEC)
276a	Confidential
276b	New South Wales Medical Staff Executive Council (NSW MSEC)
277	Name suppressed
278	Old Bonalbo CWA
279	Dementia Australia
280	Name suppressed
281	Name suppressed
282	Name suppressed
283	Name suppressed
284	Name suppressed
285	Confidential
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328	Confidential
329	Confidential
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331	Confidential
332	Confidential
333	Name suppressed
334	Confidential
335	Confidential
336	Confidential
337	Confidential
338	Confidential
339	Confidential
340	Confidential
341	Walgett Shire Council
342	Confidential
343	Confidential
344	Can Assist Coleambally
345	Local Government NSW
345a	Local Government NSW
346	Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN)
347	Mrs Sharon Bird, Bonalbo Pharmacy
348	Physician Group Tamworth Base Hospital
349	New Yass Hospital with Maternity Working Group
350	Australian Pompe Association
351	Ms Jamelle Wells
352	Mr Frank Mesina
353	Mr Kevin Richard Martin
354	Dr Ian Dumbrell
355	Dr Robert Lodge
356	Miss Vicki Morrison
356a	Miss Vicki Morrison
357	Mr John Cruickshanks
358	Mr Simon Goddard
359	Mr Victor Dossan

No.	Author
360	Mr Raymond Dean
361	Name suppressed
362	Dr Danny Wotherspoon
363	Mr Tom Newby
364	Ms Ellie Mclaughlin
365	Mrs Jessica Elwell
366	Mrs Louise Eggelton
367	Mr Denis Strangman AM
368	Ms Trish Doyle MP, Member for Blue Mountains
369	Name suppressed
370	Dr Tom Bennett
371	Dr Neil McCarthy
372	Dr John England
373	Mr David Young
374	Mr Robert Heather
375	Mr Clive Bingham
376	Mr Bill Behsman
377	Mr Rick Campbell
378	Mrs Cheryl McDonnell
379	Dr Simon Holliday
380	Mr Peter Marheine
381	Name suppressed
382	Warrumbungle Shire Council
383	Confidential
384	Confidential
385	Mission Australia
386	Mrs Annette Holman
387	Chamber of Commerce and Industry Lawson
388	Confidential
389	Name suppressed
390	Ms Nicole Scholes-Robertson
391	Office of the National Rural Health Commissioner
392	Confidential
393	Clr Nina Digiglio
394	NSW Rural Doctors Network (RDN)

No.	Author
395	Name suppressed
396	Confidential
397	Warren Shire Council
398	Broken Hill City Council
399	Western Parkland Councils
400	Yass Valley Council
401	Charles Sturt University
402	Port Stephens Council
403	Australian College of Rural and Remote Medicine (ACRRM)
404	Ms Sue Harris
405	Mr Peter Connell
406	Mrs Sally Milson-Hawke
407	Miss Emma Gane
408	Ms Jennifer Clarke
409	Mr Steven Vella
410	Wentworth District Community Medical Centre Inc.
411	Mrs Vicki Kearines
412	Mr Brian Jeffrey
413	Mr James Burns
414	Name suppressed
415	Mr Adam Hannelly
416	Mrs Barbara Seis
417	Mrs Eleanor Cook
418	Mrs Jennifer Wykes
419	Ms Shan Elliott
420	Ms Carla Bower
421	Mrs Elizabeth Mayberry
422	Ms Denise Davidson
423	Mrs Sharon Bird
424	Confidential
425	Mrs Margaret Thomson
426	Mr Chris Hoare
427	Mrs Julie Layton
428	Mrs Cecily Carter
429	Mrs Jenny Caslick

No.	Author
430	Mr Keith O'Maley
431	Mrs Carmel Trengove
432	Mrs Christine Robertson
432a	Mrs Christine Robertson
433	Mrs Erika Rogers
434	Mr Andrew Johnson
435	Cr Ben Shields
436	Name suppressed
437	Name suppressed
438	Name suppressed
439	Name suppressed
440	Medical Staff Council Blue Mountain and Springwood Hospitals
441	Merriwa Pharmacy
442	Gunnedah Community Roundtable
443	Genetic Alliance Australia
444	The Kaden Centre
445	Country Women's Association of NSW (CWA of NSW)
446	Rural Doctors' Association of NSW
447	Karitane
448	GP Synergy Limited
449	The Office of Helen Dalton MP, Member for Murray
450	Juvenile Arthritis Foundation Australia
451	Tenterfield Shire Council
452	NSW Rural Primary Health Networks (PHNs)
453	Australian Salaried Medical Officers' Federation (NSW) (ASMOF)
454	Centre for Rural and Remote Mental Health
455	John Hunter Hospital Hunter New England Health
456	Exercise and Sports Science Australia (ESSA)
457	Central NSW Joint Organisation
458	The Australian and New Zealand Society of Palliative Medicine (ANZSPM)
459	Doctors for the Environment Australia
460	Ms Kate Stewart
461	My Emergency Doctor
462	Regional Cities New South Wales (RCNSW)
463	Parkes Shire Council

No.	Author
464	Blue Mountains City Council
465	Remote Vocational Training Scheme (RVTS)
466	New England Virtual Health Network (NEViHN) - University of New England
467	Hunter Medical Research Institute (HMRI)
468	Coonamble Shire Council
469	Leura Gardens Festival Inc.
470	Murrumbidgee Council
471	Orange Push for Palliative (OP4P)
472	Gwydir Cotton Growers Association
473	Services for Australian Rural and Remote Allied Health (SARRAH)
474	Australian and New Zealand College of Anaesthetists (ANZCA)
475	Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA)
476	Mental Health Commission of NSW
477	Mr Phillipe Millard
478	National Rural Health Alliance
479	Isolated Children's Parents' Association of New South Wales Inc.
480	Leura Home Garden Club
481	Confidential
482	Mr Christopher Cousins
482a	Mr Christopher Cousins
482b	Mr Christopher Cousins
483	Mr Hal Ginges and Mrs Heather Ginges
484	Ms Shirlee Burge
485	Confidential
486	Name suppressed
487	Confidential
488	Confidential
489	Cr Craig Davies
490	Name suppressed
491	Mr Rod Stowe PSM, FRSN
492	Dr Claire Cupitt
493	Name suppressed
494	Name suppressed
495	Dr Liz Jones

No.	Author
496	Name suppressed
497	Name suppressed
498	Name suppressed
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501	Ms Elizabeth Worboys
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558	Mr John Kellett
559	Name suppressed
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No.	Author
565	Name suppressed
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569	Confidential
570	Name suppressed
571	Regional Medical Specialists Association (RMSA)
572	Macquarie Health Collective
573	Australian Medical Association (NSW) Ltd
574	Mrs Christine Spradbrow
575	Mrs Hayley Olivares
576	Mrs Shelley Piper
577	Mr Chris Kem
578	Mr Grant Mistler
579	Mr Malcolm Knight
580	Mr Robert Wade
581	Miss Michelle Guest
582	Dr Joe McGirr MP, Independent Member for Wagga Wagga
583	Ms Ronda Payne
584	Ms Diann Colman
585	Mrs Janet Price
586	Dr Geoffrey Pritchard
587	Mrs Renee Murphy
588	Mr Gavin Matheson
589	Mrs Barbara Smith
590	Ms Vicky Ansin
591	Mr Michael Doyle
592	Mrs Miranda Kelly
593	Dr Dominic Horne
594	Dr Michelle King
595	Mr Jamie Gibbins
596	Mrs Colleen Fuller
596a	Mrs Colleen Fuller
597	Ms Jane Leake
598	Mr David Moran

No.	Author
599	Mr Paul Nealon
600	Mrs Leonie Hutchinson
601	Mr Lenard Fitton
602	Name suppressed
603	Mr Don Graham
604	Aged and Community Services Australia (ACSA)
605	Miss Kristy Burgess
606	Mrs Diane Simmonds
607	Dr Geoffrey Stewart
608	Tamworth Medical Staff Council
609	Name suppressed
610	Name suppressed
611	Ms Shirley Taylor
612	Ms Susan Lenehan and Mr Richard Mills
613	Ms Elizabeth Hayes
614	Mr Robert Collier
615	Mrs Kathleen Parnaby
616	Mrs Angela McCormack
617	Miss Tammy Albert
618	Mrs Jill McGovern
619	Ms Emma Priest
620	Mr Roy Butler MP, Member for Barwon
621	Ms Bernadette Robson
622	Mrs Daphne Calvert
623	Ms Menaka Wickramasinghe
624	Mr Peter Meyers
625	Mr Timothy Burge
626	Uniting NSW ACT
627	The Society of Hospital Pharmacists of Australia (SHPA)
628	National Justice Project
629	The Royal Australian College of General Practitioners (RACGP)
630	NSW Government
630a	NSW Government
631	Bourke Shire Council
632	Hay Shire Council

No.	Author
633	Leeton Shire Council
634	Confidential
635	Name suppressed
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645	Confidential
646	Mr Brian Beaumont
647	Confidential
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656	Confidential
657	Name suppressed
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664	Australian Paramedics Association (NSW)
665	Confidential
665a	Confidential
665b	Confidential

No.	Author
666	Confidential
667	Confidential
668	Confidential
669	Confidential
670	The University of Newcastle Australia, Department of Rural Health
671	Confidential
672	Confidential
673	Confidential
674	Confidential
675	Confidential
676	Confidential
677	Royal Flying Doctor Service of Australia (South Eastern Section)
678	Manning Great Lakes Community Health Action Group Inc.
679	Name suppressed
680	Confidential
681	Confidential
682	Mr Geoffrey Langford
683	Confidential
684	Confidential
685	Confidential
686	NSW Farmers' Association
687	National Farmers Federation
688	Name suppressed
689	Confidential
690	Name suppressed
691	Dr Danny Beran
692	Dr Ian G Spencer OAM
693	Name suppressed
694	Australian Lawyers Alliance
695	Confidential
696	Ms Glenis Lorna Prisk
697	Confidential
698	Confidential
699	Confidential
700	Confidential

No.	Author
701	Ms Leonie Bunyan
702	Confidential
703	Robyn Waller
704	Parkinson's NSW
705	Rural and Remote Medical Services Ltd.
706	Just Reinvest NSW
707	Confidential
708	Confidential
709	InteliCare
710	Regional Accommodation Providers Group and Can Assist
711	Name suppressed
712	Country Women's Association of NSW – Hillston Branch
713	Ms Marcia Howes
714	Australian Dental Association, NSW Branch
715	Radiation Therapy Advisory Group (RTAG)
716	Maari Ma Health Aboriginal Corporation
717	Caroline Coulston
718	Walgett Aboriginal Medical Service Limited (WAMS)
719	Mr Trevor Rowe
720	Confidential

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Friday 19 March 2021 **Macquarie Room** **Parliament House, Sydney**	Ms Colette Colman *(via videoconference)*	Director, Policy and Strategy Development, National Rural Health Alliance
	Mr Luke Sartor *(via videoconference)*	Policy and Research Officer, National Rural Health Alliance
	Dr Shehnarz Salindera	Councillor, Australian Medical Association
	Ms Dianne Kitcher *(via videoconference)*	CEO, South Eastern NSW Primary Health Network, NSW Rural Primary Health Networks
	Mr Richard Nankervis *(via videoconference)*	CEO, Hunter New England and Central Coast Primary Health Network, NSW Rural Primary Health Networks
	Dr Michael Clements *(via videoconference)*	Chair - Rural, The Royal Australian College of General Practitioners
	Dr Charlotte Hespe *(via videoconference)*	Chair - NSW & ACT, The Royal Australian College of General Practitioners
	Dr Rod Martin *(via videoconference)*	Rural Generalist, Australian College of Rural and Remote Medicine
	Dr Charles Evill	President, Rural Doctor's Association of NSW
	Mr Richard Colbran	Chief Executive Officer, NSW Rural Doctors Network
	Dr John Kramer *(via videoconference)*	Chair, NSW Rural Doctors Network
	Mr Brett Holmes	General Secretary, New South Wales Nurses and Midwives' Association
	Mrs Kristyn Paton	Registered Nurse and Branch President, New South Wales Nurses and Midwives' Association

Date	Name	Position and Organisation
	Ms Barbara Turner *(via videoconference and teleconference)*	Health Service Manager / Nurse Practitioner, Australian College of Nurse Practitioners
	Mr Gerard Hayes	Secretary, Health Services Union
	Mr Mark Jay	Organiser, Health Services Union
	Dr Tony Sara	President, Australian Salaried Medical Officers' Federation
	Dr Nigel Lyons	Deputy Secretary, Health System Strategy and Planning Division, NSW Health
	Mr Phil Minns	Deputy Secretary, People Culture and Governance Division, NSW Health
Thursday 29 April 2021 **Dunlop Room** **Deniliquin RSL, Deniliquin**	Mr Phil Stone	General Manager, Edward River Council
	Cr Norm Brennan	Mayor, Edward River Council
	Mr John Scarce	General Manager, Murrumbidgee Council
	Cr Ruth McRae	Mayor, Murrumbidgee Council
	Dr Marion Magee	Chair, Deniliquin Health Action Group
	Dr Dan Salmon	Secretary, Deniliquin Health Action Group
	Ms Lyn Bond	Chair, Deniliquin Mental Health Awareness Group
	Ms Lourene Liebenberg	Vice Chair, Deniliquin Mental Health Awareness Group
	Ms Sue Hardy	President, Can Assist Coleambally
	Ms Monica Whelan	Member, Can Assist Coleambally
	Dr Ian Dumbrell	Private individual
	Mrs Shirlee Burge	Private individual
	Mr Timothy Burge	Private individual
	Ms Jill Ludford	Chief Executive, Murrumbidgee Local Health District

Date	Name	Position and Organisation
	Dr Lenert Bruce	Executive Director, Medical Services, Murrumbidgee Local Health District
	Ms Julie Redway	Acting Chief Executive, Murrumbidgee Primary Health Network
	Dr Jodi Culbert	Chair, MPHN Board, Murrumbidgee Primary Health Network
Friday 30 April 2021 **Auditorium** **Cobar Memorial Services Club, Cobar**	Witness A	
	Witness B	
	Mr Peter Vlatko	General Manager, Cobar Shire Council
	Cr Peter Abbott	Mayor, Cobar Shire Council
	Ms Leonie Brown	Manager Corporate Services, Bourke Shire Council
	Cr Barry Hollman	Mayor, Bourke Shire Council
	Miss Ally Pearson	Private individual
	Mr Geoffrey Langford	Private individual
	Pen McLachlan	Private individual
	Mr Scott McLachlan	Chief Executive, Western NSW Local Health District
	Mr Brendan Cutmore	Executive Director, Aboriginal Health and Wellbeing, Western NSW Local Health District
	Ms Jenny Tyack	Chair, Condobolin Doctor Crisis Working Party
	Ms Annie Ryan	Deputy Chair, Condobolin Doctor Crisis Working Party
	Dr Shannon Nott	Rural Health Director of Medical Services, Western NSW Local Health District

Date	Name	Position and Organisation
Tuesday 18 May 2021 **Function Room** **Hermitage Hill, Wellington**	Cr Ben Shields	Mayor, Dubbo Regional Council
	Cr Aniello Iannuzzi	Deputy Mayor, Warrumbungle Shire Council
	Mr Neil Southorn	Director - Environmental, Planning and Building Services, Bathurst Regional Council
	Cr Warren Aubin	Councillor, Bathurst Regional Council
	Ms Sheree Staggs	Registered Nurse, New South Wales Nurses and Midwives' Association
	Ms Samantha Gregory-Jones	Registered Nurse, New South Wales Nurses and Midwives' Association
	Mr Harold Sandell	Former President, Rotary Club of Warren
	Mrs Alison Campbell	Member, Warren Health Action Group
	Dr Kitty Eggerking	Member, Gulgong Petitioners
	Mrs Kathryn Pearson	Member, Gulgong Petitioners and private individual
	Ms Sharelle Fellows	Member, Gulgong Petitioners and private individual
	Mrs Hayley Olivares	Private individual
	Mr Christopher Pearson	Private individual
	Ms Ronda Payne	Private individual
	Mrs Sally Empringham	Private individual
	Mrs Joan Staggs	Private individual
	Mrs Carol Richard	Private individual
	Mrs Diane Simmonds	Private individual
Wednesday 19 May 2021 **Auditorium** **Dubbo RSL Club, Dubbo**	Witness C	
	Witness D	
	Witness E	
	Cr Ken Keith OAM	Mayor, Parkes Shire Council

Date	Name	Position and Organisation
	Dr Kerrie Stewart	General Practitioner, Ochre Health Medical Centre
	Cr Milton Quigley	Mayor, Warren Shire Council
	Cr Heather Druce	Councillor, Warren Shire Council
	Ms Ann-Maree Chandler	Owner, Indidg Connect
	Ms Jaime Keed	Practice Manager, Dubbo Regional Aboriginal Medical Service
	Dr Amy Perron	General Practitioner, Dubbo Regional Aboriginal Medical Service
	Dr Neil McCarthy	Private individual
	Mrs Vicki Kearines	Private individual
	Ms Jessica Brown	General Manager, Strategy and Growth Business Development, Marathon Health
	Ms Julie Cullenward	Practice Lead - Allied Health, Marathon Health
	Mrs Tanya Forster	Psychologist and Director, Macquarie Health Collective
	Mr Bill Maiden	Chief Executive Officer, My Emergency Doctor
	Dr Justin Bowra	Founder & Medical Director, My Emergency Doctor
	Mr Scott McLachlan	Chief Executive, Western NSW Local Health District
	Dr Shannon Nott	Rural Health Director of Medical Services, Western NSW Local Health District
	Mr Adrian Fahy	Executive Director, Quality, Clinical Safety and Nursing, Western NSW Local Health District
	Mr Robert Strickland	Acting Chief Executive Officer, Western NSW Primary Health Network
	Dr Robin Williams	Board Chair, Western NSW Primary Health Network

Date	Name	Position and Organisation
	Ms Sonya Berryman	General Manager Primary Healthcare and Integration, Western NSW Primary Health Network
Wednesday 16 June 2021 Smithurst Theatre, Gunnedah	Mrs Kate McGrath	Former Chair and Founding Member, Gunnedah Community Roundtable
	Mrs Rebecca Dridan	Chair, Gunnedah Early Childhood Network
	Ms Rebecca Ryan	Member, Gunnedah Early Childhood Network
	Cr Jamie Chaffey	Mayor, Gunnedah Shire Council
	Mr Eric Groth	General Manager, Gunnedah Shire Council
	Dr David Scott	Chair, Tamworth Medical Staff Council and Member, Physician Group Tamworth Base Hospital
	Dr Liz Jones	Private individual
	Ms Kate Ryan	Private individual
	Ms Elizabeth Worboys	Private individual
	Ms Emma Priest	Private individual
	Mr Brian Jeffrey	Private individual
Wednesday 16 June 2021 Winning Post Function Room Manning Valley Race Club, Taree	Mr Eddie Wood	President, Manning Great Lakes Community Health Action Group
	Mrs Bree Katsamangos	Convenor, Mid Coast 4 Kids
	Ms Melissa Foster	Aboriginal Project Worker and Playgroup Coordinator – Child Care Services Taree & Districts Inc
	Ms Judy Hollingworth	Founder and Deputy Chair, Manning Valley Push for Palliative
	Ms Robyn Jenkins	Secretary, Manning Valley Push for Palliative
	Dr Nigel Roberts	Private individual
	Dr Simon Holliday	Private individual

Date	Name	Position and Organisation
	Dr Seshasayee Narasimhan	Visiting Medical Officer, Acute Care Physician and Cardiologist, Department of Medicine, Manning Base Hospital
	Mr Alan Tickle	Private individual
	Ms Marion R Hosking OAM	Private individual
	Mr Michael DiRienzo	Chief Executive, Hunter New England Local Health District
	Dr Peter Choi	Director of Medical Services, John Hunter Hospital, Hunter New England Local Health District
Thursday 17 June 2021 **Auditorium** **Lismore Workers Club,** **Lismore**	Witness F	
	Witness G	
	Witness H	
	Mrs Marilyn Grundy	Branch President, Old Bonalbo CWA
	Mr George Thompson	Member, Coraki Health Reference Group
	Ms Maureen Fletcher	Chair, Ballina Cancer Advocacy Network
	Mrs Sharon Bird *(via teleconference)*	Proprietor and Pharmacist, Bonalbo Pharmacy
	Mr Andre Othenin-Girard	Private individual
	Dr Florian Roeber	Private individual
	Mr Chris Hoare	Private individual
	Mrs Christine Robertson	Private individual
	Mr Wayne Jones	Chief Executive, Northern NSW Local Health District
	Dr David Hutton	Director of Clinical Governance, Northern NSW Local Health District
	Ms Katharine Duffy	Director of Nursing and Midwifery and Aboriginal Health, Northern NSW Local Health District

Date	Name	Position and Organisation
Friday 10 September 2021 Videoconference	Ms Jamelle Wells *(via videoconference)*	Private individual
	Ms Liz Hayes *(via videoconference)*	Private individual
	Mr Scott Beaton *(via videoconference)*	Vice President, Australian Paramedics Association (NSW) Intensive Care Paramedic, Station Officer, Gilgandra Station
	Ms Liu Bianchi *(via videoconference)*	Delegate, Australian Paramedics Association (NSW) and Intensive Care Paramedic, Extended Care Paramedic, Tuncurry Station
	Mr Ryan Lovett *(via videoconference)*	Chair, Australasian College of Paramedicine
	Ms Alecka Miles *(via videoconference)*	Chair - Rural, Remote and Community Paramedicine Special Interest Group, Australasian College of Paramedicine
	Ms Kristin Michaels *(via videoconference)*	Chief Executive, The Society of Hospital Pharmacists of Australia
	Mr Jerry Yik *(via videoconference)*	Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia
	Ms Chelsea Felkai *(via videoconference)*	NSW President, Pharmaceutical Society of Australia
	Ms Karen Carter *(via videoconference)*	Fellow, Pharmaceutical Society of Australia and Owner, Gunnedah and Narrabri Pharmacies
	Dr Sarah Wenham *(via videoconference)*	Specialist Palliative Care Physician / Clinical Director (sub-acute and non-acute care) - Far West Local Health District, appearing on behalf of The Australian and New Zealand Society of Palliative Medicine
	Dr Susie Lord *(via videoconference)*	Board member, Faculty of Pain Medicine , Australian and New Zealand College of Anaesthetists (ANZCA)

Date	Name	Position and Organisation
	Associate Professor Paul Wrigley *(via videoconference)*	Member, Learning & Development Committee and NSW Regional Committee - Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA)
	Professor Megan Smith *(via videoconference)*	Executive Dean, Faculty of Science & Health, Charles Sturt University
	Professor Lesley Forster *(via videoconference)*	Dean, School of Rural Medicine, Charles Sturt University
	Professor Jenny May *(via videoconference)*	Director, University of Newcastle, Department of Rural Health
	Professor Brigid Heywood *(via videoconference)*	Vice Chancellor and Chief Executive Officer, University of New England
	Ms Leanne Nisbet *(via videoconference)*	Project Manager, New England Virtual Health Network - University of New England
	Dr Pat Giddings *(via videoconference)*	Chief Executive Officer, Remote Vocational Training Scheme
Tuesday 5 October 2021 Videoconference	Witness I *(via videoconference)*	
	Witness J *(via videoconference)*	
	Witness K *(via videoconference)*	
	Witness L *(via videoconference)*	
	Ms Emma Phillips *(via videoconference)*	Executive Director, Can Assist
	Ms Majella Gallagher *(via videoconference)*	Relationship Manager, Can Assist
	Mr Jeff Mitchell *(via videoconference)*	Chief Executive Officer, Cancer Council NSW
	Ms Annie Miller *(via videoconference)*	Director, Cancer Information and Support Services, Cancer Council NSW

Date	Name	Position and Organisation
	Dr Ruth Arnold *(via videoconference)*	Rural Co-Chair, New South Wales Medical Staff Executive Council
	Associate Professor Peter Malouf *(via videoconference)*	Executive Director - Operations, Aboriginal Health and Medical Research Council of NSW
	Ms Margaret Cashman *(via videoconference)*	Director of Ethics, Policy and Research, Aboriginal Health and Medical Research Council of NSW
	Dr Alex Stephens *(via videoconference)*	Director of Research, Northern NSW Local Health District, and Chair, NSW Rural Health Research Alliance
	Professor Andrew Searles *(via videoconference)*	Associate Director - Health Research Economics, Hunter Medical Research Institute
Wednesday 6 October 2021 Videoconference	Cr Paul Maytom *(via videoconference)*	Mayor, Leeton Shire Council
	Mrs Jackie Kruger *(via videoconference)*	General Manager, Leeton Shire Council
	Cr Neville Kschenka *(via videoconference)*	Mayor, Narrandera Shire Council
	Mr George Cowan *(via videoconference)*	General Manager, Narrandera Shire Council
	Ms Adair Garemyn *(via videoconference)*	Policy Manager, Country Women's Association of NSW
	Mrs Linda McLean *(via videoconference)*	Branch Agriculture & Environment Officer, Country Women's Association of NSW - Hillston branch
	Dr Michael Holland *(via videoconference)*	Co-founder, ONE - One New Eurobodalla hospital
	Ms Catherine Hurst *(via videoconference)*	Private individual
	Mrs Patricia David *(via videoconference)*	Secretary, Unions Shoalhaven
	Mr John Fernando *(via videoconference)*	Chairperson, Riverina Murray Regional Alliance

Date	Name	Position and Organisation
	Mr Greg Packer *(via videoconference)*	Delegate for Wagga Wagga, Riverina Murray Regional Alliance
	Ms Stacey O'Hara *(via videoconference)*	Committee member, Murrumbidgee Aboriginal Health Consortium
	Dr Geoffrey Pritchard *(via videoconference)*	Private individual
	Dr Paul Mara *(via videoconference)*	Private individual
Thursday 2 December 2021 Videoconference	Cr Ian Woodcock *(via videoconference)*	Mayor, Walgett Shire Council
	Mr Michael Urquhart *(via videoconference)*	General Manager, Walgett Shire Council
	Cr Darriea Turley AM *(via videoconference)*	Mayor, Broken Hill City Council
	Mr Mark Burdack *(via videoconference)*	Chief Executive Officer, Rural and Remote Medical Services Ltd
	Mr Richard Anicich AM *(via videoconference)*	Chair, Rural and Remote Medical Services Ltd
	Mr Greg Sam *(via videoconference)*	Chief Executive Officer, Royal Flying Doctor Service of Australia (South Eastern Section)
	Ms Jenny Beach *(via videoconference)*	General Manager Health Services, Royal Flying Doctor Service of Australia (South Eastern Section)
	Ms Betty Kennedy Williams *(via videoconference)*	Enrolled Nurse, New South Wales Nurses and Midwives' Association
	Aunty Monica Kerwin *(via videoconference)*	Community spokesperson, Wilcannia
	Mr Michael Kennedy *(via videoconference)*	Private individual
	Mr Bob David *(via videoconference)*	Chief Executive Officer, Maari Ma Health
	Dr Hugh Burke *(via videoconference)*	Public Health Physician, Maari Ma Health

Date	Name	Position and Organisation
	Mr Carl Grant *(via videoconference)*	Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service
	Ms Christine Corby OAM *(via videoconference)*	Chief Executive Officer, Walgett Aboriginal Medical Service
	Ms Katrina Ward *(via videoconference)*	Operations Manager, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service
	Mr Umit Agis *(via videoconference)*	Chief Executive, Far West Local Health District
	Ms Dale Sutton *(via videoconference)*	Executive Director Nursing, Midwifery & Clinical Governance, Far West Local Health District
	Dr Timothy Smart *(via videoconference)*	Director Medical Services, Far West Local Health District
Friday 3 December 2021 Macquarie Room Parliament House, Sydney	Ms Jenny Lovric *(via videoconference)*	Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest
	Ms Catherine Henry *(via videoconference)*	Spokesperson, Australian Lawyers Alliance
	Ms Kathy Rankin *(via videoconference)*	Policy Director - Rural Affairs & Business Economics & Trade, NSW Farmers' Association
	Ms Sarah Thompson *(via videoconference)*	Member of the NSW Farmers Rural Affairs Policy Committee, NSW Farmers' Association
	Dr Edward Johnson *(via videoconference)*	President, Services for Australian Rural and Remote Allied Health
	Ms Catherine Maloney *(via videoconference)*	Chief Executive Officer, Services for Australian Rural and Remote Allied Health
	Ms Leanne Evans *(via videoconference)*	Senior Policy & Relations Advisor, Exercise & Sports Science Australia
	Mr John Stevens *(via videoconference)*	NSW State Chapter Co-Chair, Exercise & Sports Science Australia

Date	Name	Position and Organisation
	Dr Kristin Bell *(via videoconference)*	Chair, Specialist Training Program Committee and Chair, QEC Regional Training Network, The Royal Australian and New Zealand College of Ophthalmologists
	Associate Professor Ashish Agar *(via videoconference)*	Chair, Reconciliation Action Plan Working Group, The Royal Australian and New Zealand College of Ophthalmologists
	Dr Michael Jonas	President, Australian Dental Association - NSW branch
	Dr Sarah Raphael	Advisory Services Manager, Australian Dental Association - NSW branch
	Ms Catherine Lourey *(via videoconference)*	Commissioner, Mental Health Commission of NSW
	Dr Justine Hoey-Thompson *(via videoconference)*	Member, The Royal Australian and New Zealand College of Psychiatrists
	Professor David Perkins *(via teleconference)*	Director and Professor of Rural Health Research , Centre for Rural and Remote Mental Health
	Dr Hazel Dalton *(via videoconference)*	Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health
Tuesday 1 February 2022 **Jubilee Room** **Parliament House, Sydney**	Mr Stewart Dowrick *(via videoconference)*	Chief Executive, Mid North Coast Local Health District
	Dr Richard Tranter *(via videoconference)*	District Medical Director for Integrated Mental Health and Alcohol & Other Drugs, Mid North Coast Local Health District
	Ms Kay Hyman *(via videoconference)*	Chief Executive, Nepean Blue Mountains Local Health District
	Ms Eloise Milthorpe *(via videoconference)*	Acting Deputy Director Planning, Nepean Blue Mountains Local Health District
	Mr Scott McLachlan *(via videoconference)*	Chief Executive, Central Coast Local Health District

Date	Name	Position and Organisation
	Professor Steevie Chan *(via videoconference)*	Acting District Director Medical Service, Central Coast Local Health District
	Ms Margaret Bennett *(via videoconference)*	Chief Executive, Southern NSW Local Health District
	Dr Liz Mullins *(via videoconference)*	Executive Director of Medical Services, Southern NSW Local Health District
	Ms Margot Mains *(via videoconference)*	Chief Executive, Illawarra Shoalhaven Local Health District
	Ms Margaret Martin *(via videoconference)*	Executive Director Clinical Operations, Illawarra Shoalhaven Local Health District
	Ms Caroline Langston *(via videoconference)*	Executive Director, Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven Local Health District
	Ms Amanda Larkin *(via videoconference)*	Chief Executive, South Western Sydney Local Health District
Wednesday 2 February 2022 Jubilee Room Parliament House, Sydney	Dr Nigel Lyons *(via videoconference)*	Deputy Secretary, Health System Strategy and Planning, NSW Health
	Mr Phil Minns *(via videoconference)*	Deputy Secretary, People Culture and Governance, NSW Health

Appendix 3 Minutes

Minutes no. 23
Thursday 27 August 2020
Portfolio Committee No. 2 - Health
Members' Lounge, Parliament House, 6.52 pm

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang
Mrs Houssos *(substituting for Mr Secord)*
Mrs Maclaren-Jones
Mr Martin *(substituting for Mr Amato)*

2. Correspondence
The committee noted the following items of correspondence:

Received

- 26 August 2020 – Email from Mr Donnelly, Ms Hurst and Mr Secord requesting a meeting of Portfolio Committee No. 2 to consider a proposed self reference into health outcomes and access to health and hospital services in rural, regional and remote NSW.
- 27 August 2020 – Email from Mrs Maclaren-Jones substituting Mr Martin for Mr Amato and Mrs Houssos for Mr Secord for the purposes of the meeting on 27 August 2020.

3. Consideration of terms of reference
The chair noted the following terms of reference proposed by himself, Mr Secord and Ms Hurst as previously circulated:

That Portfolio Committee No. 2 – Health inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote NSW, and in particular:

(a) health outcomes for people living in rural, regional and remote NSW;

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

(h) the current and future provision of ambulance services in rural, regional and remote NSW;

(i) the access and availability of oncology treatment in rural, regional and remote NSW;

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and

(l) any other related matters.

Resolved, on the motion of Ms Faehrmann: That:

- the committee adopt the terms of reference
- the committee consider the timeline for the inquiry at the next deliberative meeting of the committee on Thursday 10 September 2020.

4. Adjournment

The committee adjourned at 7:15 pm until Thursday 10 September 2020 at 10.00 am.

Stephen Frappell
Committee Clerk

Minutes no. 24
Thursday 10 September 2020
Portfolio Committee No. 2 - Health
Room 1043, Parliament House Sydney, 10.03 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang *(left at 11.13 am)*
Mrs Maclaren-Jones
Mr Martin
Mr Secord

2. Previous minutes

Resolved, on the motion of Ms Hurst: That draft minutes nos. 19, 20, 21, 22 and 23 be confirmed.

3. Correspondence

The Committee noted the following items of correspondence:

Received

- 9 June 2020 – Correspondence from the Hon Natasha Maclaren-Jones MLC, Government Whip, to the secretariat, advising that the Hon Taylor Martin MLC will substitute for the Hon Lou Amato MLC for the remainder of the air quality inquiry
- 15 July 2020 – Email from Mr Ken Barnard to the Committee, attaching a document outlining issues relating to the post-discharge care for mental health patients in Southwest Sydney region, relevant to the inquiry into the current and future provision of health services in the South-West Growth region
- 27 July 2020 – Correspondence from Mr Leslie Gibbs, WHS Professional Officer, Professional Services, New South Wales Nurses and Midwives' Association, to committee, providing statistics relating to Urgency Disposition Groups as referred to during his evidence at the hearing on 14 July 2020, relevant to the inquiry into the current and future provision of health services in the South-West Growth region.

Resolved, on the motion of Mr Secord: That the committee authorise the publication of correspondence received from NSW Nurses and Midwives' Association, dated 27 July 2020.

Sent:

- 20 July 2020 – Email from the Chair to Mr Tim Reardon, Secretary, Department of Premier and Cabinet, requesting government submissions submitted to the NSW Independent Bushfire Inquiry for the inquiry into the health impacts of exposure to poor levels of air quality resulting from bushfires and drought.

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Proposed timeline

Resolved, on the motion of Mr Secord: That the committee adopt the following timeline for the administration of the inquiry:

- Submissions open: 16 September (tabling date for air quality report)
- Submissions close: 13 December
- Hearings and site visits: Early 2021.

4.2 Stakeholder list

Resolved, on the motion of Mr Secord: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

4.3 Advertising and promotion of the inquiry

Resolved, on the motion of Mr Secord: That the secretariat, in consultation with the Chair, identify strategies to promote and communicate the inquiry to rural, regional and remote stakeholders.

5. Inquiry into the current and future provision of health services in the South-West Growth region

5.1 Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to supplementary questions from Fairfield Hospital, received 28 July 2020
- answers to a question on notice from Greenfields Development Company No. 2 Pty Ltd, received 3 August 2020
- answers to supplementary questions from South Western Sydney Primary Health Network, received 10 August 2020
- answers to questions on notice from Macarthur Palliative Care Services, received 13 August 2020
- answers to supplementary questions from HammondCare, received 17 August 2020
- answers to questions on notice and supplementary questions from Liverpool Hospital Medical Staff, received 19 August 2020
- answers to supplementary questions from Ingham Institute for Applied Medical Research, received 19 August 2020
- answers to a question on notice from Health Consumers NSW, received 20 August 2020
- answers to questions on notice and supplementary questions from NSW Health, received 20 August 2020.

6. Inquiry into health impacts of exposure to poor levels of air quality resulting from bushfires and drought

6.1 Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from Ms Jess Miller, Councillor, City of Sydney Council, received 16 July 2020
- answer to question on notice from Mr Jake Field, National Health, Safety and Training Officer, Maritime Union of Australia, received 10 August 2020

- answer to question on notice from Mr Peter Dunphy, Executive Director Compliance and Dispute Resolution, SafeWork NSW, received 12 August 2020
- answer to supplementary question from Ms Michelle Dumazel, Executive Director Policy Division, Environment, Energy and Science Group, Department of Planning, Industry and Environment, received 18 August 2020
- answer to question on notice from Dr Richard Broome, A/Executive Director, Health Protection NSW, NSW Health, received 18 August 2020.

6.2 Consideration of Chair's draft report

The chair submitted his draft report, entitled 'Health impacts of exposure to poor levels of air quality resulting from bushfire and drought', which, having been previously circulated, was taken as being read.

Resolved, on the motion of Ms Faehrmann: That the following new subheading and paragraph be inserted after paragraph 1.58:

'Residents of Greater Western Sydney
Due to the geographical and physical nature of Sydney, residents of Greater Western Sydney are exposed to much higher levels of air pollution than those in other parts of Sydney.'

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 1.65:

'The committee is concerned that NSW Health did not emphasise the health impacts of exposure to any level of PM2.5 despite evidence from health professionals, including the Australian Medical Association (NSW) and Doctors for the Environment, that there is no threshold below which exposure to PM2.5 does not cause any health effects.'

Resolved, on the motion of Ms Faehrmann: That paragraph 2.104 be amended by:
(a) inserting 'permanent' before 'monitoring sensors'
(b) inserting ', including Lake Macquarie and Lithgow' after 'air pollution events'.

Resolved, on the motion of Ms Faehrmann: That the first dot point in Recommendation 1 be amended by:
(a) inserting 'permanent' before 'monitoring sensors'
(b) inserting ', including Lake Macquarie and Lithgow' after 'air pollution events'.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.108 be amended by inserting ', including ensuring that PM2.5 is reported separately and hourly' after 'measurement and reporting'.

Resolved, on the motion of Ms Faehrmann: That Recommendation 3 be amended by inserting at the end ', including ensuring that PM2.5 is reported separately and hourly'.

Resolved, on the motion of Mr Martin: That paragraph 2.111 be amended by:
(a) omitting 'an independent review of' and inserting instead 'a review on'
(b) omitting 'with the outcomes of this review to be published' and inserting instead 'with the review and any findings to be published'.

Resolved, on the motion of Mr Martin: That Recommendation 4 be amended by:
(a) omitting 'an independent review' and inserting instead 'a review'
(b) omitting 'with the outcomes of this review to be published' and inserting instead 'with the review and any findings to be published'.

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after Recommendation 5:

'Recommendation **X**
That the NSW Government provide additional resources to ensure that the air-smart public education campaign is widely advertised, particularly to vulnerable and at-risk groups.'

Resolved, on the motion of Mr Martin: That paragraph 3.27 be amended by omitting 'Some inquiry participants' and inserting instead 'Unions', subject to the secretariat checking that no broader stakeholders reflected this evidence.

Resolved, on the motion of Ms Faehrmann: That paragraph 3.79 be amended by omitting 'and endorse the position submitted by Unions NSW and the Australian Workers' Union, NSW Branch, that outdoor work should cease when air quality is at a dangerous level and a worker's health and safety is at risk' and inserting instead 'that outdoor workers have the right to cease work when air quality is at a dangerous level and their health and safety is at risk'.

Resolved, on the motion of Mr Secord: That paragraph 3.79 be amended by:
(a) omitting 'understand' and inserting instead 'understands'
(b) inserting 'Unions NSW and' before 'unions'
(c) inserting 'laws, regulations and' before 'protocols to be improved'.

Resolved, on the motion of Mr Secord: That paragraph 3.80 be amended by inserting at the end:
'Given the potential significant negative impact on the health and safety of workers from exposure to poor air quality, the collaborative tripartite work recommended above should commence immediately.'

Resolved, on the motion of Ms Hurst: That paragraph 3.81 and recommendation 6 be amended by:
(a) omitting 'NSW Government' and inserting instead 'SafeWork NSW'
(b) omitting 'unions and employers' and inserting instead 'unions, employers and other stakeholders'
(c) inserting 'and regulatory' after 'policy'
(d) inserting at the end 'In completing such work consultation will take place with medical and health experts, including thoracic specialists'.

Mr Martin moved: That paragraph 4.64 be amended by omitting 'In the committee's view it is unfortunate that some four years after work commenced on the Clean Air NSW Strategy, that task is still not completed'.

The committee divided.

Ayes: Mrs Maclaren-Jones, Mr Martin.

Noes: Ms Hurst, Ms Faehrmann, Mr Donnelly, Mr Secord.

Question resolved in the negative.

Resolved, on the motion of Mr Secord: That paragraph 4.64 be amended by omitting 'We consider it imperative that the strategy be delivered by no later than 2021 as promised, and that it' and inserting instead 'We are reassured that the Environment, Energy and Science Group in Department of Planning, Industry and Environment confirmed that the Clean Air for NSW Strategy will be finalised early 2021 and that this will'.

Mr Martin moved: That recommendation 8 be amended by:
(a) omitting 'by no later than 2021' and inserting instead 'within the next 12 months'
(b) omitting 'from industry, vehicles and wood heaters' and inserting instead 'all significant sources of' before 'air pollution'.

Question put and negatived.

Resolved, on the motion of Ms Faehrmann: That recommendation 8 be amended by omitting 'by no later than' and inserting instead 'early'.

Ms Faehrmann moved: That the following new recommendation be included at the end of the report:

'Recommendation x

That the NSW Government commit to more ambitious greenhouse gas reduction targets in line with the science to keep global warming within 1.5 degrees Celsius above industry levels or less'.

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst

Noes: Mr Donnelly, Mrs Maclaren-Jones, Mr Martin, Mr Secord

Question resolved in the negative.

Resolved, on the motion of Mr Secord: That:

- the draft report as amended be the report of the committee and that the committee present the report to the House;
- the transcripts of evidence, submissions, tabled documents, pro formas, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
- upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- upon tabling, all unpublished transcripts of evidence, submissions, pro formas, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- the committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- the committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- the secretariat table the report on 16 September 2020.
- the Chair to advise the secretariat and members if they intend to hold a press conference, and if so, the date and time.

7. Adjournment

The committee adjourned at 11.56 am.

Helen Hong / Tina Higgins
Committee Clerks

Minutes no. 27
Wednesday 17 February 2021
Portfolio Committee No. 2 - Health
Members Lounge, Parliament House Sydney, 2.18 pm

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mrs Maclaren-Jones (from 2.21 pm)
Mr Secord

2. Previous minutes
Resolved, on the motion of Mr Amato: That draft minutes no. 26 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received

- 4 February 2021 – Letter from Mr Roy Butler MP, Member for Barwon, requesting the committee refer submissions relating to the failures of NSW Health to the NSW Health Care Complaints Commission.
- 8 February 2021 – Email from Cancer Council NSW informing the committee of a media release based on their submission to the inquiry.
- 9 February 2021 – Email from Ms Leanne Nisbet, Project Manager, New England Virtual Health Network informing the committee that she is preparing a thematic analysis by region as part of her PhD research and has offered to share her analysis with the committee on request.

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Public submissions
The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos: 6, 7, 16, 17, 26, 29-34, 48-51, 53-55, 62-69 95-97, 100, 106-108, 164, 165, 167, 169-186, 188-200, 202-212, 214-223, 225, 226, 227a, 228-229, 232-269, 271-276, 277-279, 344-347, 350, 351, 353-360, 362-365, 367, 368, 370, 371, 373-380, 385-387, 390, 391, 393, 394, 397-409, 411-413, 415, 417-423, 425-427, 429-432a, 435, 440-444, 447-463, 465-471, 473-480, 489, 491.

4.2 Partially confidential submissions

Name suppressed
Resolved on the motion of Mr Fang: That the committee keep the following information confidential, as per the request of the author: names in submission nos. 2, 3, 11-15, 19-23, 25, 27, 36, 37, 38a, 39, 43, 44, 46, 52, 58, 60, 61, 70-72, 74-89, 94, 103-105, 109-112, 114, 116-125, 127, 129-141, 143-157, 159, 160b, 161-163, 224, 280-284, 286, 288-290, 292-294, 296, 298, 299, 301-304, 306, 308-313, 315-319, 333, 381, 389, 436-439, 486, 490, 493-495, 498, 499.

Identifying and/or sensitive information
Resolved, on the motion of Mr Secord: That the committee authorise the publication of submission nos. 1, 8, 18, 24, 28, 35, 38, 45, 47, 59, 73, 101, 102, 113, 115, 126, 128, 142, 158, 160, 160a, 166, 168, 187, 201, 230, 231, 231a, 270, 287, 291, 291a, 295, 297, 300a, 305, 307, 314, 348, 349, 352, 361, 369, 372, 382, 410, 416, 428, 433, 434, 445, 492, 496, 497, 500 with the exception of identifying and/or sensitive information which is to remain confidential, as per the request of the author.

4.3 Confidential submissions

Resolved, on the motion of Mr Fang: That:

- the committee keep submission nos 4, 5, 9, 10, 40-42, 90-93, 98, 99, 213, 231b, 276a, 285, 320-331, 334-343, 383, 384, 388, 392, 396, 424, 481, 487, 488 confidential, as per the request of the author as they contain identifying and/or sensitive information.
- the committee keep submission no. 213 confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information.

4.4 Letter to Local Health Districts and NSW Health

Resolved, on the motion of Mr Secord: That the committee authorise the Chair to send a letter to the Chief Executives of the Local Health Districts, Primary Health Networks and NSW Health reminding them that no detrimental action should be taken against inquiry participants.

4.5 Regional hearing locations

The committee noted that to visit a geographically diverse number of locations that reflect the bulk of the received submissions within the allocated hearing days, two of the three visits will require the use of charter aircraft as the number of commercial flights to regional locations has decreased significantly due to the COVD-19 pandemic.

Resolved, on the motion of Ms Hurst: That the committee conduct regional hearings/site visits in the following locations:.

- 29 and 30 April – Deniliquin and Cobar – using a charter flight
- 18 and 19 May – Wellington and Dubbo – using commercial flights/bus
- 16 and 17 June – Lismore and Gunnedah – using a charter flight.

The committee deferred consideration of additional regional hearings to a later date.

5. Adjournment

The committee adjourned at 2.58 pm, until 9.15 am Thursday 4 March 2021 (Budget Estimates hearing).

Vanessa O'Loan
Committee Clerk

Minutes no. 30
Friday 19 March 2021
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House Sydney, 8.48 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair* (until 9.02 am and from 11.15 am)
Mr Amato
Ms Faehrmann
Mr Fang
Mrs Maclaren-Jones (from 9.03 am)
Mr Secord

2. Correspondence

The committee noted the following items of correspondence:

Received:

- 22 February 2021 – Email from Mr Mark Burdack, Chief Executive Officer, offering the committee assistance in organising hearings or community forums on Collarenebri, Lightening Ridge, Walgett, Bingara, Warialda, Braidwood, Gilgandra and Warren.

- 25 February 2021 – Letter from Mr Norm Brennan, Mayor Edward River Council, inviting the committee to hold a hearing in the Edward River Council area.
- 26 February 2021 – Email from Dr Dan Salmon, Secretary, Deniliquin Health Action Group and Deniliquin Mental Health Awareness Group, inviting the committee to hold a hearing in the Deniliquin.
- 8 March 2021 – Email from Mr Stephen Milgate, Chief Executive Officer, Australian Doctors Federation, enquiring if the Australian Doctors Federation had been considered for giving evidence to the committee.
- 10 March 2021 – Email from Mr Nigel Roberts, Director of Obstetrics and Gynaecology - Manning Hospital, requesting that the committee consider hearing evidence from himself during the course of the inquiry.
- 10 March 2021 – Email from Mrs Shirlee Burge, founding member of the Deniliquin Health Action Group and Life Governor of Deniliquin Hospital, commending the committee for holding a hearing in Deniliquin and offering to be a witness at the Deniliquin hearing.
- 11 March 2021 – Email from the Honourable Anthony Whealy QC, requesting that the committee consider hearing from himself and Dr Seshasayee Narasimhan, the sole cardiac specialist operating in the Taree region.

Sent:

- 26 February 2021 – Letter from the Hon Greg Donnelly MLC to Local Health Districts, Primary Health Networks and NSW Health reminding them that no detrimental action should be taken against inquiry participants.

3. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

3.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 446, 464, 472, 483, 558, 571-580, 582-589, 593-600, 601, 604, 606, 607, 611-615, 616-618, 620-622, 626-632, 646, 664, 682, 686, 687, 691, 692, 696, 703, 704.

Resolved, on the motion of Ms Faehrmann: That the committee authorise the publication of submissions 258b and 482a.

3.2 Partially confidential submissions

Name Suppressed

Resolved, on the motion of Mr Fang: That the committee keep the following information confidential, as per the request of the author: names in submissions nos. 395, 414, 501-503, 505-507, 510-520, 523-526, 528, 530-548, 550-556, 559, 561-567, 570, 602, 609, 610, 637-639, 641-644, 648-653, 655, 657, 659, 662, 663, 679, 688, 693.

Identifying and/or sensitive information

Resolved, on the motion of Mr Fang: That the committee authorise the publication of submission nos. 27, 227, 366, 504, 508, 509, 549, 557, 560, 568, 581, 590, 592, 603, 608, 633, 654, 658, 661, 690, 694, with the exception of identifying and/or sensitive information which is to remain confidential, as per the request of the author.

Adverse mention

Resolved, on the motion of Mr Fang: That the committee authorise the publication of submission nos. 57, 300, 484, 521, 527, 591, 605, 619, 623-625, 635, 636, 640, 660, 678, 701 with the exception of potential adverse mention which is to remain confidential, as per the request of the author.

Resolved, on the motion of Mr Fang: That the committee authorise the publication of submission nos. 56, 482 and 591 with the exception of potential adverse mention which is to remain confidential, as per the recommendation of the secretariat.

3.3 Confidential submissions

Resolved, on the motion of Mr Fang: that the committees keep submission nos. 332, 485, 504a, 522, 529, 569, 634, 645, 647, 656, 665, 665a, 666-677, 680, 681, 683-685, 689, 695, 697-699, 700, 702 confidential, as per the request of the author as they contain identifying and/or sensitive information.

3.4 Additional regional hearing locations

The committee deferred consideration of additional regional hearings to a later date.

3.5 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Colette Colman, Director, Policy and Strategy Development, National Rural Health Alliance *(via videoconference)*
- Mr Luke Sartor, Policy and Research Officer, National Rural Health Alliance *(via videoconference)*
- Dr Shehnarz Salindera, Councillor, Australian Medical Association

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Dianne Kitcher, CEO, South Eastern NSW Primary Health Network, NSW Rural Primary Health Networks *(via videoconference)*
- Mr Richard Nankervis, CEO, Hunter New England and Central Coast Primary Health Network, NSW Rural Primary Health Networks *(via videoconference)*
- Dr Michael Clements, Chair – Rural, The Royal Australian College of General Practitioners *(via videoconference)*
- Dr Charlotte Hespe, Chair – NSW & ACT, The Royal Australian College of General Practitioners *(via videoconference)*

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Rod Martin, Rural Generalist, Australian College of Rural and Remote Medicine *(via videoconference)*
- Dr Charles Evill, President, Rural Doctor's Association of NSW
- Mr Richard Colbran, Chief Executive Officer, NSW Rural Doctors Network
- Dr John Kramer, Chair, NSW Rural Doctors Network *(via videoconference)*

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Brett Holmes, General Secretary, New South Wales Nurses and Midwives' Association
- Mrs Kristyn Paton, Registered Nurse & Branch President, New South Wales Nurses and Midwives' Association
- Ms Barbara Turner, Health Service Manager/ Nurse Practitioner, Australian College of Nurse Practitioners *(via videoconference and teleconference)*

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Gerard Hayes, Secretary, Health Services Union
- Mr Mark Jay, Organiser, Health Services Union
- Dr Tony Sara, President, Australian Salaried Medical Officers' Federation

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health

- Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health

The evidence concluded and the witness withdrew.

The public and media withdrew.

The hearing concluded at 5.02 pm.

3.6 Tendered documents

Mrs Maclaren Jones tendered the following document:

- Hendrie, D. (2019, 29 May). Financial incentives not effective in tackling rural GP shortages. *newsGP*.

Resolved, on the motion of Mr Amato: That the committee accept the following document tendered during the public hearing:

- Hendrie, D. (2019, 29 May). Financial incentives not effective in tackling rural GP shortages. *newsGP*, tendered by Mrs Maclaren-Jones.

4. Adjournment

The committee adjourned at 5.04 pm, *sine die*.

Vanessa O'Loan
Committee Clerk

Minutes no. 31
Thursday 25 March 2021
Portfolio Committee No. 2 - Health
Members Lounge, Parliament House Sydney, 2.02 pm

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mrs Maclaren-Jones (from 2.05 pm)
Mr Secord

2. Previous minutes

Resolved, on the motion of Ms Faehrmann: That draft minutes nos. 28, 29 and 30 be confirmed.

3. Correspondence

The Committee noted the following items of correspondence:

Received

- 16 March 2021 – Letter from Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association to the Chair, requesting the committee consider holding additional hearings in Moruya/Bateman's Bay, Inverell/Glen Innes and Armidale
- 17 March 2021 – Letter from Dr Warren Kealy-Bateman, Western NSW LHD Medical Staff Executive Council (MSEC) to the committee, offering to arrange a meeting between members of the (MSEC), Dr Mark Rice, Associate Professor Randall Greenburg and himself and the committee, when the committee undertakes hearings in Wellington/Dubbo on 18-19 May 2021
- 18 March 2021 – Letter from Mr Paul Miller, Acting NSW Ombudsman to the Chair, highlighting the application of the *Public Interest Disclosure Act 1994* as it may relate to the Health outcomes and services in regional, rural and remote NSW inquiry.

- 19 March 2021 – Email from Dr Marion Magee, Rural Generalist GP and Chair of the Deniliquin Medical Council, the Murrumbidgee branch of the PHN, and of the Deniliquin Health Action Group to secretariat, requesting that the committee consider hearing evidence from herself when the committee visits Deniliquin on 29 April 2021.
- 19 March 2021 – Email from Dr Louis Schetzer, Policy and Advocacy Manager, Australian Lawyers Alliance to the secretariat, advising the committee that Ms Catherine Henry is available to appear as a witness at the Sydney hearing on 12 July 2021.
- 19 March 2021 – Letter from Mr Grant Mistler to the committee, requesting that the committee consider expanding the scope of the inquiry's terms of reference to include foreign nationals who work in the horticultural industry.
- 19 March 2021 – Email from Ms Lorraine Long, Medical Error Action Group to secretariat, regarding her objections to the committee's redactions to submission 56.
- 19 March 2021 – Email from Mr Christopher Cousins to the Chair and secretariat, regarding his objections to the committee's redactions to submission 482.
- 21 March 2021 – Email from Dr Seshasayee Narasimhan, General & Interventionist Cardiologist, Manning Base Hospital to secretariat, requesting that the committee consider hearing evidence from himself during the course of the inquiry.
- 22 March 2021 – Email from the Hon Ryan Park MP, Shadow Minister for Health, to the secretariat, requesting that Rural and Remote Medical Service (RARMS) be invited to give evidence at one of the upcoming hearings.
- 22 March 2021 – Email from Mr Julius Timmerman to the committee, rebutting the claims made by the Chamber of Commerce and Industry Lawson in submission 387.
- 23 March 2021 – Email from Ms Joy Allan to the committee, requesting that the committee consider hearing evidence from herself when the committee visits Deniliquin on 29 April 2021.

Resolved, on the motion of Mr Amato: That the committee keep the emails from Ms Long and Mr Cousins dated 19 March 2021 confidential, due to potential adverse mention of named individuals.

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Public submissions

Resolved, on the motion of Mrs Maclaren-Jones: That the committee authorise the publication of submission 258c.

4.2 Additional regional hearings

Resolved, on the motion of Mr Secord: That the committee hold the following additional hearings, the dates of which are to be determined by the Chair after consultation with members regarding their availability:

- two further 2-day regional hearings/site visits in September/October/November
- a further single reserve regional hearing day, potentially flying to the regional location the night before
- one additional Sydney hearing following the last of the regional hearings.

4.3 Provision of documents to participating member

Resolved, on the motion of Mrs Maclaren-Jones: That Mr Farraway, who has advised the Chair that he intends to participate for the duration of the inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales:

- be provided with copies of all inquiry related documents, including meeting papers, unpublished submissions and the Chair's draft report
- has travel costs associated with his participation in the inquiry covered by the committee.

5. Adjournment
The committee adjourned at 2.35 pm until Thursday 29 April 2021, Deniliquin (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 32
Thursday 29 April 2021
Portfolio Committee No. 2 - Health
Execujet Flight Lounge, 394 Ross Smith Ave, Mascot, 6.30 am

1. Members present
Mr Donnelly, *Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mr Secord

2. Apologies
Ms Hurst, *Deputy Chair*
Mrs Maclaren-Jones
Mr Farraway (participating)

3. Previous minutes
Resolved, on the motion of Mr Amato: That draft minutes no. 31 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 23 March 2021 – Email from Associate Professor Allan Molloy, to the secretariat, suggesting that the committee should consider requesting submissions from icare, the Agency for Clinical Innovation and eHealth
- 23 March 2021 – Email from Ms Christine Carmichael, to the committee, opposing the claims made by the Chamber of Commerce and Industry Lawson in submission 387
- 30 March 2021 – Email from Ms Danica Leys, Chief Executive Officer of the Country Women's Association (CWA), to the secretariat, requesting that the committee consider hearing from the CWA at one of the scheduled hearings
- 5 April 2021 – Email from Dr Rosalie Goldsmith, to the committee, registering her strong objections to the contents of submission 387 from the Chamber of Commerce and Industry Lawson
- 6 April 2021 – Email from Dr Cesidio Parissi, to the secretariat, opposing the claims made by the Chamber of Commerce and Industry Lawson in submission 387
- 9 April 2021 – Email from Dr Justin Bowra, Founder, My Emergency Doctor, to the secretariat, requesting that the committee consider hearing from himself and Mr Bill Maiden in Dubbo on Wednesday 19 May 2021
- 13 April 2021 – Email from Ms Alicia Hargreaves, Executive Assistant, Rural Doctor's Association of NSW, to the secretariat, on behalf of Dr Ian Kamerman, requesting the committee consider hearing from Dr Kamerman at the hearing in Gunnedah on Wednesday 16 June 2021
- 20 April 2021 – Email from Mr Derek Francis, General Manager, Bogan Shire Council, to the secretariat, declining the committees invitation to give evidence at the Cobar hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry

- 20 April 2021 – Letter from Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, to the Chair, requesting the committee consider hearing from identified members at the Deniliquin and Cobar hearings
- 21 April 2021 – Email from Ms Denise Gordon, Executive Manager of Clinical Services, The NSW Outback Division of General Practice, to the secretariat, declining the committees invitation to give evidence at the Cobar hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 21 April 2021 – Email from Mr Jemeil Wallis, Practice Manager, Bogan Shire Medical Centre, to the secretariat, declining the committees invitation to give evidence at the Cobar hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 21 April 2021 – Letter from the Hon Brad Hazzard MP, Minister for Health and Medical Research, confirming the committee site visit to the Deniliquin Health Service on Thursday 29 April 2021
- 22 April 2021, Email from Ms Sue Bruce, Interim Chief Executive Officer, Bourke Aboriginal Health Service, to the secretariat, declining the committees invitation to give evidence at the Cobar hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 23 April 2021, Email from Ms Maggie Potts, Executive Assistant to the General Secretary, to the secretariat, requesting that a NSW Nurses and Midwives' Association staff member be permitted to attend and observe the *in camera* hearing as a support person for their members

Sent

- 14 April 2021 – (sent via email) from the Hon Greg Donnelly MLC to Minister Brad Hazzard about the site visit to the Deniliquin Health Service on Thursday 29 April 2021
- 19 April 2021 – Letter from the Chair to Dr Joe McGirr MP, Member for Wagga Wagga, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to Mr Dugald Saunders MP, Member for Dubbo, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to the Hon Kevin Anderson MP, Member for Tamworth, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to Mr Roy Butler MP, Member for Barwon, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to Mr Stephen Bromhead MP, Member for Myall Lakes, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to Mrs Helen Dalton MP, Member for Murray, advising that the committee will be visiting their electorate
- 19 April 2021 – Letter from the Chair to Ms Janelle Saffin MP, Member for Lismore, advising that the committee will be visiting their electorate.

Resolved, on the motion of Mr Fang: That the letter from Mr Holmes dated 20 April 2021 be kept confidential, as it contains the names of potential *in camera* witnesses.

5. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission no. 705

5.2 Partially confidential submissions

Identifying and/or sensitive information

Resolved, on the motion of Mr Fang: That the committee keep identifying and/or sensitive information in submission no. 682 confidential, as pre the request of the author.

5.3 *In camera* evidence from witnesses nominated by the NSW Nurses and Midwives' Association

Resolved, on the motion of Mr Secord: That the committee hear evidence from witnesses nominated by the NSW Nurses and Midwives Association in Cobar *in camera*.

Resolved, on the motion of Ms Faehrmann: That the committee agree to the request from the NSW Nurses and Midwives' that the following NSWNMA staff be permitted to attend and observe the *in camera* hearing as a support person for their members:

- Ms Tracey Coyte, NSWNMA Officer
- Ms Patricia Gooney, NSWNMA member.

5.4 Site visit to Deniliquin Health Service

The committee visited the Deniliquin Health Service and received a tour of the facility, led by:

- Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District
- Mr Craig McColm, Acting District Clinical Operations Manager Sector West
- Ms Virginia Lange, Facility Manager – Deniliquin Hospital

The committee departed at 10.00 am for the public hearing at the Dunlop Room, Deniliquin RSL, 72 End Street, Deniliquin.

5.5 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Phil Stone, General Manager, Edward River Council
- Cr Norm Brennan, Mayor, Edward River Council
- Mr John Scarce, General Manager, Murrumbidgee Council
- Cr Ruth McRae, Mayor, Murrumbidgee Council

Cr Brennan tendered the following document:

- Document entitled 'Edward River Council Advocacy Strategy, 1 January 2021'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Marion Magee, Chair, Deniliquin Health Action Group
- Dr Dan Salmon, Secretary, Deniliquin Health Action Group

Dr Magee tendered the following document:

- Document entitled 'Deniliquin Health Action Group – Community Opinion Survey 2019".

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Lyn Bond, Chair, Deniliquin Mental Health Awareness Group
- Ms Lourene Liebenberg, Vice Chair, Deniliquin Mental Health Awareness Group
- Ms Sue Hardy, President, Can Assist Coleambally
- Ms Monica Whelan, Member, Can Assist Coleambally

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Ian Dumbrell, Private citizen
- Mrs Shirlee Burge, Private citizen
- Mr Timothy Burge, Private citizen

Mrs Burge tendered the following documents:

- Murrumbidgee Local Health District – Draft V1 Strategic plan 2021-2026 .
- Copy of Mrs Burge's opening statement.

Mr Burge tendered the following document:
- Copy of Mr Burge's opening statement.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District
- Dr Lenert Bruce, Executive Director, Medical Services, Murrumbidgee Local Health District
- Ms Julie Redway, Acting Chief Executive, Murrumbidgee Primary Health Network
- Dr Jodi Culbert, Chair, MPHN Board, Murrumbidgee Primary Health Network

The evidence concluded and the witnesses withdrew.

The hearing concluded at 3.46 pm.

The public and media withdrew.

5.6 Tendered documents

Resolved, on the motion of Mr Secord: That the committee accept and publish the following documents tendered during the public hearing:
- Document entitled 'Edward River Council Advocacy Strategy, 1 January 2021', tendered by Cr Norm Brennan.
- Document entitled 'Deniliquin Health Action Group – Community Opinion Survey 2019', tendered by Dr Marion Magee.
- Murrumbidgee Local Health District – Draft V1 Strategic plan 2021-2026, tendered by Mrs Shirlee Burge.
- Copy of opening statement, tendered by Mrs Shirlee Burge.
- Copy of opening statement, tendered by Mr Timothy Burge.

6. Adjournment

The committee adjourned at 3.54 pm until Friday 30 April 2021, Cobar (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 33
Friday 30 April 2021
Portfolio Committee No. 2 - Health
Auditorium, Cobar Memorial Services Club, Cobar, 8.45 am

1. Members present

Mr Donnelly, *Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mr Secord

2. Apologies

Ms Hurst, *Deputy Chair*
Mrs Maclaren-Jones

Mr Farraway (participating)

3. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

3.1 *In camera* hearing

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Ms Sharon Ohnesorge, Ms Vanessa O'Loan, Ms Lauren Monaghan, Mr Andrew Ratchford, Ms Tracey Coyte, Ms Patricia Gooney and Hansard reporters.

The following witnesses were sworn and examined:

- Witness A
- Witness B

The evidence concluded and the witnesses withdrew.

3.2 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Peter Vlatko, General Manager, Cobar Shire Council
- Cr Peter Abbott , Mayor, Cobar Shire Council
- Ms Leonie Brown, Manager Corporate Services, Bourke Shire Council
- Cr Barry Hollman, Mayor, Bourke Shire Council

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Miss Ally Pearson, Private citizen
- Mr Geoffrey Langford, Private citizen
- Pen McLachlan, Private citizen

Mr Langford tendered the following documents:

- Copy of the booklet 'Back to Cobar Week – 7th to 14th Nov 1959'.
- Newspaper article entitled, 'Health Minister will open new Cobar hospital', Cobar Age, dated 19 September 1968.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District
- Mr Brendan Cutmore, Executive Director, Aboriginal Health and Wellbeing, Western NSW Local Health District

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Jenny Tyack, Chair, Condobolin Doctor Crisis Working Party
- Ms Annie Ryan, Deputy Chair, Condobolin Doctor Crisis Working Party

The evidence concluded and the witnesses withdrew.

The Chair reminded the following witness that he did not need to be sworn, as he had been sworn earlier in the hearing:

- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District

The following witness was sworn:

- Dr Shannon Nott, Rural Health Director of Medical Services, Western NSW Local Health District

The committee examined the witnesses.

The evidence concluded and the witnesses withdrew.

The hearing concluded at 3.05 pm.

The public and media withdrew.

3.3 Tendered documents

Resolved, on the motion of Ms Faehrmann: That the committee accept and publish the following documents tendered during the public hearing:

- Copy of the booklet 'Back to Cobar Week – 7th to 14th Nov 1959', tendered by Mr Geoffrey Langford
- Newspaper article entitled, 'Health Minister will open new Cobar hospital', Cobar Age, dated 19 September 1968, tendered by Mr Geoffrey Langford.

4. Adjournment

The committee adjourned at 3.06 pm until 2.15 pm, Wednesday 12 May 2021, Budget Estimates report deliberative.

Vanessa O'Loan
Committee Clerk

Minutes no. 34
Wednesday 12 May 2021
Portfolio Committee No.2 – Health
Members' Lounge, Parliament House, 2.17 pm

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann (from 2.30 pm)
Mr Fang
Mrs Maclaren-Jones
Mr Secord

2. Correspondence

The committee noted the following items of correspondence:

Received:

- 25 March 2021 – Letter from Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health to secretariat, requesting a redaction to his transcript of evidence dated 4 March 2021
- 7 April 2021 – Letter from Ms Susan Pearce, Deputy Secretary, Patient Experience and System Performance, NSW Health to secretariat, clarifying the evidence given during the hearing on 4 March 2021
- 4 May 2021 – Email from Ms Jamelle Wells, to the Chair and Deputy Chair, requesting that regional hearings are livestreamed and that hearing transcripts be made available in a timely manner
- 5 May 2021 – Letter from Mr Roy Butler MP, Member for Barwon to the Chair, requesting that regional hearing be livestreamed
- 5 May 2021 – Email from Ms Clare Eves, National Practice Leader – Medical Law, Shine Lawyers, to the committee, expressing her disappointment that the hearings in Deniliquin and Cobar were not livestreamed and noting journalists complaints regarding the availability of transcripts

- 7 May 2021 – Email from Ms Carrie Fellner, Investigative Journalist, Sydney Morning Heard, Ms Liz Hayes, 60 Minutes and Ms Natalie Clancy, 60 Minutes, to the committee, asking the committee to explain why the regional hearings are not webcast
- 10 May 2021 – Email from Ms Laura Thomas, Producer, ABC Goulburn Murray, asking why regional hearings are not livestreamed or recorded.

Sent:

- 9 March 2021 – Email from secretariat to Hon Brad Hazzard MP, Minister for Health and Medical Research, attaching transcript of evidence with questions on notice highlighted and supplementary questions
- 16 March 2021 – Email from secretariat to Hon Bronnie Taylor MLC, Minister for Mental Health, Regional Youth and Women, attaching transcript of evidence with questions on notice highlighted and supplementary questions.

3. Inquiry into Budget Estimates 2020-2021

3.1 Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution establishing the Inquiry:

- answers to questions on notice and supplementary questions from the Hon Brad Hazzard MP, Minister for Health and Medical Research, received 30 March 2021
- answers to questions on notice and supplementary questions from the Hon Bronnie Taylor MLC, Minister for Mental Health, Regional Youth and Women, received 6 April 2021.

3.2 Transcript clarifications

Resolved, on the motion of Ms Hurst: That the committee authorise the redaction of information inadvertently disclosed by Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health from the transcript of evidence dated 4 March 2021 as per the request of the witness.

3.3 Consideration of Chair's draft report

The Chair submitted his draft report entitled *Budget Estimates 2020-2021,* which, having been circulated previously, was taken as being read.

Resolved, on the motion of Mr Secord: That:

a) The draft report be the report of the committee and that the committee present the report to the House;
b) The transcripts of evidence, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
c) Upon tabling, all unpublished transcripts of evidence, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
d) The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
e) That the report be tabled on 18 May 2021.

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Webcasting of regional hearings

Mr Scott Fuller, Senior Program Manager, Digital Transformation briefed the committee on the webcasting of the committee's regional hearings.

Mr Fang moved: That the matter of webcasting regional committee hearings be referred to the Procedure Committee for inquiry and report.

Question put and negatived.

Resolved, on the motion of Ms Faehrmann: That the committee:

- authorise the filming and broadcasting of its public proceedings held outside of Parliament House, on a trial basis

- authorise the following statement to be included on the inquiry webpage:

  'Hearings and transcripts

  In light of recent media and public interest in viewing the committee's regional hearings, the committee will be trialling the live webcasting of its public hearings in Wellington and Dubbo. The webcasts will be available on the NSW Parliament's website at: https://www.parliament.nsw.gov.au/Pages/webcasts.aspx

  Transcripts are published as soon as they are available under the 'Hearings and Transcripts' tab below.'

4.2 *In camera* hearing in Dubbo

Resolved, on the motion of Ms Faehrmann: That the committee invite three members of the Western NSW LHD Medical Staff Executive Council to give evidence at the Dubbo hearing *in camera*.

5. Adjournment

The committee adjourned at 2.53 pm, until Tuesday 18 May 2021, 6.10 am, Terminal 2, Sydney Airport (public hearing).

Emma Rogerson
Committee Clerk

Minutes no. 35
Tuesday 18 May 2021
Portfolio Committee No. 2 - Health
Sydney Domestic Airport, Terminal 2, Keith Smith Avenue Mascot, 6.10 am

1. Members present

Mr Donnelly, *Chair (until 3.00 pm)*
Ms Hurst, *Deputy Chair (Acting Chair from 3.00 pm)*
Mr Amato
Ms Faehrmann
Mr Fang
Mrs Maclaren-Jones
Mr Secord

2. Apologies

Mr Farraway *(participating member)*

3. Previous minutes

Resolved, on the motion of Ms Faehrmann: That draft minutes no. 32 and 33 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 19 April 2021 – Letter from Ms Rosemary Dillion, Chief Executive Officer, Blue Mountains City Council, to the Chair, regarding the future use of South Lawson Park, Lawson
- 28 April 2021 – Email from Ms Tayla Kennedy, to the secretariat, declining the committees invitation to give evidence at the Dubbo hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 30 April 2021 – Email form Mr Simon Jones, Director – Community, Mid-Western Regional Council, to the secretariat, declining the committees invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry

- 30 April 2021 – Email from Ms Carmel Bartlett, Honorary Secretary, Manning Great Lakes Community Health Action Group, to the secretariat, requesting that the committee consider hearing from the Manning Great Lakes Community Health Action Group in Taree on Wednesday 16 June 2021
- 5 May 2021 – Email from Mr Will Jones, to the secretariat, declining the committees invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 7 May 2021 – Email from Ms Marie Wyatt, Executive Secretary, Parkes Shire Council, to the Chair, requesting that the committee consider hearing from Parkes Mayor Ken Keith OAM at the Dubbo for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 8 May 2021 – Email from Ms Jane Redden, General Manager, Narromine Shire Council, to the secretariat, declining the committee's invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 9 May 2021 – Email from Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council (NSW MSEC), requesting the committee hear from the Orange MSEC via video link at the Dubbo hearing and that the committee hear from NSW MSEC at a Sydney hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 10 May 2021 – Email from Ms Lisa Grisinger, Administration Officer to the CEO, Dubbo Regional Council, declining the committee's invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 11 May 2021 – Email from Mr William Robinson, Chief Executive Officer, Dubbo local Aboriginal Land Council, declining the committee's invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 12 May 2021 – Letter from the Hon Brad Hazzard MP, Minister for Health and Medical Research, to the Chair, confirming the committee site visit to the Wellington Health Service on Tuesday 18 May 2021.

Sent

- 28 April 2021 – (sent via email) from the Hon Greg Donnelly MLC to Minister Brad Hazzard about the site visit to the Wellington Health Service on Tuesday 18 May 2021.

5. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

5.1 Site Visit

The committee visited the Wellington Hospital and received a tour of the facility, led by:

- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District
- Ms Debbie Bickerton General Manager, Dubbo Health Service
- Mr Steven Dwyer, Health Service Manager.

The committee departed at 10.10 am for the public hearing at Hermitage Hill, 135 Maxwell St Wellington.

5.2 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Cr Ben Shields, Mayor, Dubbo Regional Council
- Cr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Shire Council
- Mr Neil Southorn, Director - Environmental, Planning and Building Services, Bathurst Regional Council

- Cr Warren Aubin, Councillor, Bathurst Regional Council

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Sheree Staggs, Registered Nurse, New South Wales Nurses and Midwives' Association
- Ms Samantha Gregory-Jones, Registered Nurse, New South Wales Nurses and Midwives' Association

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Harold Sandell, Former President, Rotary Club of Warren
- Mrs Alison Campbell, Member, Warren Health Action Group
- Dr Kitty Eggerking, Member, Gulgong Petitioners
- Mrs Kathryn Pearson, Member, Gulgong Petitioners and private citizen
- Ms Sharelle Fellows, Member, Gulgong Petitioners and private citizen

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mrs Hayley Olivares, Private citizen
- Mr Christopher Pearson, Private citizen
- Ms Ronda Payne, Private citizen
- Mrs Sally Empringham, Private citizen

Mr Pearson tendered the following document:
- Copy of Mr Pearson's opening statement including map.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mrs Joan Staggs, Private citizen
- Mrs Carol Richard, Private citizen
- Mrs Diane Simmonds, Private citizen

Mrs Richard tendered the following document:
- Document entitled 'Submission'.
- Copy of Mrs Richard's opening statement.

The evidence concluded and the witnesses withdrew.

The hearing concluded at 4.00 pm.

The public and media withdrew.

5.3 Tendered documents

Resolved, on the motion of Mrs Maclaren-Jones: That the committee accept and publish the following documents tendered during the public hearing:
- Copy of opening statement including map, tendered by Mr Christopher Pearson.
- Document entitled 'Submission', tendered by Mrs Carol Richard.
- Copy of opening statement, tendered by Mrs Carol Richard.

6. Other business

6.1 Election of Deputy Chair

Resolved, on the motion of Mr Secord: That, in the absence of Mr Donnelly, Ms Faehrmann be elected Deputy Chair for the purpose of the hearing in Dubbo on 19 May 2021.

7. Adjournment
The committee adjourned at 4.20 pm until 9.00 am, Wednesday 19 May 2021, Dubbo (*in camera* hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 36
Wednesday 19 May 2021
Portfolio Committee No. 2 - Health
Auditorium, Dubbo RSL Club, Dubbo, 8.58 am

1. Members
Ms Hurst, *Acting Chair*
Ms Faehrmann, *Acting Deputy Chair*
Mr Amato
Mr Fang
Mrs Maclaren-Jones
Mr Secord

2. Apologies
Mr Donnelly, *Chair*
Mr Farraway (participating)

3. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

3.1 *In camera* hearing
The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Mr Sam Griffith, Ms Vanessa O'Loan, Ms Emily Treeby, Mr Bojan Spanovic and Hansard reporters.

The following witnesses were sworn and examined:
- Witness C
- Witness D
- Witness E

Witness C tendered the following document:
- Mental Health Drug and Alcohol Service – Information Guide for Families & Carers.

Witness D tendered the following document:
- Document entitled 'Discussion paper regarding review of interfacility transfer process for adults requiring specialist care PD2011_031'.

The evidence concluded and the witnesses withdrew.

3.2 Public hearing
Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:
- Cr Ken Keith OAM, Mayor, Parkes Shire Council
- Dr Kerrie Stewart, General Practitioner, Ochre Health Medical Centre
- Cr Milton Quigley, Mayor, Warren Shire Council

- Cr Heather Druce, Councillor, Warren Shire Council

Cr Ken Keith OAM tendered the following documents:

- Copy of a letter to Hon Michael McCormack MP from Cr Ken Keith OAM dated 8 April 2021.
- Copy of a letter to Hon Mark Coulton MP from Cr Ken Keith OAM dated 8 April 2021.
- Copy of a letter to Hon Greg Donnelly MLC from Cr Ken Keith OAM dated 7 May 2021.

Dr Kerrie Stewart tendered the following document:

- Copy of a letter to Cr Ken Keith OAM from Dr David Harwood.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Ann-Maree Chandler, Owner, Indidg Connect
- Ms Jaime Keed, Practice Manager, Dubbo Regional Aboriginal Medical Service
- Dr Amy Perron, General Practitioner, Dubbo Regional Aboriginal Medical Service

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Neil McCarthy, Private citizen
- Mrs Vicki Kearines, Private citizen

Mrs Vicki Kearines tendered the following document:

- Copy of letter to Mr Mark Coulton MP from Mrs Vicki Kearines entitled 'Mental Health and the Public System'.

Dr Neil McCarthy tendered the following document:

- Discussion Paper, Reimagining Primary Health Care Workforce in Rural and Underserved Settings, August 2020, By Roger Strasser and Sarah Strasser.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Jessica Brown, General Manager, Strategy and Growth Business Development, Marathon Health
- Ms Julie Cullenward, Practice Lead - Allied Health, Marathon Health
- Mrs Tanya Forster, Psychologist and Director, Macquarie Health Collective
- Mr Bill Maiden, Chief Executive Officer, My Emergency Doctor
- Dr Justin Bowra, Founder & Medical Director, My Emergency Doctor

The evidence concluded and the witnesses withdrew.

The following witnesses were examined under a former oath or affirmation:

- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District
- Dr Shannon Nott, Rural Health Director of Medical Services, Western NSW Local Health District

The following witnesses were sworn and examined:

- Mr Adrian Fahy, Executive Director, Quality Clinical Safety and Nursing, Western NSW Local Health District
- Mr Robert Strickland, Acting Chief Executive Officer, Western NSW Primary Health Network
- Dr Robin Williams, Board Chair, Western NSW Primary Health Network
- Ms Sonya Berryman, General Manager Primary Healthcare and Integration, Western NSW Primary Health Network

The evidence concluded and the witnesses withdrew.

The hearing concluded at 3.18 pm.

The public and media withdrew.

3.3 Tendered documents

Resolved, on the motion of Mrs Maclaren-Jones: That the committee accept and keep confidential the following documents tendered during the *in camera* hearing:

- Mental Health Drug and Alcohol Service – Information Guide for Families & Carers, tendered by Witness C.
- Document entitled 'Discussion paper regarding review of interfacility transfer process for adults requiring specialist care PD2011_031', tendered by Witness D.

Resolved, on the motion of Mr Secord: That the committee accept and publish the following document tendered during the public hearing:

- Copy of a letter to Hon Michael McCormack MP from Cr Ken Keith OAM dated 8 April 2021, tendered by Cr Ken Keith OAM.
- Copy of a letter to Hon Mark Coulton MP from Cr Ken Keith OAM dated 8 April 2021, tendered by Cr Ken Keith OAM.
- Copy of a letter to Hon Greg Donnelly MLC from Cr Ken Keith OAM dated 7 May 2021 , tendered by Cr Ken Keith OAM.
- Copy of a letter to Cr Ken Keith OAM from Dr David Harwood, tendered by Dr Kerrie Stewart.
- Copy of letter to Mr Mark Coulton MP from Ms Vicki Kearines entitled 'Mental Health and the Public System', tendered by Mrs Vicki Kearines.
- Discussion Paper, Remaining Primary Health Care Workforce in Rural and Underserved Settings, August 2020, By Roger Strasser and Sarah Strasser, tendered by Dr Neil McCarthy.

4. Other business

5. Adjournment

The committee adjourned at 3.18 pm until Wednesday 16 June 2021, Gunnedah (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 37
Wednesday 8 June 2021
Portfolio Committee No. 2 - Health
Members' Lounge, Parliament House, Sydney, 1.33 pm

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair* (from 1.36 pm)
Mr Amato
Ms Faehrmann
Mr Fang
Mrs Maclaren-Jones (from 1.38 pm)
Mr Secord

2. Previous minutes

Resolved, on the motion of Mr Secord: That draft minutes no. 34, 35 and 36 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 16 May 2021 – Email from Ms Jenny Lovric, Manager - Community Engagement & Partnerships, Just Reinvest NSW, to the committee, requesting that the committee consider holding a hearing in Moree
- 24 May 2021 – Email from Ms Lorraine Long, Medical Error Action Group, to the committee, questioning the ability of the committee to undertake the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 26 May 2021 – Email from Dr Alexandre Stephens, Director of Research, NSW Rural Health Research Alliance, to the secretariat, declining the committee's invitation to give evidence at the Lismore hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry and seeking consideration for the NSW Rural Health Research Alliance to appear at the Sydney hearing on 12 July or 2 December 2021
- 31 May 2021 – Email from Ms Jamelle Wells, Journalist and submission author, to the committee, requesting that the committee consider hearing from herself at the Sydney hearing on 12 July 2021 or another convenient hearing date

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Proposed Local Health District and Primary Health network appearance at the Taree and Lismore hearings

Mr Fang moved: That the relevant Primary Health Networks be called as witnesses alongside the Local Health Districts at the Taree and Lismore hearings on 16 and 17 June 2021.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Fang, Mrs Maclaren-Jones.

Noes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Question resolved in the negative.

Resolved, on the motion of Mr Secord: That:

- the committee hear from the Hunter New England LHD from 5.30 pm to 6.30 pm on Wednesday 16 June 2021 at the Taree hearing.
- the committee hear from the Northern NSW LHD from 2.00 pm to 3.30 pm on Thursday 17 June 2021 at the Lismore hearing.

5. Adjournment

The committee adjourned at 1.48 pm, until Wednesday 16 June 2021, Gunnedah (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 38
Wednesday 16 June 2021
Portfolio Committee No. 2 - Health
Execujet Flight Lounge, 394 Ross Smith Ave, Mascot, 6.30 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang

Mr Khan (substituting for Mr Amato)
Mrs Maclaren-Jones
Mr Secord

2. Apologies
Mr Farraway (participating member)

3. Previous minutes
Resolved, on the motion of Ms Hurst: That draft minutes no. 37 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 30 April 2021 – Letter from Ms Leonie Brown, Manager Corporate Services, Bourke Shire Council, provided to the committee, dated 19 April 2021, from Dr Roger Chatoor to a Bourke Shire Council constituent advising of the closure of the Cardiac Clinic at Bourke
- 16 May 2021 – Email from Mrs Carmel Trengrove, to the secretariat, declining the committee's invitation to give evidence at the Wellington hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry due to illness
- 16 May 2021 – Letter from Mrs Gayle Murphy, Chair, Murrumbidgee Local Health District, to the Chair, expressing her displeasure with aspects of the committee's site visit to Deniliquin Health Service and the Deniliquin hearing
- 19 May 2021 – Email from Dr Simon Halliday, to the secretariat, requesting the committee consider hearing evidence from himself at the Taree hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 20 May 2021 – Email from Ms Judy Hollingworth, Deputy Chair, Manning Valley Push for Palliative, to the secretariat, requesting the committee consider hearing evidence from Manning Valley Push for Palliative at the Taree hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 24 May 2021 – Email from Ms Joanna Woodburn, Senior Journalist, ABC News, to the secretariat, asking if the remaining regional hearings will be webcast
- 24 May 2021 – Email from Ms Val Schaefer, Community Development Project Officer, Mid Coast 4 Kids, to the secretariat, requesting the committee consider hearing evidence from Mid Coast 4 Kids at the Taree hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 27 May 2021 – Email from Ms Maria Cade, Business Manager – Office of the CEO, Royal Flying Doctor Service – South Eastern Section, to the committee, requesting that the committee consider hearing from the Royal Flying Doctor Service – South Eastern Section at the Broken Hill hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 27 May 2021 – Email from Mrs Merrill Carr, Bonalbo United Hospital Auxiliary, to the secretariat, declining the committee's invitation to give evidence at the Lismore hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry
- 28 May 2021 – Email from Mr Neil Shaba, to the secretariat, noting the lack of information about Fairfield Hospital staffing or medical imaging equipment issues in the Current and future provision of health services in the South-West Sydney Growth Region inquiry report
- 31 May 2021 – Email from Ms Alicia Hargreaves, Executive Assistant, Rural Doctor's Association of NSW, to the secretariat, on behalf of Dr Ian Kamerman, declining the committee's invitation to give evidence at the Gunnedah hearing for the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry

- 1 June 2021 – Email from Dr Louis Schetzer, Policy & Advocacy Manager, Australian Lawyers Alliance, to the secretariat, requesting that the committee consider hearing from Ms Catherine Henry at the Sydney hearing on 12 July or 2 December 2021.

5. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission no. 706.

5.2 Changes to submission publication status

Resolved, on the motion of Mr Khan: That submissions 278, 495, 501 and 677 be made public, at the request of the submission authors.

5.3 Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Ms Colette Colman, Director, Policy and Strategy Development, National Rural Health Alliance received 1 April 2021
- Dr Charles Evill, , President, Rural Doctor's Association of NSW received 19 April 2021
- Dr Danielle McMullen for Dr Shehnarz Salindera, Councillor, Australian Medical Association received 19 April 2021
- Ms Dianne Kitcher, CEO, South Eastern NSW Primary Health Network, NSW Rural Primary Health Networks and Mr Richard Nankervis, CEO, Hunter New England and Central Coast Primary Health Network, NSW Rural Primary Health Networks received 19 April 2021
- Mr Gerard Hayes, Secretary, Health Services Union received 19 April 2021 (2)
- Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning Division, NSW Health and Mr Phil Minns, Deputy Secretary, People Culture and Governance Division, NSW Health received 19 April 2021
- Dr Tony Sara, President, Australian Salaried Medical Officers' Federation received 19 April 2021
- Dr Michael Clements, Chair – Rural, The Royal Australian College of General Practitioners and Dr Charlotte Hespe, Chair – NSW & ACT, The Royal Australian College of General Practitioners received 30 April 2021
- Mr Brett Holmes, General Secretary, New South Wales Nurses and Midwives' Association received 7 May 2021.

5.4 Public hearing - Gunnedah

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mrs Kate McGrath, Former Chair and Founding Member, Gunnedah Community Roundtable
- Mrs Rebecca Dridan, Chair, Gunnedah Early Childhood Network
- Ms Rebecca Ryan, Member, Gunnedah Early Childhood Network
- Cr Jamie Chaffey, Mayor, Gunnedah Shire Council
- Mr Eric Groth, General Manager, Gunnedah Shire Council

Mr Groth tendered the following documents:

- Document entitled 'State of Play of the GP Workforce in Gunnedah Shire, 15 February 2021'.
- Document entitled 'Ordinary council meeting minutes, 21 April 2021'.
- Document entitled ' Results of the 2021 Gunnedah Shire Community Survey on primary Health Care Service Provisions, June 2021'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr David Scott, Chair, Tamworth Medical Staff Council and Member, Physician Group Tamworth Base Hospital
- Dr Liz Jones, Private citizen

Dr Scott tendered the following document:

- Document entitled 'Distribution of RACP Members in Remote Areas in Australia'.

Dr Jones tendered the following documents:

- Document entitled 'Employment Arrangements for Medical Officers in the NSW Public Service, July 2019'.
- Document entitled 'Public Hospital Medical Officers (State) Award 2019'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Kate Ryan, Private citizen
- Ms Elizabeth Worboys, Private citizen

Ms Ryan tendered the following documents:

- Document entitled 'Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative, March 2017'.
- Document entitled 'Nurse Practitioners 2017 Factsheet'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Emma Priest, Private citizen
- Mr Brian Jeffrey, Private citizen

Mr Jeffery tendered the following documents:

- Document entitled 'Gunnedah GP Super Clinic, August 2014'.
- Document entitled 'Recommendations, 16 June 2021'.

The evidence concluded and the witnesses withdrew.

The hearing concluded at 12.16 pm.

The public and media withdrew.

The committee travelled to Taree for a public hearing for health outcomes and services in regional, rural and remote NSW inquiry.

5.5 Public hearing - Taree

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Eddie Wood, President, Manning Great Lakes Community Health Action Group
- Mrs Bree Katsamangos, Convenor, Mid Coast 4 Kids
- Ms Melissa Foster, Aboriginal Project Worker and Playgroup Coordinator – Child Care Services Taree & Districts Inc
- Ms Judy Hollingworth, Founder and Deputy Chair, Manning Valley Push for Palliative
- Ms Robyn Jenkins, Secretary, Manning Valley Push for Palliative

Mr Wood tendered the following document:

- Document entitled 'Background, Trauma Services'.

Mrs Katsamangos tendered the following document:

- Document entitled 'Midcoast 4 Kids'.

Ms Hollingworth tendered the following document:

- Document entitled 'Manning Valley Push for Palliative'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Nigel Roberts, Private citizen
- Dr Simon Holliday, Private citizen
- Dr Seshasayee Narasimhan, Visiting Medical Officer, Acute Care Physician and Cardiologist, Department of Medicine, Manning Base Hospital

Dr Narasimhan tendered the following documents:

- Document entitled 'CSP for Department of Medicine'.
- Document entitled 'Bureau of health Information – Manning Base Hospital'.
- Document entitled 'The Heart of Inequality, 18 October, 2017'.
- Document entitled 'No way out, The NSW Doctor, March/April 2020'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Alan Tickle, Private citizen
- Ms Marion R Hosking OAM, Private citizen

Mr Tickle tendered the following documents:

- Document entitled 'Hunter New England Health – Lower Mid North Coast Clinical Services Plan 2013-2017, July 2013'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District
- Dr Peter Choi, Director of Medical Services, John Hunter Hospital, Hunter New England Local Health District

Mr DiRienzo tendered the following documents:

- Document entitled 'Site Name – Taree (Manning Hospital)'.

The evidence concluded and the witnesses withdrew.

The hearing concluded at 6.50 pm.

The public and media withdrew.

5.6 Tendered documents

Resolved, on the motion of Mr Khan: That the committee accept and publish the following documents tendered during the public hearing in Gunnedah:

- Document entitled 'State of Play of the GP Workforce in Gunnedah Shire, 15 February 2021', tendered by Mr Groth .
- Document entitled 'Ordinary council meeting minutes, 21 April 2021', tendered by Mr Groth.
- Document entitled ' Results of the 2021 Gunnedah Shire Community Survey on primary Health Care Service Provisions, June 2021', tendered by Mr Groth.
- Document entitled 'Distribution of RACP Members in Remote Areas in Australia', tendered by Dr Scott.
- Document entitled 'Employment Arrangements for Medical Officers in the NSW Public Service, July 2019', tendered by Dr Jones.
- Document entitled 'Public Hospital Medical Officers (State) Award 2019', tendered by Dr Jones.

- Document entitled 'Improving Access to Primary Care in Rural and Remote Areas (s19(2) Exemptions) Initiative, March 2017', tendered by Ms Ryan.
- Document entitled 'Nurse Practitioners 2017 Factsheet', tendered by Ms Ryan.
- Document entitled 'Gunnedah GP Super Clinic, August 2014', tendered by Mr Jeffery.
- Document entitled 'Recommendations, 16 June 2021', tendered by Mr Jeffery.

Resolved, on the motion of Mr Kahn: That the committee accept and keep confidential the following document tendered during the public hearing in Taree:

- Document entitled 'Background, Trauma Services', tendered by Mr Wood.

Resolved, on the motion of Mr Khan: That the committee accept and publish the following documents tendered during the public hearing in Taree:

- Document entitled 'Midcoast 4 Kids', tendered by Mrs Katsamangos.
- Document entitled 'Manning Valley Push for Palliative', tendered by Ms Hollingworth.
- Document entitled 'CSP for Department of Medicine', tendered by Dr Narasimhan.
- Document entitled 'Bureau of health Information – Manning Base Hospital', tendered by Dr Narasimhan.
- Document entitled 'The Heart of Inequality, 18 October, 2017', tendered by Dr Narasimhan.
- Document entitled 'No way out, The NSW Doctor, March/April 2020', tendered by Dr Narasimhan.
- Document entitled 'Hunter New England Health – Lower Mid North Coast Clinical Services Plan 2013-2017, July 2013', tendered by Mr Tickle.
- Document entitled 'Site Name – Taree (Manning Hospital)', tendered by Mr DiRienzo.

6. Adjournment

The committee adjourned at 6.54 pm until 10.15 am, Thursday 17 June 2021, Lismore (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 39
Thursday 17 June 2021
Portfolio Committee No. 2 - Health
Auditorium, Lismore Workers Club, Lismore, at 10.13 am

1. Members

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann,
Mr Fang
Mr Khan (substituting for Mr Amato)
Mrs Maclaren-Jones
Mr Secord

2. Apologies

Mr Farraway (participating)

3. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

3.1 *In camera* hearing

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Ms Sharon Ohnesorge, Ms Vanessa O'Loan, Ms Emily Treeby, Mr Andrew Ratchford and Hansard reporters.

The following witnesses were sworn and examined:

- Witness F
- Witness G
- Witness H

The evidence concluded and the witnesses withdrew.

3.2 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mrs Marilyn Grundy, Branch President, Old Bonalbo CWA
- Mr George Thompson, Member, Coraki Health Reference Group
- Ms Maureen Fletcher, Chair, Ballina Cancer Advocacy Network
- Mrs Sharon Bird, Proprietor and Pharmacist, Bonalbo Pharmacy (via teleconference)

Mrs Grundy tendered the following documents:

- Document entitled 'Patient experiences'.
- A table detailing issues, outcomes, evidence and recommendations
- Maps showing the distance from Bonalbo to Lismore Base Hospital and Urbenville to Lismore Base Hospital.

Ms Fletcher tendered the following document:

- Document entitled 'Case Study 1'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Andre Othenin-Girard, Private citizen
- Dr Florian Roeber, Private citizen
- Mr Chris Hoare, Private citizen
- Mrs Christine Robertson, Private citizen

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Wayne Jones, Chief Executive, Northern NSW Local Health District
- Dr David Hutton, Director of Clinical Governance, Northern NSW Local Health District
- Ms Katharine Duffy, Director of Nursing and Midwifery and Aboriginal Health, Northern NSW Local Health District

The evidence concluded and the witnesses withdrew.

The hearing concluded at 3.33 pm.

The public and media withdrew.

3.3 Tendered documents

Resolved, on the motion of Mr Khan: That the committee accept and publish the following documents tendered during the public hearing:

- Document entitled 'Patient experiences', tendered by Mrs Grundy.
- A table detailing issues, outcomes, evidence and recommendations, tendered by Mrs Grundy.
- Maps showing the distance from Bonalbo to Lismore Base Hospital and Urbenville to Lismore Base Hospital, tendered by Mrs Grundy.

- Document entitled 'Case Study 1', tendered by Ms Fletcher.

4. Adjournment
The committee adjourned at 3.35 pm until Monday 12 July 2021, Macquarie Room, Parliament House (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 43
Friday 10 September 2021
Portfolio Committee No. 2 - Health
Via Webex, 8.47 am

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang
Mr Khan
Mrs Maclaren-Jones (until 9.59 am, and from 10.30 am)
Mr Secord

2. Apologies
Mr Farraway (participating)

3. Previous minutes
Resolved, on the motion of Ms Faehrmann: That draft minutes nos. 38 and 39 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 30 April 2021 – Email from Ms Monica Whelan, Member, Can Assist Coleambally, to the secretariat, providing clarification to her evidence during the Health outcomes and services in regional, rural and remote NSW hearing in Deniliquin on Thursday 29 April 2021
- 2 June 2021 – Letter from Mr Tim Burge, to the committee, providing additional information to the committee regarding that ability for residents of Deniliquin to access oncology and other services
- 3 June 2021 – Letter from Mrs Shirlee Burge, to the committee, reflecting on the Health outcomes and services in regional, rural and remote NSW inquiry hearing in Deniliquin on 29 April 2021 and providing additional information to the committee about recent experiences at Deniliquin Hospital
- 8 June 2021 – Letter from Mr Michael Neall, Honorary Secretary, Lawson Chamber of Commerce and Industry, to the Chair, disputing the claims of Blue Mountains City Council that Katoomba is a convenient location for the new hospital
- 18 June 2021 – Email from Ms Michelle Vo, Business Partner - Parliament and Cabinet – Executive and Ministerial Services, NSW Health, to the committee, requesting copies of the video recording for the sessions attended by NSW Health representatives
- 21 June 2021 – Email from Dr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Council, General Practitioner and Visiting Medical Officer, to the committee, providing additional commentary regarding issues with governance and culture within NSW Health arising from the the Health outcomes and services in regional, rural and remote NSW inquiry hearing in Dubbo on 19 May 2021

- 22 June 2021 – Email from Mr Christopher Cousins, to the committee, regarding the model of Intensive Care Paramedic provision across NSW
- 22 June 2021 – Letter from the Hon Shayne Mallard MLC, Government Whip, to the committee, advising that the Hon Mr Khan will be permanently substituting for the Hon Mr Amato for the duration of the Health outcomes and services in regional, rural and remote NSW inquiry
- 23 June 2021 – Email from Ms Samantha Gregory-Jones, Registered Nurse, to the secretariat, providing clarification to her evidence during the Health outcomes and services in regional, rural and remote NSW hearing in Wellington on Tuesday 18 May 2021
- 24 June 2021 – Email from Mrs Sharon Bird, owner and proprietor, Bonalbo Pharmacy, to the secretariat, discussing transport, clothing and accommodation options when patients are discharged from hospital, dental health and a proposed pharmacist home visit program
- 14 July 2021 – Email from Ms Marion Hosking OAM, to the committee, reflecting on her appearance at the Taree hearing and the recent concern expressed by the Australian Medical Association
- 19 July 2021 – Email from Dr Seshasayee Narasimhan, Cardiologist, Manning Base Hospital to the Hon Emma Hurst, regarding the lack of stakeholder engagement and transparency in finalising the Hunter New England Health Clinical Service Plan
- 19 July 2021 – Email from Dr Seshasayee Narasimhan, Cardiologist, Manning Base Hospital to the Hon Emma Hurst, requesting that the committee procure and publish a copy of the Hunter New England Health Clinical Service Plan
- 20 July 2021 – Email from Mr Eddie Wood, President, Manning Great Lakes Community Health Action Group, to the committee, regarding the Hunter New England Local Health District Clinical Services Plan and the lack of a cardiac catheterisation lab at Manning Base Hospital
- 3 August 2021 – Email from Dr Louis Schetzer, Policy & Advocacy Manager, Australian Lawyers Alliance, to the secretariat, requesting that the committee consider hearing from Ms Catherine Henry at the Sydney hearing on 2 or 3 December 2021
- 3 August 2021 – Email from Ms Michelle Vo, Business Partner - Parliament and Cabinet – Executive and Ministerial Services, NSW Health, to the committee, thanking the committee for copies of the video recordings of the sessions attended by NSW Health representatives
- 25 August 2021 – Email from Ms Jenny Lovric, Manager, Community Engagement and Partnerships, Just Reinvest NSW, to the committee, requesting that the committee consider hearing from Just Reinvest NSW at the Sydney hearing on Friday 10 September 2021

Resolved, on the motion of Mr Secord: That the committee keep the letter from Mrs Burge dated 3 June 2021 confidential, due to potential adverse mention of named individuals.

5. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 709, 710, 712 and 713.

5.2 Partially confidential submissions *(previously circulated)*

Identifying and/or sensitive information

Resolved, on the motion of Ms Hurst: That the committee authorise the publication of submission no. 711 with the exception of identifying and/or sensitive information which is to remain confidential, as per the request of the author.

5.3 Confidential submissions

Resolved, on the motion of Ms Faehrmann: That the committee keep submission nos 707 and 708 confidential as per the request of the author, as they contain identifying and/or sensitive information.

5.4 Changes to submission publication status

Resolved, on the motion of Mr Fang: That submission 670 be made public, at the request of the submission author.

5.5 Answers to questions on notice and supplementary questions

The committee noted the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Dr Rod Martin, Rural Generalist, Australian College of Rural and Remote Medicine received 11 May 2021
- Mr Richard Colbran, Chief Executive Officer, NSW Rural Doctors Network received 13 May 2021
- Cr Ruth McRae, Mayor, Murrumbidgee Council received 31 May 2021
- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District received 2 June 2021
- Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District received 4 June 2021
- Ms Julie Redway, Acting Chief Executive, Murrumbidgee Primary Health Network received 6 June 2021
- Ms Sheree Staggs, Registered Nurse, New South Wales Nurses and Midwives' Association received 9 June 2021
- Dr Justin Bowra, Founder & Medical Director, My Emergency Doctor received 10 June 2021
- Mr Scott McLachlan, Chief Executive, Western NSW Local Health District received 11 June 2021
- Dr Shannon Nott, Rural Health Director of Medical Services, Western NSW Local Health District received 11 June 2021
- Cr Ken Keith OAM, Mayor, Parkes Shire Council, and Dr Kerrie Stewart, General Practitioner, Ochre Health Medical Centre received 19 June 2021
- Cr Aniello Iannuzzi, Deputy Mayor, Warrumbungle Shire Council General Practitioner and Visiting Medical Officer received 21 June 2021
- Ms Samantha Gregory-Jones, Registered Nurse, New South Wales Nurses and Midwives' Association received 23 June 2021
- Ms Sharelle Fellows, Member, Gulgong Petitioners and private citizen received 24 June 2021
- Mr Christopher Pearson, Private citizen received 24 June 2021
- Mrs Joan Staggs, Private citizen received 24 June 2021
- Mrs Alison Campbell, Member, Warren Health Action Group received 25 June 2021
- Mr Neil Southorn, Director - Environmental, Planning and Building Services, Bathurst Regional Council, and Cr Warren Aubin, Councillor, Bathurst Regional Council, received 25 June 2021
- Ms Lourene Liebenberg, Vice Chair, Deniliquin Mental Health Awareness Group received 27 June 2021
- Dr Liz Jones, Private citizen received 2 July 2021
- Ms Emma Priest, Private citizen received 19 July 2021
- Dr Simon Holliday, Private citizen received 20 July 2021
- Mr Eddie Wood President, Manning Great Lakes Community Health Action Group received 20 July 2021
- Dr David Scott, Chair, Tamworth Medical Staff Council and Member, Physician Group Tamworth Base Hospital received 23 July 2021
- Mrs Sharon Bird, Proprietor and Pharmacist, Bonalbo Pharmacy received 25 July 2021
- Cr Jamie Chaffey, Mayor, Gunnedah Shire Council received 27 July 2021
- Ms Maureen Fletcher, Chair, Ballina Cancer Advocacy Network received 27 July 2021
- Mrs Kate McGrath, Former Chair and Founding Member, Gunnedah Community Roundtable received 27 July 2021
- Mr Alan Tickle, Private citizen received 27 July 2021
- Ms Judy Hollingworth, Founder and Deputy Chair, Manning Valley Push for Palliative received 28 July 2021
- NSW Health received 3 August 2021
- NSW Health received 4 August 2021

Resolved, on the motion of Mr Secord: That the committee keep the responses to questions on notice provided by Witness B and Witness C confidential to protect the identity of the witnesses.

5.6 Clarifications to evidence

Resolved, on the motion of Mr Fang:

- That the committee authorise the publication of the following correspondence:
  - Ms Monica Whelan, Member, Can Assist Coleambally, who has corrected an error in evidence made during the Health outcomes and services in regional, rural and remote NSW hearing in Deniliquin on Thursday 29 April 2021.
  - Ms Samantha Gregory-Jones, Registered Nurse, who has corrected errors in evidence made during the Health outcomes and services in regional, rural and remote NSW hearing in Wellington on Tuesday 18 May 2021.
- That the committee authorise the addition of a footnote to the evidence of Ms Monica Whelan, 29 April 2021, reflecting her clarification of evidence.
- That the committee authorise the addition of footnotes to the evidence of Ms Samantha Gregory-Jones, 18 May 2021, reflecting her clarification of evidence.

5.7 Request for video footage

Resolved, on the motion of Mr Khan: That the committee provide video recordings to NSW Health of the following sessions attended by NSW Health representatives, noting that NSW Health have provided an undertaking that they will only utilise the footage for the disclosed purpose and in accordance with the Legislative Council's' Media Guidelines – Broadcast of Proceedings':

- Parliament House hearing on 19 March 2021 for the 3.30 to 5.00 pm session that Dr Nigel Lyons and Mr Phil Minns attended
- Dubbo hearing on 19 May 2021 for the 2.15 to 3.15 pm session that Mr Scott McLachlan, Dr Shannon Nott and Mr Adrian Fahy attended
- Taree hearing on 16 June 2021 for the 5.30 to 6.30 pm session that Mr Michael DiRienzo and Dr Peter Choi attended
- Lismore hearing on 17 June 2021 for the 2.00 to 3.30 pm session that Mr Wayne Jones, Dr David Hutton and Ms Katharine Duffy attended.

5.8 Livestream and recording of hearing

Resolved, on the motion of Mr Secord: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

5.9 Photo of committee for social media

Resolved, on the motion of Mrs Maclaren-Jones: That the secretariat take a screenshot of the committee during its deliberative for the purposes of publishing on social media.

5.10 Public hearing

The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Jamelle Wells, Private citizen
- Ms Liz Hayes, Private citizen

Ms Wells tendered the following document:

- Article from the Daily Liberal and Macquarie Advocate, '380 Spaces – Tenders for $30 million car parks to be called early next year' by Kim Bartley, 6 November 2020.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Scott Beaton, Vice President, Australian Paramedics Association (NSW) Intensive Care Paramedic, Station Officer, Gilgandra Station

- Ms Liu Bianchi, Delegate, Australian Paramedics Association (NSW) and Intensive Care Paramedic, Extended Care Paramedic, Tuncurry Station
- Mr Ryan Lovett, Chair, Australasian College of Paramedicine
- Ms Alecka Miles, Chair - Rural, Remote and Community Paramedicine Special Interest Group, Australasian College of Paramedicine.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Kristin Michaels, Chief Executive, The Society of Hospital Pharmacists of Australia
- Mr Jerry Yik, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia
- Ms Chelsea Felkai, NSW President, Pharmaceutical Society of Australia
- Ms Karen Carter, Fellow, Pharmaceutical Society of Australia and Owner, Gunnedah and Narrabri Pharmacies

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Dr Sarah Wenham, Specialist Palliative Care Physician / Clinical Director (sub-acute and non-acute care) – Far West Local Health District, appearing on behalf of The Australian and New Zealand Society of Palliative Medicine
- Dr Susie Lord, Board member, Faculty of Pain Medicine , Australian and New Zealand College of Anaesthetists (ANZCA)
- Associate Professor Paul Wrigley, Member, Learning & Development Committee and NSW Regional Committee - Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA)

Dr Lord tendered the following documents:
- 'NSW Pain Management Plan 2012-2016', NSW Health
- 'NSW pain service locations', NSW Agency for Clinical Innovation, NSW Health
- 'National Strategic Action Plan for Pain Management 2019', Department of Health.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Professor Megan Smith, Executive Dean, Faculty of Science & Health, Charles Sturt University
- Professor Lesley Forster, Dean, School of Rural Medicine, Charles Sturt University
- Professor Jenny May, Director, University of Newcastle, Department of Rural Health

Professor Smith tendered the following document:
- Document entitled 'Opening statement from Charles Sturt University'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Professor Brigid Heywood, Vice Chancellor and Chief Executive Officer, University of New England
- Ms Leanne Nisbet, Project Manager, New England Virtual Health Network - University of New England
- Dr Pat Giddings, Chief Executive Officer, Remote Vocational Training Scheme

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.19 pm.

5.11 Tendered documents

Resolved, on the motion of Ms Hurst: That the committee accept and publish the following documents tendered during the public hearing:
- Article from the Daily Liberal and Macquarie Advocate, '380 Spaces – Tenders for $30 million car parks to be called early next year' by Kim Bartley, 6 November 2020, tendered by Ms Wells.
- 'NSW Pain Management Plan 2012-2016', NSW Health, tendered by Dr Lord.

- 'NSW pain service locations', NSW Agency for Clinical Innovation, NSW Health, tendered by Dr Lord.
- 'National Strategic Action Plan for Pain Management 2019', Department of Health, tendered by Dr Lord.
- Document entitled 'Opening statement from Charles Sturt University', tendered by Professor Smith.

6. Adjournment
The committee adjourned at 3.22 pm until Tuesday 5 October 2021, via Webex (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 44
Tuesday 5 October 2021
Portfolio Committee No. 2 - Health
Via Webex, 9.01 am

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Fachrmann
Mr Fang
Mr Khan (until 9.40 am)
Mrs Maclaren-Jones (until 9.13 am)
Mr Secord

2. Previous minutes
Resolved, on the motion of Ms Hurst: That draft minutes no. 43 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received

- 28 June 2021 – Email from Justice 4 Dubbo, to the committee, making allegations of corruption and abuse in the Western Local Health District
- 8 September 2021 – Email from Ms Zoe de Saram, Director - Performance Audit, Audit Office of New South Wales, to the secretariat, inviting the committee to attend virtual briefings on their 2021-2022 Annual Work program
- 10 September 2021 – Email from Ms Amy Fulham, Assistant Director, Medical Workforce Reform Advisory Committee, to the secretariat, declining the committee's invitation to appear at the Health outcomes and services in regional, rural and remote NSW inquiry hearing on 6 October 2021
- 12 September 2021 – Email from Ms Nicole Koerner, to the secretariat, highlighting issues on the Northern Beaches and calling on the committee to expand the inquiry to the whole of NSW
- 14 September 2021 – Email from Mr Paul Haines, Clinical Nurse Specialist, Yass District Hospital, to the committee, requesting that the committee consider hearing from staff at Yass District Hospital at an inquiry hearing
- 19 September 2021 – Email from Ms Deborah Castle, Secretary, Isolated Children's Parents' Association of NSW, to the secretariat, declining the committee's invitation to appear at the Health outcomes and services in regional, rural and remote NSW inquiry hearing on 6 October 2021
- 20 September 2021 – Email from Ms Marcia Howes, to the secretariat, advising that she is unlikely to be available to appear at the Health outcomes and services in regional, rural and remote NSW inquiry hearing on 6 October 2021

Resolved, on the motion of Mr Khan: That the secretariat be authorised to respond to the correspondence from Justice 4 Dubbo dated 28 June 2021, indicating that the appropriate course would be for them to direct their email to the Independent Commission Against Corruption.

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Public submissions
The committee noted that the following submission was published by the committee clerk under the authorisation of the resolution appointing the committee: submission no. 714.

4.2 Recordings of prior regional hearings
Resolved, on the motion of Ms Faehrmann: That the committee agree to the recordings of the Wellington, Dubbo, Gunnedah, Lismore and Taree hearings being placed on the inquiry webpage as soon as practicable.

4.3 Allocation of questioning
Resolved, on the motion of Mr Khan: That the sequence of questions be left in the hands of the Chair.

4.4 Livestream and recording of hearing
Resolved, on the motion of Mr Secord: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

4.5 Photo of committee for social media
Resolved, on the motion of Mr Secord: That the secretariat take a screenshot of the committee during its deliberative for the purposes of publishing on social media.

4.6 *In camera* hearing
Resolved, on the motion of Ms Hurst: That the committee proceeded to take *in camera* evidence.

Persons present other than the committee: Ms Sharon Ohnesorge, Ms Vanessa O'Loan, Mr Andrew Rode and Mr Andrew Ratchford.

The following witnesses were admitted via video link, sworn and examined:
- Witness I
- Witness J
- Witness K
- Witness L

The evidence concluded and the witnesses withdrew.

4.7 Public hearing
The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:
- Ms Emma Phillips, Executive Director, Can Assist
- Ms Majella Gallagher, Relationship Manager, Can Assist
- Mr Jeff Mitchell, Chief Executive Officer, Cancer Council
- Ms Annie Miller, Director, Cancer Information and Support Services, Cancer Council

Ms Phillips tendered the following document:
- IPTAAS Presentation to NSW Health, 23 September 2021.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Dr Ruth Arnold, Rural Co-Chair, New South Wales Medical Staff Executive Council

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Associate Professor Peter Malouf, Executive Director - Operations, Aboriginal Health and Medical Research Council of NSW
- Ms Margaret Cashman, Director of Ethics, Policy and Research, Aboriginal Health and Medical Research Council of NSW

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Alex Stephens, Director of Research, Northern NSW Local Health District, and Chair, NSW Rural Health Research Alliance
- Professor Andrew Searles, Associate Director – Health Research Economics, Hunter Medical Research Institute

Professor Searles tendered the following document:

- A Searles, M Gleeson, P Reeves, C Jorm, S Leeder, J Karnon, et al., 'The Local Level Evaluation of Healthcare in Australia: Health Systems Improvement and Sustainability (HSIS) National Initiative', Australian Health Research Alliance (2019).

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.00 pm.

4.8 Tendered documents

Resolved, on the motion of Mr Secord: That the committee accept and publish the following documents tendered during the public hearing:

- IPTAAS Presentation to NSW Health, 23 September 2021, tendered by Ms Phillips.
- A Searles, M Gleeson, P Reeves, C Jorm, S Leeder, J Karnon, et al., 'The Local Level Evaluation of Healthcare in Australia: Health Systems Improvement and Sustainability (HSIS) National Initiative', Australian Health Research Alliance (2019), tendered by Professor Searles.

5. Adjournment

The committee adjourned at 3.05 pm until Wednesday 6 October 2021, via Webex (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 45
Wednesday 6 October 2021
Portfolio Committee No. 2 - Health
Via Webex, 9.00 am

1. Members

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang (until 9.52 am, and then from 11.16 am)
Mr Khan (until 9.52 am, and then from 1.10 pm)
Mrs Maclaren-Jones
Mr Secord
Mr Amato (substituting for Mr Fang from 9.52 am until 11.16 am)

2. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

2.1 Allocation of questioning
Resolved, on the motion of Mr Secord: That the sequence of questions be left in the hands of the Chair.

2.2 Livestream and recording of hearing
Resolved, on the motion of Ms Hurst: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

2.3 Photo of committee for social media
Resolved, on the motion of Mr Secord: That the secretariat take a screenshot of the committee during its deliberative for the purposes of publishing on social media.

2.4 Public hearing
The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:
- Cr Paul Maytom, Mayor, Leeton Shire Council
- Mrs Jackie Kruger, General Manager, Leeton Shire Council
- Cr Neville Kschenka, Mayor, Narrandera Shire Council
- Mr George Cowan, General Manager, Narrandera Shire Council

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Adair Garemyn, Policy Manager, Country Women's Association of NSW
- Mrs Linda McLean, Branch Agriculture & Environment Officer, Country Women's Association of NSW – Hillston branch

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Dr Michael Holland, Co-founder, ONE - One New Eurobodalla hospital
- Ms Catherine Hurst, Private individual
- Mrs Patricia David, Secretary, Unions Shoalhaven

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr John Fernando, Chairperson, Riverina Murray Regional Alliance
- Mr Greg Packer, Delegate for Wagga Wagga, Riverina Murray Regional Alliance
- Ms Stacey O'Hara, Committee member, Murrumbidgee Aboriginal Health Consortium

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Dr Geoffrey Pritchard, Private individual
- Dr Paul Mara, Private individual

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 2.54 pm.

3. Adjournment
The committee adjourned at 2.55 pm, *sine die*.

Vanessa O'Loan
Committee Clerk

Minutes no. 49
Thursday 2 December 2021
Portfolio Committee No. 2 - Health
Jubilee Room, Parliament House, Sydney, 9.01 am

1. **Members**
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair* (from 9.05 am)
Ms Faehrmann (from 9.03 am)
Mr Fang (from 9.07 am)
Mr Khan
Mrs Maclaren-Jones (until 11.40 am)
Mr Secord

2. **Previous minutes**
Resolved, on the motion of Mr Secord: That draft minutes nos. 44 and 45 be confirmed.

3. **Correspondence**
The committee noted the following items of correspondence:

Received

- 17 June 2021 – Email from Ms Sharon Bird, Proprietor and Pharmacist, Bonalbo Pharmacy, to the secretariat, clarifying her comments about Gunnedah
- 27 July 2021 – Letter from Mr Alan Tickle, to the secretariat, providing additional information to the committee about the experience of Visiting Medical Officers at Manning Hospital
- 27 July 2021 – Email from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to the secretariat, providing clarification to his evidence during the Health outcomes and services in regional, rural and remote NSW hearing in Taree on Wednesday 16 June 2021
- 28 July 2021 – Email from Ms Kate Ryan, to the secretariat, providing clarification to her evidence during the Health outcomes and services in regional, rural and remote NSW hearing in Gunnedah on Wednesday 16 June 2021
- 5 October 2021 – Letter from the Hon Shayne Mallard MLC, Government Whip, to the committee, advising that the Mr Amato will substitute for Mr Fang from 10.00 am to 12.00 pm during the virtual Health outcomes and services in regional, rural and remote NSW hearing on Wednesday 6 October 2021
- 9 November 2021 - Email from Ms Wendy Spencer, Project Manager, Dharriwaa Elders Group, to the secretariat, declining the committee's invitation to appear at the Health outcomes and services in regional, rural and remote NSW inquiry hearing on 2 December 2021
- 24 November 2021 – Email from Mr Martin Rocks, Assistant Secretary – Health Training Branch, Australian Government Department of Health, to the Chair, informing the committee about their submission to the Senate Community Affairs References Committee Inquiry into Provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians.

4. **Briefing by the Auditor-General**
The committee noted that on 29 November 2021, members attended a virtual private briefing conducted by the Auditor-General on her 2021-2022 Annual Work Program.

5. **Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales**

5.1 Public submissions
The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 276b, 345a, 715 and 716.

5.2 Changes to submission publication status
Resolved, on the motion of Mrs Maclaren-Jones: That submission 341 be made public, at the request of the submission author.

5.3 Clarifications to evidence
Resolved on the motion of Mr Khan:

- That the committee authorise the publication of the following correspondence:
  - Email from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, dated 27 July 2021, correcting an error in evidence made during the Health outcomes and services in regional, rural and remote NSW hearing in Taree on 16 June 2021
  - Email from Ms Kate Ryan Monica, dated 28 July 2021, correcting an error in evidence made during the Health outcomes and services in regional, rural and remote NSW hearing in Gunnedah on 16 June 2021
- That the committee authorise the addition of a footnote to the evidence of Mr Michael DiRienzo, 16 June 2021, reflecting his clarification of evidence.
- That the committee authorise the addition of footnotes to the evidence of Ms Kate Ryan, 16 June 2021, reflecting her clarification of evidence.

5.4 February hearings
The committee noted that 1 and 2 February 2022 have been confirmed as hearing dates and that the proposed witness list has been circulated and agreed.

5.5 Report deliberative and reporting date
Resolved on the motion of Mrs Maclaren-Jones: That the committee report by 29 April 2022, with the report deliberative to take place on a date to be determined by the Chair after consultation with members regarding their availability.

5.6 Livestream and recording of hearing
Resolved, on the motion of Mr Secord: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

5.7 Public hearing
The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Cr Ian Woodcock, Mayor, Walgett Shire Council
- Mr Michael Urquhart, General Manager, Walgett Shire Council
- Cr Darriea Turley AM, Mayor, Broken Hill City Council

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Mark Burdack, Chief Executive Officer, Rural and Remote Medical Services Ltd
- Mr Richard Anicich AM, Chair, Rural and Remote Medical Services Ltd

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Sam Greg, Chief Executive Officer, Royal Flying Doctor Service of Australia (South Eastern Section)

- Ms Jenny Beach, General Manager Health Services, Royal Flying Doctor Service of Australia (South Eastern Section)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Betty Kennedy Williams, Enrolled Nurse, New South Wales Nurses and Midwives' Association

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Aunty Monica Kerwin, Community spokesperson, Wilcannia
- Mr Michael Kennedy, Private citizen

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Bob David, Chief Executive Officer, Maari Ma Health
- Dr Hugh Burke, Public Health Physician, Maari Ma Health
- Mr Carl Grant, Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service
- Ms Christine Corby OAM, Chief Executive Officer, Walgett Aboriginal Medical Service
- Ms Katrina Ward, Operations Manager, Walgett Aboriginal Medical Service and Brewarrina Aboriginal Medical Service

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Umit Agis, Chief Executive, Far West Local Health District
- Ms Dale Sutton, Executive Director Nursing, Midwifery & Clinical Governance, Far West Local Health District
- Dr Timothy Smart, Director Medical Services, Far West Local Health District

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 4.43 pm.

6. Adjournment

The committee adjourned at 4.45 pm until Friday 3 December 2021, Macquarie Room, Parliament House, Sydney (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 50
Friday 3 December 2021
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney, 9.02 am

1. Members

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Ms Faehrmann
Mr Fang (until 9.11 am and from 10.50 am)
Mr Khan (from 9.04 am)
Mrs Maclaren-Jones (from 9.04 am until 10.19 am, and then from 11.19 am until 11.40 am)
Mr Secord

2. Correspondence

The committee noted the following items of correspondence:

Received

- 2 December 2021 – Letter from Ms Hurst, Ms Faehrmann and Mr Secord requesting a meeting of Portfolio Committee No. 2 to consider a proposed self-reference into the use of primates and other animals in medical research in New South Wales.

3. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

3.1 Livestream and recording of hearing

Resolved, on the motion of Mr Secord: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

3.2 Public hearing

The committee proceeded to take evidence in public.

Witnesses were admitted to the hearing room and via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Ms Jenny Lovric, Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest (*via videoconference*)

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Catherine Henry, Spokesperson, Australian Lawyers Alliance *(via videoconference)*
- Ms Kathy Rankin, Policy Director – Rural Affairs & Business Economics & Trade, NSW Farmers Association (*via videoconference*)
- Ms Sarah Thompson, Member of the NSW Farmers Rural Affairs Policy Committee, NSW Farmers Association (*via videoconference*)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Edward Johnson, President, Services for Australian Rural and Remote Allied Health (*via videoconference*)
- Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health (*via videoconference*)
- Ms Leanne Evans, Senior Policy & Relations Advisor, Exercise and Sports Science Australia (*via videoconference*)
- Mr John Stevens, NSW State Chapter Co-Chair, Exercise and Sports Science Australia (*via videoconference*)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Kristin Bell, Chair, Specialist Training Program Committee and Chair, QEC Regional Training Network, The Royal Australian and New Zealand College of Ophthalmologists (*via videoconference*)
- Associate Professor Ashish Agar, Chair, Reconciliation Action Plan Working Group, The Royal Australian and New Zealand College of Ophthalmologists (*via videoconference*)
- Dr Michael Jonas, President, Australian Dental Association – NSW Branch
- Dr Sarah Raphael, Advisory Services Manager, Australian Dental Association – NSW Branch

Dr Bell tendered the following documents:

- M J Burton et al, 'The Lancet Global Health Commission on Global Eye Health: vision beyond 2020', The Lancet (2021)
- J Huang-Lung, B Angell, A Palagyi, H R Taylor, A White, P McCluskey, L Keay, 'The true cost of hidden waiting times for cataract surgery in Australia', Public Health Research & Practice (2021)
- Document entitled 'Proposal Brief: RANZCO Regionally Enhanced Training Network (RETN)' including two appendices
- Document entitled 'National Health Reform Agreement (NHRA) Long-term Health Reforms Roadmap'
- Document entitled 'The Outback Eye Service: Saving sight in the West' prepared by Ideology Consulting.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW (*via videoconference*)
- Dr Justine Hoey-Thompson, Member, The Royal Australian and New Zealand College of Psychiatrists (*via videoconference*)
- Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health (*via teleconference*)
- Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health (*via videoconference*)

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.08 pm.

3.3 Tendered documents

Resolved, on the motion of Mr Secord: That the committee accept and publish the following documents tendered during the public hearing:

- M J Burton et al, 'The Lancet Global Health Commission on Global Eye Health: vision beyond 2020', The Lancet (2021), tendered by Dr Bell.
- J Huang-Lung, B Angell, A Palagyi, H R Taylor, A White, P McCluskey, L Keay, 'The true cost of hidden waiting times for cataract surgery in Australia', Public Health Research & Practice (2021), tendered by Dr Bell.
- Document entitled 'Proposal Brief: RANZCO Regionally Enhanced Training Network (RETN)' including two appendices, tendered by Dr Bell.
- Document entitled 'National Health Reform Agreement (NHRA) Long-term Health Reforms Roadmap', tendered by Dr Bell.
- Document entitled 'The Outback Eye Service: Saving sight in the West' prepared by Ideology Consulting, tendered by Dr Bell.

4. Consideration of terms of reference

The Chair tabled the letter proposing the following self-reference:

That Portfolio Committee No. 2 - Health inquire into and report on the use of primates and other animals in medical research in New South Wales, and in particular:

(a) the nature, purpose and effectiveness of medical research being conducted on animals in New South Wales, and the potential public health risks and benefits posed by this research;

(b) the costs associated with animal research, and the extent to which the New South Wales and Federal Government is commissioning and funding the importing, breeding and use of animals in medical research in New South Wales;

(c) the availability, effectiveness and funding for alternative approaches to animal research methods and technologies, and the ability of researchers to meet the 3 R's of Replacement, Reduction and Refinement;

(d) the ethical and animal welfare issues surrounding the importing, breeding and use of animals in medical research;

(e) the adequacy of the current regulatory regime regarding the use of animals in medical research, particularly in relation to transparency and accountability;

(f) overseas developments regarding the regulation and use of animals in medical research; and

(g) any other related matters.

Ms Hurst moved: That the committee adopt the terms of reference.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Fang, Mr Khan.

Question resolved in the affirmative.

5. Conduct of the inquiry into the use of primates and other animals in medical research in New South Wales

5.1 Proposed timeline

Resolved, on the motion of Ms Faehrmann: That the committee commence the inquiry on 1 February 2022.

6. Adjournment

The committee adjourned at 3.15 pm, until Tuesday 1 February 2021, Jubilee Room, Parliament House, Sydney (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 51
Tuesday 1 February 2022
Portfolio Committee No. 2 - Health
Jubilee Room and via Webex, 9.01 am

1. Members

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mr Mallard (from 9.04 am)
Mr Secord

2. Change of membership

The committee noted that Mr Mallard replaced Mrs Maclaren-Jones as a substantive member of the committee from 25 January 2022, and that Mr Kahn, who was substituting for Mr Amato for the duration of the inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales, resigned from the Legislative Council on 6 February 2022.

3. Previous minutes

Resolved, on the motion of Mr Secord: That draft minutes nos. 49 and 50 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 9 November 2021 – Email from Witness L, to the committee, providing additional information regarding the Far West Local Health District
- 15 November 2021 – Letter from Mr David Shoebridge MLC, to the Chair, regarding correspondence received by the Public Accountability Committee from the Hon Mark Latham MLC and the Hon Brad Hazzard MP, Minster for Health and Medical Research about the application of Public Health Orders and isolation requirements
- 8 December 2021 – Email from Dr Allan Molloy, to the secretariat, regarding the implementation of best practice COVID and extreme event safety rapid recovery protocols and requesting to be called as a witness at a Health outcomes and services in regional, rural and remote NSW inquiry hearing
- 15 December 2021 – Email from Ms Marion Collier, to the secretariat, recounting her experience at Mudgee Hospital in 2011
- 24 December 2021 – Email from Dr Allan Molloy, to the Chair, providing additional information about the cancellation of the proposed pilot of the Recovery App and reiterating his request to appear as a witness
- 7 January 2022 – Email from Ms Christine Corby OAM, Chief Executive Officer, Walgett Aboriginal Medical Service, to the secretariat, providing an overview of the support required by the Walgett Aboriginal Medical Service to ensure it continues to provide culturally appropriate care to the community in Walgett and its surrounds
- 17 January 2022 – Letter from Mr Trevor Rowe, to the Chair, requesting that the committee consider hearing evidence from an independent patient advocate as a witness at a Health outcomes and services in regional, rural and remote NSW inquiry hearing.

Resolved, on the motion of Mr Fang: That the committee keep the following correspondence confidential, due to sensitive and/or identifying information regarding third parties, and potential adverse mention:

- Email from Witness L dated 9 November 2021
- Email from Ms Collier dated 15 December 2021
- Email from Dr Allan Molloy dated 24 December 2021

5. Inquiry into the use of primates and other animals in medical research New South Wales

5.1 Closing date for submissions

Resolved, on the motion of Ms Hurst: That the closing date for submissions be 31 March 2022.

5.2 Stakeholder list

Resolved, on the motion of Ms Faehrmann: That:

- the stakeholders on the attached list be invited to make a submission
- members have two days to nominate additional stakeholders to make submissions and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

5.3 Hearing date

Resolved, on the motion of Ms Hurst: That the committee hold two hearings and set aside one additional reserve hearing date in May/June 2022, the dates of which are to be determined by the Chair after consultation with members regarding their availability.

6. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

6.1 Public submissions

The committee noted that the following submission was published by the committee clerk under the authorisation of the resolution appointing the committee: submissions nos. 630a, 717-719.

6.2 Attachments to submissions
Resolved, on the motion of Mr Fang: That the committee authorise the publication of attachment 1 to submission no. 630a.

6.3 Changes to submission publication status
Resolved, on the motion of Mr Fang: That submission 201 be made fully confidential, at the request of the submission author.

6.4 Answers to questions on notice and supplementary questions – Public hearing
The committee noted the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Ms Jamelle Wells, Private citizen, received 15 October 2021
- Ms Liz Hayes, Private citizen, received 15 October 2021
- Ms Alecka Miles, Chair - Rural, Remote and Community Paramedicine Special Interest Group, Australasian College of Paramedicine, received 15 October 2021
- Mr Jerry Yik, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia, received 18 October 2021
- Dr Susie Lord, Board member, Faculty of Pain Medicine , Australian and New Zealand College of Anaesthetists (ANZCA), received 15 October 2021
- Ms Majella Gallagher, Relationship Manager, Can Assist, received 10 November 2021
- Ms Annie Miller, Director, Cancer Information and Support Services, Cancer Council, received 10 November 2021
- Dr Alex Stephens, Director of Research, Northern NSW Local Health District, and Chair, NSW Rural Health Research Alliance, received 3 November 2021
- Cr Paul Maytom, Mayor, Leeton Shire Council received 10 November 2021
- Mrs Linda McLean , Branch Agriculture & Environment Officer, Country Women's Association of NSW – Hillston branch, received 9 November 2021
- Dr Michael Holland, Co-founder, ONE - One New Eurobodalla hospital, received 2 November 2021
- Ms Catherine Hurst, Private citizen, received 10 November 2021
- Ms Stacey O'Hara, Committee member, Murrumbidgee Aboriginal Health Consortium, received 20 October 2021
- Dr Geoffrey Pritchard, Private citizen, received 8 November 2021.

6.5 Livestream and recording of hearing
Resolved, on the motion of Mr Amato: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

6.6 Public hearing
The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:
- Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District (via videoconference)
- Dr Richard Tranter, District Medical Director for Integrated Mental Health and Alcohol & Other Drugs, Mid North Coast Local Health District (via videoconference)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Kay Hyman, Chief Executive, Nepean Blue Mountains Local Health District (via videoconference)
- Ms Eloise Milthorpe, Acting Director Planning, Nepean Blue Mountains Local Health District (via videoconference)

- Professor Steevie Chan, Acting District Director Medical Service, Central Coast Local Health District (via videoconference)

The following witness was examined on their former oath/affirmation:

- Mr Scott McLachlan, Chief Executive, Central Coast Local Health District (via videoconference)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Margaret Bennett, Chief Executive, Southern NSW Local Health District (via videoconference)
- Dr Liz Mullins, Executive Director of Medical Services, Southern NSW Local Health District (via videoconference)

Mr Secord tabled the following document:

- Response to Ryan Park MP – Petition – Eurobodalla Hospital, 22 December 2021.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Margot Mains, Chief Executive, Illawarra Shoalhaven Local Health District (via videoconference)
- Ms Margaret Martin, Executive Director Clinical Operations, Illawarra Shoalhaven Local Health District (via videoconference)
- Ms Caroline Langston, Executive Director, Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven Local Health District (via videoconference)
- Ms Amanda Larkin, Chief Executive, South Western Sydney Local Health District (via videoconference)

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.32 pm.

6.7 Tendered documents

Resolved, on the motion of Mr Secord: That the committee accept and publish the following documents tabled during the public hearing:

- Response to Ryan Park MP – Petition – Eurobodalla Hospital, 22 December 2021, tabled by Mr Secord.

7. Adjournment

The committee adjourned at 3.33 pm until Wednesday 2 February 2022, Jubilee Room, Parliament House, Sydney and via Webex (public hearing for health outcomes and services in regional, rural and remote NSW inquiry).

Vanessa O'Loan
Committee Clerk

Minutes no. 52
Wednesday 2 February 2022
Portfolio Committee No. 2 - Health
Jubilee Room and via Webex, 9.05 am

1. Members

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mr Mallard (from 9.20 am)
Mr Secord

2. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

2.1 Publication of reporting date
Resolved, on the motion of Mr Secord: That the committee authorise the publication of the reporting date on the inquiry webpage.

2.2 Livestream and recording of hearing
Resolved, on the motion of Mr Secord: That the committee agree to record the hearing, and that this recording be placed on the inquiry webpage as soon as practicable after the hearing.

2.3 Public hearing
The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were examined on their former oath/affirmation:

- Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, NSW Health (via videoconference)
- Mr Phil Minns, Deputy Secretary, People Culture and Governance, NSW Health (via videoconference)

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 11.20 am.

3. Adjournment
The committee adjourned at 11.23 am, *sine die*.

Vanessa O'Loan
Committee Clerk

Minutes no. 54
Thursday 3 March 2022
Portfolio Committee No. 2 - Health
Jubilee Room, Parliament House, Sydney, at 9.17 am

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair (until 11:45 am; 2.45 pm to 4.32 pm)*
Mr Amato *(from 2.00 pm)*
Ms Faehrmann *(until 3.45 pm)*
Mr Fang *(until 2.00 pm)*
Mr Mallard
Mr Secord
Ms Boyd *(participating from 11.25 am to 11.45 am; 3.45 pm to 4.15 pm)*
Ms Jackson *(participating from 11.15 am to 11.35 am)*

2. Previous minutes
Resolved, on the motion of Mr Secord: That draft minutes no. 53 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received

- 25 February 2022 - Email from Isabelle Gillespie, Office of The Hon. Bronnie Taylor MLC, providing final list of departmental witnesses

Sent

- 24 February 2022 - Email from the secretariat, to the Hon Brad Hazzard MP, Minister for Health, issuing witness invitations for the Budget Estimates 2021-2022 additional hearings
- 24 February 2022 - Email from the secretariat, to the Hon Bronnie Taylor MLC, Minister for Women, Minister for Regional Health, and Minister for Mental Health, issuing witness invitations for the Budget Estimates 2021-2022 additional hearings
- 1 March 2022 - Letter from The Honourable Damien Tudehope MLC, Leader of the Government in the Legislative Council, to Mr David Blunt, Clerk of the Parliaments, advising of changes in committee membership

4. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

4.1 Partially confidential submission

Resolved, on the motion of Ms Hurst: That the committee authorise the publication of submission no 482b with the exception of identifying and/or sensitive information which is to remain confidential, as per the recommendation of the secretariat.

4.2 Confidential submissions

Resolved, on the motion of Mr Fang: That the committee keep submission nos 665b and 720 confidential, as per the request of the author as they contain identifying and/or sensitive information.

5. Inquiry into Budget Estimates 2021-2022 – supplementary hearings

5.1 Order for examination of portfolios

The committee noted that under the Budget Estimates 2021-2022 resolution each portfolio, except The Legislature, be examined concurrently by Opposition and Crossbench members only, from 9.30 am to 11.00 am, and from 11.15 am to 12.45 pm, then from 2.00 pm to 3.30 pm, and from 3.45 pm to 5.15 pm, with 15 minutes reserved for Government questions at the end of the morning and afternoon sessions, if required.

5.2 Public hearing: Women, Regional Health, Mental Health

Departmental witnesses were admitted.

The Honourbale Bronnie Minister Taylor MLC, Minister for Women, Minister for Regional Health, and Minister for Mental Health was admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters. The Chair noted that members of Parliament swear an oath to their office, and therefore do not need to be sworn prior to giving evidence before a committee.

The Chair also reminded the following witnesses that they did not need to be sworn, as they had been sworn at another Budget Estimates hearing for the same committee:

- Ms Elizabeth Koff, Secretary, NSW Health
- Dr Murray Wright, Chief Psychiatrist, NSW Health
- Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, NSW Health
- Mr Phil Minns, Deputy Secretary, People, Culture and Governance, NSW Health
- Ms Tanya Smyth, Director, Women NSW, Department of Communities and Justice
- Ms Catherine Lourey, NSW Mental Health Commissioner, NSW Mental Health Commission

The following witnesses were sworn:

- Ms Pia Van De Zandt, Acting Executive Director, Department of Communities and Justice
- Ms Maureen Lewis, Acting Executive Director, NSW Health

The Chair declared the proposed expenditure for the portfolios of Women, Regional Health, Mental Health open for examination.

The Minister and departmental witnesses were examined by the committee.

The Minister and Ms Elizabeth Koff withdrew at 12.45 pm.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 4.30 pm.

6. Adjournment
The committee adjourned at 4.32 pm, until 9.15 am, Thursday 10 March 2022, Macquarie Room, Budget Estimates hearing — Health

Lauren Evans
Committee Clerk

Draft minutes no. 56
Friday 29 April 2022
Portfolio Committee No. 2 - Health
Room 1043, Parliament House, Sydney, 9.34 am

1. Members
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato (via Webex)
Ms Faehrmann
Mr Farlow (substituting for Mr Rath, from 1.00 pm)
Mr Fang
Mr Rath (via Webex until 1.00 pm)
Mr Secord

2. Change of membership
Committee noted that Mr Rath replaced Mr Mallard as a substantive member of the committee from 29 March 2022.

3. Previous minutes
Resolved, on the motion of Ms Faehrmann: That draft minutes nos. 51 and 52 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 3 February 2022 – Letter from Ms Caroline Langston, Executive Director, Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven LHD, to the Chair, providing clarification to her evidence during the Health outcomes and services in regional, rural and remote NSW hearing 1 February 2022
- 4 February 2022 – Letter from Mr Roy Butler MP, Member for Barwon to the Chair, regarding maintenance of Broken Hill Airport
- 8 February 2020 – Email from Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, to the secretariat, informing the committees about a white paper authored by Dr Tonelle Handley on behalf of the Centre for Innovation in Regional Health about end of life care in regional and rural New South Wales
- 30 March 2022 – Letter from Mr David Shoebridge MLC, to the Chair, regarding correspondence received by the Public Accountability Committee from Dr Winston Cheung and others in relation to the pandemic's impact on the health care system

- 27 April 2022 – Email from the Office of Ms Cate Faehrmann, to the secretariat, advising that Ms Boyd will substitute for Ms Faehrmann for the duration of the inquiry into the use of primates and other animals for medical research in NSW
- 28 April 2022 – Email from the Office of Minister Sam Farraway MLC, to the secretariat, noting Mr Farraway's non-participation in the health outcomes and access to health and hospital services in rural, regional and remote New South Wales inquiry.

Resolved, on the motion of Mr Fang: That the Chair, on behalf of the committee, after the Federal election write to the Commonwealth Minister for Infrastructure, Transport and Regional Development, the New South Wales Minister for Women, Minister for Regional Health and Minister for Mental Health, the Hon. Bronnie Taylor MLC and Cr Tom Kennedy, Mayor, Broken Hill Council alerting them to the issues at Broken Hill Airport as raised by Mr Butler and encouraging them to work together to resolve the issues as soon as possible.

5. Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

5.1 Clarifications to evidence

Resolved, on the motion of Mr Secord:

- That the committee authorise the publication of the following correspondence:
  - Email from Ms Caroline Langston, Executive Director, Integrated Care, Mental Health, Planning, Information and Performance, Illawarra Shoalhaven Local Health District, dated 3 February 2022, correcting an error in evidence made during the hearing in Sydney on 1 February 2022
- That the committee authorise the addition of footnotes to the evidence of Ms Langston reflecting her clarification of evidence.

5.2 Answers to questions on notice and supplementary questions – Public hearing

The committee noted the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Ms Christine Corby OAM, Chief Executive Officer, Walgett Aboriginal Medical Service, received 6 December 2022
- Cr Ian Woodcock, Mayor, Walgett Shire Council, received 7 January 2022
- Mr Carl Grant, Chief Executive Officer, Bila Muuji Aboriginal Corporation Health Service, received 14 January 2022
- Mr Umit Agis, Chief Executive, Far West Local Health District, received 21 January 2022
- Ms Betty Kennedy, Enrolled Nurse, New South Wales Nurses and Midwives' Association, received 17 February 2022
- Mr Greg Sam, Chief Executive Officer, Royal Flying Doctor Service of Australia (South Eastern Section), received 17 February 2022
- Dr Justine Hoey-Thompson, Member, The Royal Australian and New Zealand College of Psychiatrists, received 22 December 2021 and 11 January 2022
- Ms Leanne Evans, Senior Policy & Relations Advisor, Exercise and Sports Science Australia, received 11 January 2022
- Dr Hazel Dalton, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, received 14 January 2022
- Professor David Perkins, Director and Professor of Rural Health Research , Centre for Rural and Remote Mental Health, received 8 February 2022
- Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW, received 14 January 2022
- Ms Kathy Rankin, Policy Director – Rural Affairs & Business Economics & Trade, NSW Farmers Association, received 17 January 2022
- Ms Jenny Lovric, Manager, Community Engagement & Partnerships - Aboriginal Legal Service, Just Reinvest, received 19 January 2022
- NSW Health, received 23 March 2022

- NSW Health, received 28 March 2022

5.3 Report deliberative and reporting date

Resolved, on the motion of Ms Hurst: That the committee report by 5 May 2022, with the report deliberative to take place on a 29 April 2022.

5.4 Consideration of Chair's draft report

The Chair submitted his draft report, entitled 'Health outcomes and access to health and hospital services in rural, regional and remote New South Wales', which, having been previously circulated, was taken as being read.

Chapter 1

Ms Faehrmann moved: That Finding 1 be amended by inserting 'significantly' before 'poorer health outcomes'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Resolved, on the motion of Mr Secord: That Finding 1 be amended by inserting 'greater incidents of chronic disease' after 'poorer health outcomes'.

Chapter 2

Resolved, on the motion of Ms Faehrmann: That paragraph 2.3 be amended by inserting 'severe shortage of nurses and midwives' after 'emergency departments with no doctors'.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.18 be amended by:

- omitting 'North West Coast' and inserting instead 'North [East] Coast'
- omitting '6m' and inserting instead '6 [months]'.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.25 be amended by inserting 'the' before 'primary reason'.

Resolved, on the motion of Ms Faehrmann: That paragraphs 2.38 to 2.42 under the heading 'Culturally and linguistically diverse communities' be omitted from Chapter 2 and inserted into Chapter 1 after paragraph 1.39.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.69 be amended by omitting 'have' before 'heard these stories all too often'.

Resolved, on the motion of Ms Faehrmann: That Finding 2 be amended by inserting at the end: 'which has led to instances of patients receiving substandard levels of care'.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.78 be amended by omitting 'The aim for bureaucracy should be to' and inserting instead 'The bureaucracy should aim to'.

Resolved, on the motion of Ms Faehrmann: That paragraph 2.79 be amended by omitting 'appropriateness of the current reimbursement rates' and inserting instead 'inadequacy of the current reimbursement rates'.

Resolved, on the motion of Ms Faehrmann: That Recommendation 2 be amended by omitting 'as a matter of priority, including' and inserting instead 'as a matter of priority, with a view to'.

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after paragraph 2.80:

'Recommendation X

That NSW Health, the rural and regional Local Health Districts and Transport for NSW work collaboratively to ensure, where feasible, more frequent and appropriately timed affordable transport services are available to support people to attend medical appointments in regional, rural and remote areas.'

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after paragraph 2.83:

'Recommendation X

That NSW Health and the rural and regional Local Health Districts actively engage with local community groups and charities to understand the services and resources they provide, and to ensure that where possible and appropriate, service gaps are filled by government.'

Chapter 3

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 3.28:

'Rural and Remote Medical Services Ltd also highlighted some of the challenges associated with the process of obtaining rights for GPs to work as Visiting Medical Officers in each Local Health District, which can exacerbate doctor shortages:

> GP practices like RARMS are required to make offers to GPs on the assumption they will be granted VMO rights which may not be forthcoming. This impacts on the capacity to recruit GPs to rural and remote practice.
>
> RARMS has had a situation where a highly qualified doctor with years of experience in emergency medicine in Sydney hospitals, and without any concerns or complaints lodged with the Australian Health Practitioners Registration Agency, was recruited to a small rural town and subsequently refused VMO rights on the ground that his metropolitan experience was not translatable to a small rural hospital. This forced the closure of our medical services in this town…
>
> A state-wide system of VMO approvals would enable common standards to be established for working in rural and remote hospitals, increase transparency and reduce the impact of local factors in decision-making. [FOOTNOTE: Submission 705, Rural and Remote Medical Services Ltd, p 36]'

Ms Faehrmann moved: That the following new section be inserted after paragraph 3.67:

'Role of primary health care

A number of witnesses told the committee that, while primary health care is the responsibility of the Australian Government, New South Wales should play more of a role in primary health care due to the impact that poor primary health care services has on the state health budget, particularly as a result of increased hospitalisations when people can't access GPs. For example, Rural and Remote Medical Services Ltd stated:

> There is an urgent need for the NSW Government to make a strategic commitment to a central role for Primary Health Care in rural and remote communities. While the Rural Health Plan acknowledges the importance of "integration" of primary and hospital care, there is a lack of consistency in the approach across NSW to supporting the sustainability of Primary Health Care and general practice.
>
> […]
>
> RARMS has spent 20 years engaging doctors to work in rural and remote NSW within their Primary Health Care and local hospital sectors; we have been delivering face to face quality care that has resulted in a reduction in potential preventable hospitalisations across our locations of 65 percent in the last 5 years; and, our communities are accessing health services at a higher rate than other towns without GPs because we have a model that has been shown to be among the most stable and sustainable of rural and remote health care models in Australia. [FOOTNOTE: Submission 705, Rural and Remote Medical Services Ltd, pp 9, 28.]

Similarly, the Australian College of Rural and Remote Medicine wrote in its submission:

> AIHW research indicates that lack of access is leading to people presenting when conditions have escalated, or when they are unable to seek appropriate primary care through their local GP. The rate of potentially preventable hospitalisations doubles in rural areas, leading to poorer health outcomes and consequent increased health care costs, losses in economic productivity and poorer quality of life. [FOOTNOTE: Submission 403, Australian College of Rural and Remote Medicine, p 3.]'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Ms Faehrmann moved: That Finding 4 be omitted: 'That rural, regional and remote medical staff are under resourced when compared with their metropolitan counterparts', and that the following new finding be inserted instead:

'Finding X

That rural, regional and remote medical staff are significantly under resourced when compared with their metropolitan counterparts, exacerbating health inequities.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That paragraph 3.128 be amended by inserting 'the' before 'NSW Government'.

Resolved, on the motion of Ms Faehrmann: That the following new finding be inserted after paragraph 3.128:

'Finding X

That the Commonwealth/state divide in terms of the provision of health funding has led to both duplication and gaps in service delivery.'

Resolved, on the motion of Ms Hurst: That following new committee comment and recommendation be inserted after Recommendation 5:

'Committee comment

Despite the role played by the Australian Government, the committee also believes that, given the interdependency between primary health and hospital care, there is a need for the NSW Government to investigate ways to support the growth and development primary health sector in rural, regional and remote areas and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

Recommendation X

That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.'

Resolved, on the motion of Ms Hurst: That paragraph 3.129 be amended by inserting after the first sentence: 'There are fundamental differences between the operation of hospitals in metropolitan areas, as compared to hospitals in rural and remote areas (where there is a greater interdependency between primary health and hospital care), and it is essential that NSW Health implement specialist systems for the management of rural and remote hospitals which reflect the needs of each community.'

Resolved, on the motion of Ms Faehrmann: That the following new finding be inserted after paragraph 3.130:

'Finding X

That activity-based funding is not appropriate for all rural and remote based hospitals with many marginally viable at best under this funding model.'

Resolved, on the motion of Ms Faehrmann: That paragraph 3.134 be amended by omitting 'to seamlessly provide both primary and secondary health care' and inserting instead 'to enhance the provision of both primary and secondary health care'.

Resolved, on the motion of Ms Hurst: That Recommendation 8 be amended by inserting 'mental health nurses, psychologists, psychiatrists, counsellors, social workers' after 'nurse practitioners'.

Ms Faehrmann moved: That the following new finding be inserted after paragraph 3.139:

'Finding X

That the existing GP/VMO model is creating difficulties for NSW Health in ensuring doctor coverage in hospitals, and many doctors working under this model experience enormous pressure.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Resolved, on the motion of Ms Hurst: That the following new committee comment and recommendation be inserted after Recommendation 9:

'Committee comment

The committee notes the evidence received regarding the challenges surrounding the process of obtaining rights for GPs to work as VMOs, which currently is a separate and variable process for each Local Health District. The committee recommends that a state-wide system be established to accredit VMOs.

Recommendation X

That NSW Health establish a state-wide system of GP/VMO accreditation, which is independent of the Local Health Districts. As part of this system, NSW Health should ideally look to establish an online GP/VMO availability system where GP/VMOs can nominate dates and locations they are available to work that can be accessed by the rural and regional Local Health Districts and general practices in filling vacancies.'

Chapter 4

Resolved, on the motion of Ms Faehrmann: That paragraph 4.70 be amended by:

- omitting 'having worked as nurses for decades' and inserting instead 'having worked in the profession for decades'
- omitting 'only' before 'magnified during the pandemic'.

Ms Faehrmann moved: That the following new finding be inserted after paragraph 4.72:

'Finding X

That there is a perception by many frontline healthcare workers that NSW Health does not appear to appreciate the extent of the exhaustion and depth of concerns felt by many nurses and allied health workers in regional, rural and remote New South Wales.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Ms Faehrmann moved: That Recommendation 12 be omitted and that the following new recommendation be inserted instead:

'Recommendation X

That NSW Health urgently mandate minimum nurse and midwifery staff ratios to ensure patient safety across rural, regional and remote New South Wales. The outcome should ensure there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Rath, Mr Secord.

Question resolved in the negative.

Ms Hurst moved: That the following new committee comment and recommendation be inserted after Recommendation 12:

'Committee comment

The committee also agrees that, consistent with evidence given by peak bodies such as the NSW Nurses and Midwives Association, the best way to ensure optimal patient care and a safe environment for staff is to introduce minimum staff-to-patient ratios for nursing staff in regional, rural and remote hospitals.

Recommendation X

That the NSW Government introduce minimum nurse staffing ratios in accordance with the NSW Nurses and Midwives Association 2022 Ratios claim.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Rath, Mr Secord.

Question resolved in the negative.

Ms Faehrmann moved: That the following new committee comment be inserted after paragraph 4.75:

'Committee comment

The committee acknowledges the evidence given by peak bodies such as the NSW Nurses and Midwives Association that the best way to ensure optimal patient care and a safe environment for staff is to introduce minimum staff-to-patient ratios for nursing staff in regional, rural and remote hospitals.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Rath, Mr Secord.

Question resolved in the negative.

Ms Faehrmann moved: That the following new recommendation be inserted after Recommendation 12:

'Recommendation X

That NSW Health develop, in consultation with NSW Treasury, and following consultation with rural and remote communities, a classification scheme for rural and remote health facilities that establishes minimum required staffing levels at each level of facility based on population catchment size.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Rath, Mr Secord.

Question resolved in the negative.

Resolved, on the motion of Ms Faehrmann: That Recommendation 12 be amended by inserting at the end: 'NSW Health should publicly report on an annual basis its performance in meeting this outcome.'

Resolved, on the motion of Ms Faehrmann: That Recommendation 16 be amended by omitting:

- 'consider' after 'review of the nursing and midwifery workforce'
- 'developing stronger partnerships' and inserting instead 'develop stronger partnerships'
- 'developing partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career specialised or are experienced' and inserting instead 'develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either earlier career, specialised or are experienced'.

Chapter 5

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 5.22:

'The Cancer Council also highlighted that 70 per cent of specialist medical services require patients to make a co-payment of $75 on average and that the introduction of public-private partnerships is driving up costs in communities that cannot access public cancer clinics. They further acknowledged that out of pocket costs placed a significant burden on cancer patients, finding between 28 per cent to 43 per cent of cancer patients reporting financial distress and a further 21 per cent of cancer patients skipping treatments due to costs. The Council called on NSW Health to investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services with no additional out-of-pocket costs. [FOOTNOTE: Submission 173, Cancer Council NSW, pp 14-15.]

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 5.88:

'One Door Mental Health – Great Lakes Mental Health Carer Support Group stated:

> Currently there are no mental health services in the Great Lakes area other than Community Health which is only available during business hours by referral to a case worker or the Psychiatrist weekly for people on a community treatment order. The closest support service available is Flourish (only for NDIS clients) and Parramatta Mission for those without a NDIS package, located in Taree.' [FOOTNOTE: Submission 249, One Door Mental Health, p 2.]

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 5.94:

'The Centre also drew attention to the paucity of data when it comes to mental health outcomes in rural New South Wales, stating that the last national mental health and wellbeing survey was conducted in 2007 and did not adequately sample rural areas. Furthermore, they noted that the 'landmark Australian Rural Mental Health Study, delved much deeper into the social, environmental, economic and rural determinants of mental health' but that that data is now ten years old. The Centre therefore highlighted the 'great and pressing need for comprehensive data on the mental health of rural and remote New South Wales residents and the factors that impact this'. [FOOTNOTE: Submission 454, Centre for Rural and Remote Mental Health, p 4.]

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 5.123:

'A number of stakeholders argued that that the 'midwifery continuity of care model' should be implemented across regional, rural and remote New South Wales, to ensure women receive consistent support throughout their pregnancy and birth from a known midwife.' [FOOTNOTE: Submission 349, New Yass Hospital with Maternity Working Group, p 1; Evidence, Ms Adair Garemyn, Policy Manager, Country Women's Association of NSW, 6 October 2021, p 10.]

Resolved, on the motion of Ms Faehrmann: That paragraph 5.141 be omitted: ' The Australian Paramedics Association (NSW) acknowledged that because patient transport services do not run 24 hours per day, this has led to reports that one in two regional paramedics have been consistently or usually called out to undertake frequent, and sometimes unnecessary, long distance transfers at night.', and that the following new paragraph be inserted instead:

'The Australian Paramedics Association (NSW) reported that the limited resourcing, coverage and operating hours of patient transport services (PTS) has led to reports that one in two regional paramedics have been consistently or usually called out to undertake frequent, and sometimes unnecessary, long distance transfers at night, diverting limited emergency resources to low-acuity cases for which they are not required.' [FOOTNOTE: Submission 664, Australian Paramedics Association (NSW), pp 6-7.]

Resolved, on the motion of Ms Faehrmann: That paragraph 5.193 be omitted: 'In relation to the specific issues discussed in this chapter, we note with concern the evidence regarding the heavy burden of out of pocket costs for patients, particularly in the context of cancer treatment. We urge all health providers to accept the clear message that patients must be informed of out of pocket treatment costs upfront, prior to the commencement of treatment.' and that the following new paragraphs be inserted instead:

'The evidence presented to the committee regarding out of pocket costs was alarming. In particular, evidence that a significant proportion of cancer patients are experiencing severe financial distress as a result of accessing cancer treatment and stories of patients choosing to forgoing life-saving treatments entirely because they simply cannot afford to pay for them.

The committee acknowledges evidence that public-private partnerships could contribute to the increased cost burden for cancer patients. As such the committee recommends that NSW Health investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services while reducing out-of-pocket costs.'

Resolved, on the motion of Ms Faehrmann: That the following new finding be inserted after paragraph 5.193:

'Finding X

That cancer patients in New South Wales face significant out of pocket costs which is resulting in patients experiencing severe financial distress and/or choosing to skip life-saving cancer treatments.'

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after paragraph 5.193 and the new finding above:

'Recommendation X

That NSW Health working with the Commonwealth and all relevant service providers investigate strategies to ensure public patients being treated in regional cancer centres can access private-public services while reducing out-of-pocket costs.'

Resolved, on the motion of Ms Faehrmann: That Finding 8 be amended by omitting 'dearth of support for' and inserting instead 'lack of'.

Resolved, on the motion of Ms Faehrmann: That Recommendation 18 be amended by:

- omitting 'and' after 'Royal Australian College of General Practitioners'
- inserting 'and the Aboriginal Health and Medical Research Council of NSW' before 'urgently establish a palliative care taskforce'
- insert the following new dot point at the end: 'ensure culturally appropriate palliative care services are available to First Nations peoples.'

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 5.201:

'The committee was very concerned by the number of stakeholders who raised the issue of the lack of adequate mental health services in regional, rural and remote New South Wales. The committee believes it is unacceptable that this unmet demand for mental health services contributes to greater than average rates of high or very high psychological distress in adults and higher suicide and intentional self-harm hospitalisation rates. However, as mental health services in regional, rural and remote New South Wales were not within the Terms of Reference for this inquiry, the committee was unable to explore the issue with the thoroughness it deserves. Hence, the committee recommends that Portfolio Committee No. 2 - Health consider undertaking an inquiry into mental health, including into mental health services in regional, rural and remote New South Wales in the future.'

Ms Faehrmann moved: That the following new recommendation be inserted after paragraph 5.201 and the new paragraph above:

'Recommendation X

That Portfolio Committee No. 2 – Health consider undertaking an inquiry into mental health, including into mental health services in regional, rural and remote New South Wales in the future.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Rath.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That paragraph 5.202 be amended by omitting 'In addition' at the start of the paragraph.

Ms Hurst moved: That paragraph 5.202 be amended by omitting 'is concerning' and inserting instead 'is unacceptable. One way to overcome some of these barriers would be to implement the midwifery continuity of care model in regional, rural and remote communities.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Hurst moved: That a new recommendation be inserted after paragraph 5.202:

'Recommendation X

That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That a new finding be inserted after paragraph 5.205:

'Finding X

That a lack of regional Patient Transport Services is being supplemented by Ambulance NSW, resulting in paramedics frequently attending patients who do not require emergency care and reducing Ambulance NSW's capacity to respond to emergencies, and that this comes at great cost to patient and paramedic safety.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That Recommendation 21 be amended to insert the words 'to provide 24-hour coverage and minimise the number of low-acuity jobs that paramedics attend to' before 'to relieve pressure on ambulance crews'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That the following new finding be inserted after paragraph 5.208

'Finding X

That there are significant barriers to the training and deployment of Extended Care and Intensive Care Paramedics in rural, regional and remote New South Wales despite the fact that these roles would provide significant health benefits in those communities'.

Resolved, on the motion of Ms Faehrmann: That Recommendation 22 be omitted: 'That NSW Health in conjunction with NSW Ambulance: • undertake a community profiling program across rural, regional and remote New South Wales to identify the paramedic needs of communities • ensure the equitable distribution of paramedics at all levels, including Extended and Intensive Care Paramedics • increase training opportunities for paramedics in rural, regional and remote locations • explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor', and that the following new recommendation be inserted instead:

'Recommendation X

That NSW Health in conjunction with NSW Ambulance:

- undertake a community profiling program across rural, regional and remote New South Wales to identify the paramedic needs of communities
- ensure the equitable distribution of paramedics at all levels, including Extended Care and Intensive Care Paramedics and update ambulance deployment modelling to reflect present day demand, ensuring that ambulances are deployed as rostered
- expand the Intensive Care and Extended Care Paramedics program across rural, regional and remote New South Wales and allow paramedics outside metropolitan areas to undertake training, skills consolidation and skills maintenance locally
- explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor
- undertake a review of the efficacy of the current call triaging system and referral services.'

Ms Hurst moved: That Recommendation 23 be amended by inserting 'commit to providing continuity of quality care with the aim of a regular on-site doctor in regional, rural and remote communities' before the first dot point.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Hurst moved: That Recommendation 23 be amended by inserting 'ensure that the use of virtual care if required is undertaken in consultation with community members, health providers and local governments in regional, rural and remote areas.' after the final dot point.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That Recommendation 23 be amended by inserting 'investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.' after the final dot point.

Chapter 6

Resolved, on the motion of Ms Faehrmann: That the following new finding be inserted after paragraph 6.56:

'Finding X

That it is unacceptable that some First Nations people still experience discrimination when seeking medical assistance in some regional, rural and remote hospitals in New South Wales.'

Resolved, on the motion of Ms Faehrmann: That the following new committee comment, finding and recommendation be inserted after paragraph 6.57:

'Committee comment

The committee notes with concern the evidence received from First Nations witnesses regarding the significant challenge that telehealth services pose for their communities.

Finding X

That telehealth has created another barrier for First Nations people in terms of accessing culturally appropriate health services.'

Recommendation X

That NSW Health acknowledge the significant cultural barriers that telehealth poses for First Nations communities and work to ensure face-to-face consultations are prioritised.'

Chapter 7

Resolved, on the motion of Ms Faehrmann: That paragraph 7.5 be amended by omitting 'In an attempt to address' and inserting instead 'As a result of'.

Resolved, on the motion of Ms Faehrmann: That the following new paragraphs be inserted after paragraph 7.11:

'However, Rural and Remote Health Medical Services noted that 'rural and remote communities share no similarities with inner regional and metropolitan cities in terms of the availability of health infrastructure, workforce or models of care' and that the 'differences in the way in which health systems operate in urban and regional cities, and in rural and remote communities, are poorly articulated in NSW health planning and policy'. Further, in its submission the organisation was critical of the *Rural Health Plan - Towards 2021*, arguing:

> 'While the document identifies the importance of community engagement, integrated primary health and hospital care and the application of new technologies, it is principally designed to set the direction of hospital services in regional NSW and does not contain any specific actions or measures to address improvements to health outcomes in rural and remote communities.'[FOOTNOTE: Submission 705, Rural and Remote Medical Services Ltd, pp 23-24.]

Further, Rural and Remote Health Medical Services said it was not clear whether people living in rural and remote communities had been consulted in the development of the Plan and whether it addressed their priorities. Finally, they stated:

> 'The lack of a clear definition of 'what success looks like', the absence of specific targets for rural and remote health access and outcomes, and the lack of measurable performance indicators limits the capacity of the NSW Rural Health Plan to drive the broader health system reform to bridge the gap in health access and outcomes and makes it difficult for health services (hospitals, GPs, NGOs) to collaborate towards common goals.' [FOOTNOTE: Submission 705, Rural and Remote Medical Services Ltd, p 25.]

Ms Faehrmann moved: That the following new paragraphs be inserted after paragraph 7.47:

'Health as a whole-of-government priority

The submission by Rural and Remote Medical Services stressed the importance of health being considered in all government decision-making. They used the example of the South Australian government which has adopted a Health in All Policies (HiAP) approach. Rural and Remote Medical Services' submission states:

> The HiAP approach aims to systematically account for the health implications of all public policy decisions and promote horizontal collaboration across multiple policy domains to reduce harmful health impacts in order to improve population health and health equity. The website of the program states:
>
> > 'Health in All Policies is about promoting healthy public policy, based on the understanding that health is not merely the product of health care activities, but is

> influenced by a wide range of social, economic, political, cultural and environmental determinants of health. Actions to address complex, multi-faceted 'wicked problems' such as preventable chronic disease and health care expenditure require joined-up policy responses.
>
> The South Australian Health in All Policies initiative is an approach to working across government to better achieve public policy outcomes and deliver co-benefits for agencies involved including to improve population health and wellbeing.
>
> Established in 2007, the successful implementation of Health in All Policies in South Australia has been supported by a high-level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process.' [FOOTNOTE: Submission 705, Rural and Remote Medical Services Ltd, p 46.]

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new finding be inserted after paragraph 7.49:

'Finding X

That there is a lack of transparency and accountability of NSW Health and the rural and regional Local Health Districts in terms of governance.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That paragraph 7.50 be amended to omit 'It is a moot point whether or not the NSW Government would have acted to appoint a Regional Health Minister in December last year and most recently in April announced the establishment of a new Regional Health Division in NSW Health had not this inquiry been undertaken. However,'.

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 7.50:

> 'The committee welcomes the appointment of a Regional Health Minister in December last year and the establishment of a new Regional Health Division in NSW Health and urges the NSW Government to ensure this Minister has the appropriate authority to address issues raised in the inquiry and future issues that affect the rural, regional and remote health system and its communities.'

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after paragraph 7.50 and the new paragraph above:

> **'Recommendation X**
>
> That the NSW Government maintain a Regional Health Minister in cabinet and provide that Minister with appropriate authority to address issues raised in the inquiry and future issues that affect the rural, regional and remote health system and its communities.'

Resolved, on the motion of Ms Faehrmann: That paragraph 7.51 be omitted: 'The committee was very concerned to hear that the new Regional Health Minister is proceeding with the development of the new rural health plan without having undertaken and publishing an informed and comprehensive evaluation of *NSW Rural Health Plan: Towards 2021*. Without a thorough analysis of what worked well and what didn't, and publication of this analysis to inform consultation with stakeholders, any subsequent plan is setting itself up for failure and will further reinforce the idea that the residents of rural, regional and remote New South Wales are not equal to their metropolitan counterparts. The committee therefore recommends that NSW Health complete and publish the final evaluation of the *NSW Rural Health Plan: Towards 2021* before finalising the new rural health plan.', and the following new paragraphs be inserted instead:

'The committee also wishes to stress the importance of there being an informed and comprehensive evaluation of *NSW Rural Health Plan: Towards 2021* being undertaken before finalising the new health plan. The committee therefore recommends that NSW Health complete and publish the final evaluation of the *NSW Rural Health Plan: Towards 2021* before finalising the new rural health plan.

The committee urges the new Regional Health Minister to ensure that the development of the new rural health plan includes genuine consultation with rural and remote communities and acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems. Further, the committee was convinced by evidence that without realistic, measurable and quantifiable goals in terms of health outcomes in rural, regional and remote communities it is impossible to ensure accountability for decisions made by the government, including NSW Health and the Local Health Districts.'

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after Recommendation 28:

'Recommendation X

That the NSW Government ensure that the development of the next Rural Health Plan:

- acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems
- includes genuine consultation with rural and remote communities
- contains realistic, measurable and quantifiable goals in terms of tangible health outcomes
- provides the funding and support required to deliver against those goals.

Ms Faehrmann moved: That Recommendation 30 be amended by omitting 'independent review of their complaints management mechanisms' and inserting instead 'independent review of workplace culture including complaints management mechanisms'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Hurst moved: That Recommendation 30 be amended by inserting as a final dot point: 'develop and fund a plan to eliminate bullying and harassment within rural and regional Local Health Districts'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That Recommendation 31 be amended by inserting at the end: 'Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new recommendation be inserted after Recommendation 31:

'Recommendation X

That the NSW Government urgently establish and fund an independent statutory Rural and Remote Health Commissioner who will report to the Minister through a board comprised of representatives of rural and remote communities including residents, general practices, local government, community and First Nations organisations and which is responsible for consulting with rural and remote communities about their needs, advising the Minister regarding rural and remote health policy and reform and monitoring, and reporting on the performance of NSW Health in delivering the population health outcomes set out in the Rural and Remote Health Plan.

That the Rural and Remote Health Commissioner provide annually an independent report to Parliament and the public detailing the performance of NSW Health in meeting health workforce, service accessibility, service coordination, rural employment and health outcome targets.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Farlow, Mr Secord.

Question resolved in the negative.

Resolved, on the motion of Ms Faehrmann: That the following new recommendation be inserted after Recommendation 32:

'Recommendation X

That the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.'

Ms Faehrmann moved: That the following new paragraph be inserted after Recommendation 32:

'The committee agrees with the views put forward that the health of the people of New South Wales should be central to government decision making. Indeed, the pandemic has brought the importance of this to the fore. Therefore the committee believes that the NSW Government should adopt a policy similar to the South Australian Government's Health in All Policies framework to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. The framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new recommendation be inserted after Recommendation 32 and the new paragraph above:

'Recommendation X

That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Ms Hurst, Mr Secord.

Noes: Mr Amato, Mr Fang, Mr Farlow.

Question resolved in the affirmative.

Resolved, on the motion of Mr Secord: That:

- the draft report as amended be the report of the committee and that the committee present the report to the House;
- the transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
- upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- the committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- the committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- dissenting statements be provided to the secretariat by 4.00 pm Monday 2 May 2022;
- the report be tabled on Thursday 5 May 2022;
- the Chair to advise members if he intends to hold a press conference, and if so, the date and time.

6. Inquiry into the use of primates and other animals for medical research in NSW

6.1 Treatment of short submissions from individuals

Committee noted that the inquiry has received approximately 900 submissions, the majority of which are from individuals and are less than half a page in length. Many are a few short lines as observed with the first 110 submissions circulated to the committee.

Resolved, on the motion of Ms Faehrmann: That the committee:

- define a 'short' submission from an individual as being half a page or less in length
- collate and process any 'short', and non-confidential submissions into a single document for publication on the website

- process and publish all other submissions, that is, those from organisations and more substantive individual submissions as normal.

7. Adjournment

The committee adjourned at 3.08 pm until Monday 16 May 2022, Macquarie Room, Parliament House, Sydney (public hearing for the use of primates and other animals in medical research New South Wales inquiry).

Vanessa O'Loan
Committee Clerk

Appendix 4 Dissenting statements

Hon Emma Hurst MLC
Animal Justice Party

It is incredibly disappointing that both the Liberal-National Government and Labor Opposition have failed to support a recommendation to mandate minimum staffing ratios for nurses in regional, rural and remote NSW.

The Committee heard damning evidence about the nurse understaffing crisis in regional, rural and remote hospitals. We heard that many facilities are operating with bare minimum nursing staff, often without a doctor on site. We heard that hospitals are so understaffed, nurses are sometimes forced to ask kitchen staff to watch over patients. We heard that nurses feel they have unsafe patient loads, particularly when emergency situations occur, causing significant stress for nurses and potential risks to patient care.

It is clear that the current situation in regional, rural and remote hospitals is not sustainable. Research shows a strong link between staffing levels and patient outcomes.

The Animal Justice Party agrees with the NSW Nurses and Midwives' Association that mandating minimum staffing ratios for nurses is the best way to ensure optimal patient care, and also to ensure that nurses are able to work in a professionally, physically and psychologically safe environment. The omission of staffing ratios from the recommendations in this Report is a major failure of this Inquiry.

Overall, this report falls short on its commitment to the health of people in rural, remote and regional NSW. Rather than taking the opportunity to make robust, outcomes-based recommendations for change, this Report is largely comprised of weaker recommendations which I am concerned will not lead to any substantial change. The people of rural, remote and regional NSW deserve better.

Ms Cate Faehrmann MLC
The Greens

While I strongly support this report and sincerely hope that the government uses the findings and recommendations contained herein to reform the regional, rural and remote health system, there were a few of my many amendments that weren't supported by both government and opposition members.

Staff to Patient Ratios and Minimum Staffing Levels

Disappointingly, the Liberal, National and Labor members of the committee did not support the Greens' amendments to the report which would have ensured that the requirement for safe nurse-to-patient ratios, as advocated by the NSW Nurses and Midwives Association (NSWNMA) and their members, was included in the report as a recommendation.

I moved the following recommendation regarding ratios in the first instance

Recommendation X

That NSW Health urgently mandate minimum nurse and midwifery staff ratios to ensure patient safety across rural, regional and remote New South Wales. The outcome should ensure there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment.

This was not supported by a majority of members, after which I moved the below amendment, as a compromise hoping to gain support.

Recommendation X

That NSW Health develop, in consultation with NSW Treasury, and following consultation with rural and remote communities, a classification scheme for rural and remote health facilities that establishes minimum required staffing levels at each level of facility based on population catchment size.

This was also not supported. As a further compromise, I moved the following amendment in an attempt to ensure that at least the evidence of the NSWNMA was contained as a committee comment in the final report:

The committee acknowledges the evidence given by peak bodies such as the NSW Nurses and Midwives Association that the best way to ensure optimal patient care and a safe environment for staff is to introduce minimum staff-to-patient ratios for nursing staff in regional, rural and remote hospitals.

It was discouraging to say the least that this statement was not supported by all government and opposition members.

I, for one, was convinced by the evidence presented by frontline healthcare workers and their unions of the urgent need to mandate shift-by-shift staff-to-patient ratios to ensure safe staffing and working conditions and patient safety.

The evidence presented to the inquiry by the NSWNMA made it clear that there is a link between staffing levels and health outcomes. Witnesses consistently told the inquiry that current staffing levels are dangerously inadequate and that the Government's preferred staffing model was outdated and failed to ensure safe staffing levels.

Shockingly, the inquiry was told that due to not enough nurses in many regional, rural and remote hospitals, patients were sometimes cared for by kitchen or security staff when nurses were required to attend an emergency. We heard time and time again that not enough nurses on duty was creating an unsafe work environment for nurses and midwives, and that this meant they were more likely to experience burnout and psychological trauma.

Safe nurse to patient ratios is one of the central demands of the NSWNMA and the Health Services Union and their members who have engaged in unprecedented industrial action this year. The NSWNMA told the inquiry that violent incidents often resulted from poor staffing levels and that violence and aggression is far more common in regional hospitals than in metropolitan hospitals.

While the drivers of the many issues raised throughout this inquiry are complex, many of which have been dealt with by the final recommendations in the report, the issue of not enough nurses and midwives in regional, rural and remote NSW won't be resolved until nurses are satisfied that they are working in an environment that is both safe for them and their patients. We are a far cry from that being the reality. In fact, it seems to be getting worse by the day, especially as the increased pressure on our hospitals due to Covid does not appear to be going away any time soon.

Rural and Remote Health Commissioner

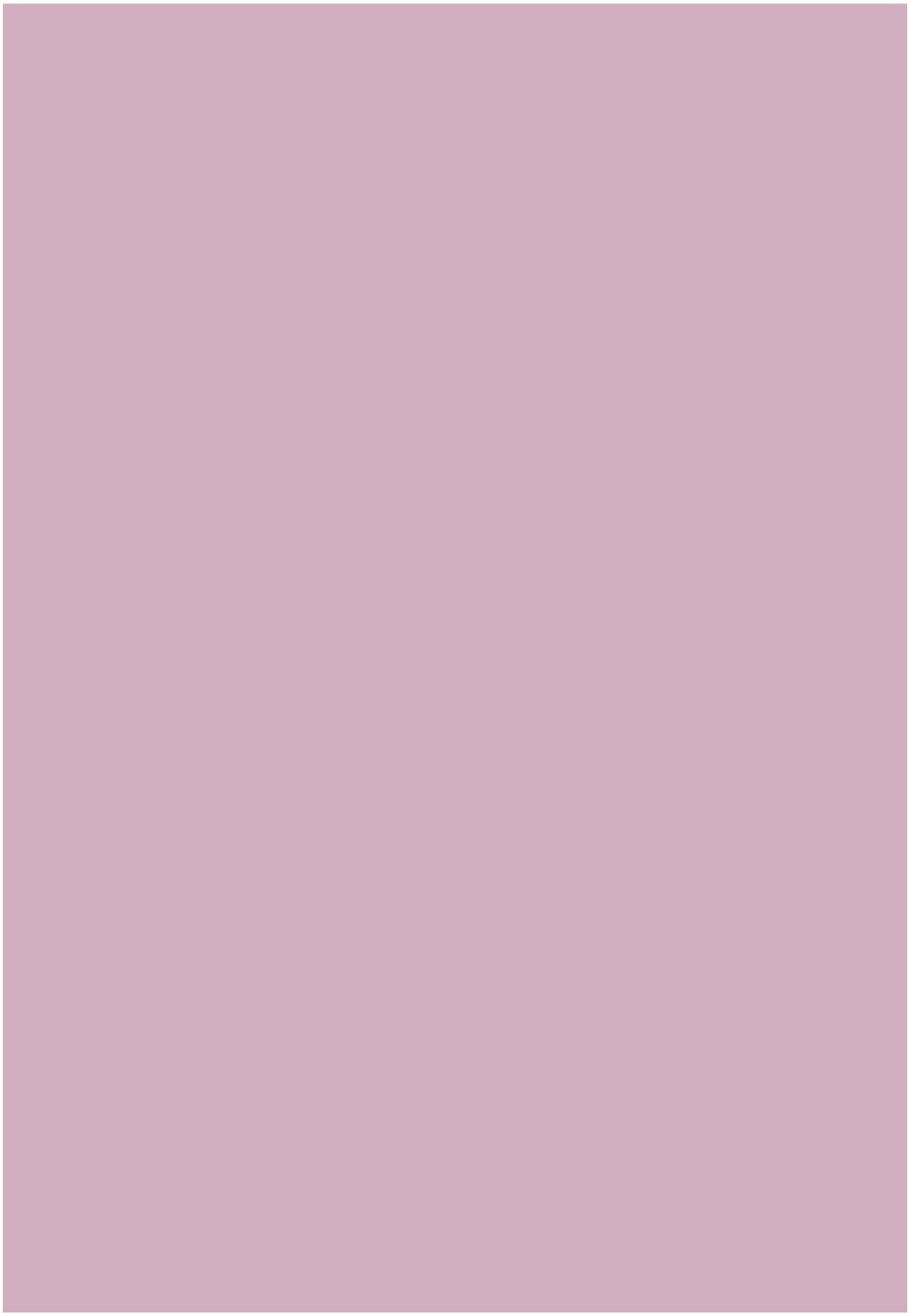
I also proposed the following recommendation be included in the chair's report:

Recommendation X

That the NSW Government urgently establish and fund an independent statutory Rural and Remote Health Commissioner who will report to the Minister through a board comprised of representatives of rural and remote communities including residents, general practices, local government, community and First Nations organisations and which is responsible for consulting with rural and remote communities about their needs, advising the Minister regarding rural and remote health policy and reform and monitoring, and reporting on the performance of NSW Health in delivering the population health outcomes set out in the Rural and Remote Health Plan.

That the Rural and Remote Health Commissioner provide annually an independent report to Parliament and the public detailing the performance of NSW Health in meeting health workforce, service accessibility, service coordination, rural employment and health outcome targets.

This, too, unfortunately failed to pass as neither government nor opposition members supported it. While I wholeheartedly support the Health Administration Ombudsman's recommendation, this position, if established, won't fulfil the role of proactively advising, monitoring and reporting on the government's actions to improve regional, rural and remote health services following this inquiry. A Rural and Remote Health Commissioner would, and it would also help reassure the many health experts and professionals, communities and individuals who contributed to this inquiry that any momentum gained over the past 18 months is maintained for years to come, not just to the next election.



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YASS VALLEY COUNCIL

DELEGATIONS TO THE GENERAL MANAGER

Instrument of Delegation

Local Government Act 1993

Delegation of Functions to General Manager

Yass Valley Council, pursuant to s377 of the *Local Government Act 1993* and a resolution passed at a duly convened meeting of the Council held on 26 May 2022,

(a) revokes all delegations previously given by the governing body of the Council to the General Manager, and

(b) delegates to the General Manager, in accordance with this instrument of delegation, the Functions specified or described in Schedule 1 subject to:

  (i) the exceptions specified or described in Schedule 2, and

  (ii) the conditions and limitations specified or described in Schedule 3.

.....

Mayor – Cr Allan McGrath Date:.....

Definitions

In this instrument:

Act means the *Local Government Act 1993*.

Application means an application for an Approval made to the Council.

Approval means approval, consent, licence, permission or any authorisation.

EPA Act means the *Environmental Planning and Assessment Act 1979*.

Function means a function of the Council within the meaning of the Act, and for the avoidance of doubt excludes:

(a) the functions of the General Manager referred to in s335 of the Act,

(b) the role of the governing body referred to in s223 of the Act,

(c) the role of the Mayor referred to in s226 of the Act.

General Manager means the person appointed by the Council pursuant to s334 of the Act to the position of general manager, and a person appointed by the Council pursuant to s336 of the Act to act in the vacant position of general manager.

Minister means a Minister of the Crown in right of the Commonwealth or New South Wales.

Commencement

The delegations conferred on the General Manager by this instrument of delegation commence on the 26 May 2022.

ACKNOWLEDGEMENT

I, Christopher Godfrey Berry, acknowledge receipt of, and understand, the terms of this instrument of delegation.

.....

General Manager Date : .....

Schedule 1

Functions Delegated

All Functions of the Council under the Act, and any other enactment, capable of being lawfully delegated under s377 of the Act.

Note: This Schedule must be read in conjunction with:

- Schedule 2 (Functions Not Delegated)
- Schedule 3 (Conditions and Limitations Applying to Delegated Functions)

Schedule 2

Functions Not Delegated

1 A Function for the time being delegated by the Council to any other person or body.

2 Adopting or varying a policy, plan, program, practice, strategy or the like adopted or approved by resolution of the Council.

3 Creating a committee of the Council of which all of the members are councillors.

4 Adopting or varying any of the following adopted or approved by resolution of the Council:

- 4.1 a planning proposal,
- 4.2 a development control plan,
- 4.3 a contributions plan,
- 4.4 a local approvals policy,
- 4.5 a local orders policy.

5 Adopting, varying or supplementing the Council's:

- 5.1 the code of conduct,
- 5.2 the code of meeting practice,
- 5.3 community strategic plan,
- 5.4 resourcing strategy,
- 5.5 delivery plan,
- 5.6 community engagement strategy,
- 5.7 annual report.

6 Deciding to decline to accept any tenders after a full assessment of all tenders has been undertaken for the purpose of determining whether any tender should be accepted by the Council.

7 Making an application, written proposal, representation, or submission to the Governor or a Minister or public authority on behalf of the Council which is not made by reference to policies, plans, programs, practices, strategies or the like adopted or approved by resolution of the Council.

8 Commencing and maintaining proceedings in any court or tribunal against any Minister or public authority.

9 Giving a notice, direction, order or the like to, or taking action to enforce any law against, a Minister or public authority.

10 Deciding to take a poll of electors for the purposes of holding a constitutional referendum.

11 Fixing of annual fees to be paid to the Mayor and the Councillors.

12 Determining:

- 12.1 the senior staff positions within the organisation structure of the council,

12.2 the roles and reporting lines (for other senior staff) of holders of senior staff positions,

12.3 the resources to be allocated towards the employment of staff.

13 Entering into a public-private partnership on behalf of the Council in the absence of a resolution of the Council to do so.

14 Entering into a Voluntary Regional Organisation of Councils.

15 Appointing or terminating the appointment of the Council's auditor.

16 Except in accordance with established policies or practices of the Council:

16.1 deciding to dedicate land as a public road,

16.2 deciding whether a public road should be closed,

16.3 preparing a proposal to fix or vary the levels of a public road or widen or realign a public road.

17 Ordering or consenting to the imposition of covenants or restrictions on the use of land vested in the Council.

18 Adding fluorine to any public water supply under the control of the Council.

19 Entering into or modifying an agreement or arrangement referred to in ss12 or 12A of the *Library Act 1939*.

20 Adopting a program for the inspection of swimming pools under s22B of the *Swimming Pools Act 1992*.

21 Exhibiting a draft coastal zone management plan under the *Coastal Protection Act 1979*.

22 Adopting an agency information guide under the *Government Information (Public Access) Act 2009*.

23 Making an interim heritage order for a place, building, work, relic, moveable object or precinct in the Council's area under s25 of the *Heritage Act 1977*.

24 Agreeing to combine the emergency management arrangements of Council with another council under s27 of the *State Emergency and Rescue Management Act 1989*.

Schedule 3

Conditions & Limitations Applying to Delegated Functions

1 The Functions delegated must be exercised lawfully.

2 The Functions delegated must be exercised consistently with adopted policies of the Council.

3 A Function may not be exercised under delegation if the matter in respect of which the Function would otherwise be exercised under delegation:

3.1 is called-up to the governing body in accordance with an adopted policy of the Council, and

3.2 written notice is given to the General Manager of the matter being called-up before the Function delegated is exercised.

4 A function may not be exercised under delegation in relation to a matter if the General Manager has a pecuniary or significant non-pecuniary conflict of interests in relation to the matter.

5 A Function may not be exercised under delegation if it involves incurring expenditure on behalf of the Council that is not within a vote of money for expenditure by the Council in an amount exceeding $75,000.

6 A Function may not be exercised under delegation if it involves incurring a cost (other than by means of expenditure) to the Council (including foregoing monies otherwise due to the Council) in an amount exceeding $150,000 or for any reason that is inconsistent with established policies or practices of the Council.

7 A Function may not be exercised under delegation if it involves writing-off a debt owing to the Council in an amount exceeding $3,000

8 A Function may not be exercised under delegation if it involves deciding to provide goods, services or facilities to any person or group of persons which have not been previously provided by the Council to any person.

9 A Function may not be exercised under delegation if it involves deciding to vary, suspend or terminate the provision of goods, services or facilities to any person or group of persons except in accordance with a contract between the Council and the person.

10 A Function may not be exercised under delegation if it involves determining an Application:

10.1 which the Council has resolved is to be determined by resolution of the Council,

10.2 in breach of a development standard applying to the carrying out of development the subject of the Application,

10.3 in respect of which more than 3 submissions by way of objection have been made to the subject-matter of the Application,

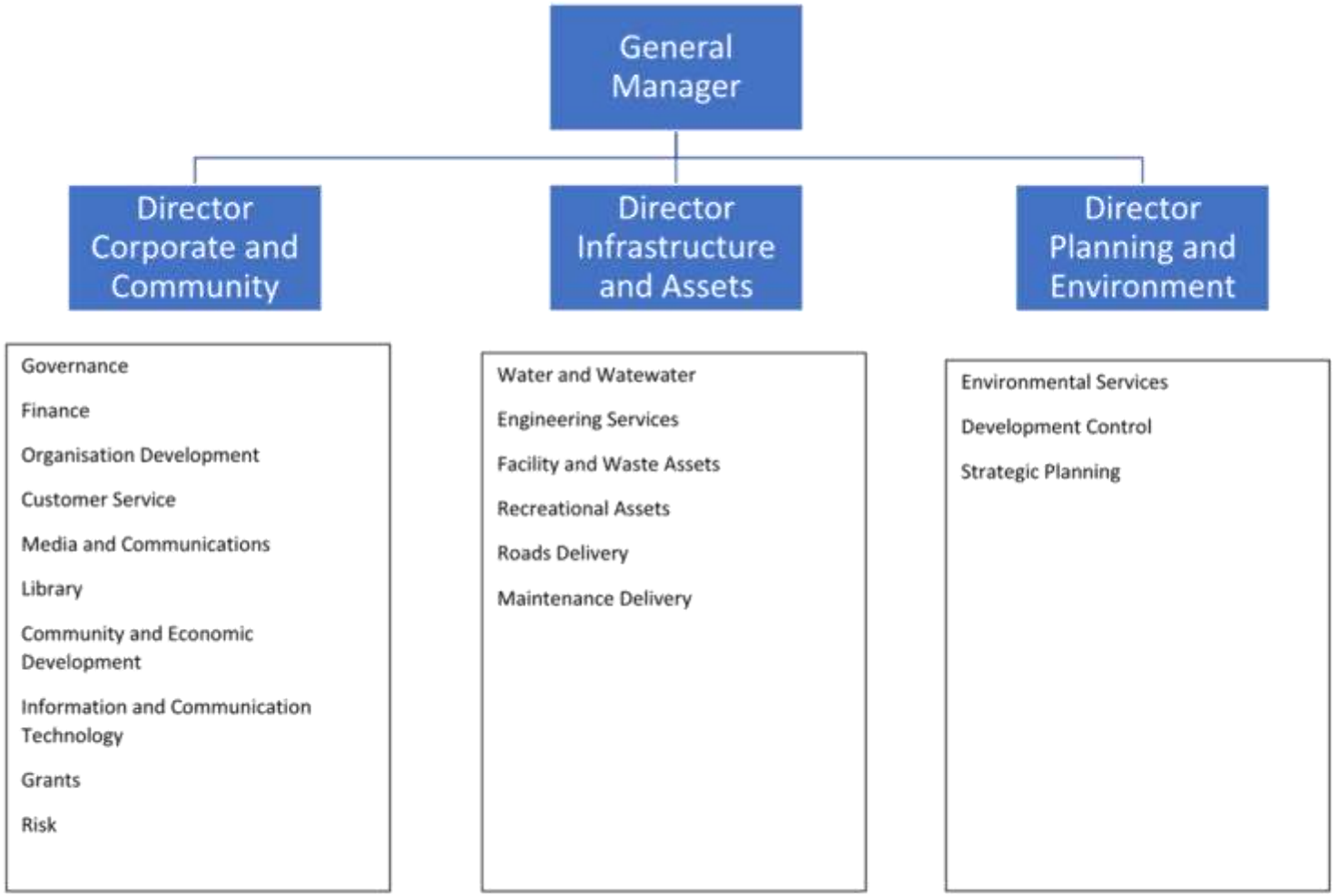
10.4 in a manner that is inconsistent with the purpose, objectives or intended outcomes of any policy adopted or approved by resolution of the Council applying to the Application.

11 A Function may not be exercised under delegation if it involves granting an Approval that is at variance with any requirement or standard fixed or specified by or under any law or any adopted policy of the Council.

12 A Function may not be exercised under delegation if it involves deciding to carry out an activity or granting an Approval in relation to an activity for the purposes of Part 5 of the EPA Act where an environmental impact statement is required in connection with the activity.

13 Except as authorised by resolution of the Council, a Function may not be exercised under delegation if it involves entering into or amending or revoking a voluntary planning agreement or works-in-kind agreement entered into pursuant to a resolution of the Council.

14 A Function may not be exercised under delegation if it involves modifying or revoking an order given to a person by resolution of the Council.


General Manager
Director Corporate and Community
Director Infrastructure and Assets
Director Planning and Environment
Governance
Finance
Organisation Development
Customer Service
Media and Communications
Library
Community and Economic Development
Information and Communication Technology
Grants
Risk
Water and Watewater
Engineering Services
Facility and Waste Assets
Recreational Assets
Roads Delivery
Maintenance Delivery
Environmental Services
Development Control
Strategic Planning

Council Policy

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Title: KERB & GUTTER CONSTRUCTION **ENG-POL-4**

Service: **URBAN STREET FACILITIES**

Responsible Officer: **DIRECTOR OF OPERATIONS**

Objective

To outline policy in regard to the construction of new kerb and gutter in existing streets.

Policy

1. Applicability

1.1 This policy applies to all urban areas within Yass Valley where Council elects to construct new kerb and gutter in an existing street.

1.2 Any new works to which the policy applies shall be included in an annual Council Management Plan

1.3 This policy does not apply to work that is not included in Councils construction program. Any such work that is approved in an existing street must be fully funded by the developer.

2. Levying of Charges

2.1 Contributions towards the cost of kerbing and guttering works shall be levied pursuant to Section 217 of the Roads Act, 1993;

2.2 The unit rate for Kerb and Gutter Construction for the determinate of contributions shall be levied at a uniform rate annually, irrespective of location, road type or kerb and gutter type;

2.3 The unit rate for Kerb and Gutter Construction shall be set annually in Council's Fees and Charges and comprise the construction of kerb and gutter sub-base, kerb and gutter, 2.0 metres of road shoulder (including bitumen sealing);

2.4 Contributions shall be based on property boundary frontages;

2.5 The contribution levied shall be 50% of the unit rate for the frontage to the street address shown in Council's rate records; 25% for side frontage and 25% for rear frontage;

2.6 Contributions towards the cost of kerb and guttering may be made by instalments:

2.6.1. Where a landowner faces financial difficulty, they may choose to pay charges in equal instalments over a maximum three (3) year period with interest charges applicable;

2.6.2. Where, because of extreme financial hardship a landowner is unable to meet instalments, the outstanding costs by mutual agreement will be logged as a "charge against the land" (with interest charges being applicable).

3. Laybacks

Where upright kerb is constructed, Council will provide one standard 4m wide layback per block. Additional laybacks or wider laybacks shall be charged at 100% of the current kerb and gutter rate (measured per lineal metre).

Council Policy

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4. Steep Accesses

4.1. Standard Vehicle

Council will provide adjustments to access during kerb and gutter construction to allow access for a standard vehicle only (as defined by AUSTROADS).

Following a request in writing special requirements to accommodate long or low vehicles will be constructed at full cost to the property owner.

4.2. Bitumen Sealing

Accesses that are caused to be steepened beyond 16% by the construction of kerb and guttering will be sealed with a two coat bitumen seal to the property boundary at no cost to the owner. Maintenance thereafter shall be the responsibility of the property owner.

5. Reinstatement

Driveways shall be reinstated with similar material as existed prior to the kerb and gutter construction. Driveways will only be constructed to the point of providing access to a standard vehicle as defined in 4.1 above.

6. Credit for Existing Laybacks

Credit for existing laybacks shall only apply where the concrete layback has been constructed with Council approval to levels set by Council.

Other Relevant Policies/Procedures

Previously known as Policy K.1 & USF-POL-3

History

Minute No	*Date of Issue*	*Action*	*Author*	*Checked by*
482	*16 December 1998*	*Amended*		*David Rowe*
	9 May, 2001			
	15 May, 2008	*Reviewed*	*David Rowe*	*EMT*
280	*25 June, 2008*	*Amended*		*Council Meeting*
153	*11 May 2011*	*Amended*		*Special Planning Committee Meeting*

Document No:ENG-POL-4	Created/Revised: May 2011	Review date: October 2016
Version No: 4	Author: Director of Operations	Doc Type: 30
File Name: Kerb & Gutter Construction	Approved By: SPCM 11 May 2011	

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Minutes of the Traffic Facilities Committee Meeting

Wednesday 4 May 2022
10.30am
Chambers Room
Yass Valley Council
209 Comur Street, Yass

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Minutes of the Traffic Facilities Committee Meeting held on 4 May 2022

Acknowledgement of Country

I acknowledge that we are meeting on the ancestral land of the Ngunnawal people. I recognise the Ngunnawal as the traditional custodians and pay respect to the Elders of the community and their descendants.

1.0 Present:
Cr Adrian Cameron (Chairperson), Terry Cooper (Manger Engineering Services – YVC), Mel Lausz (TfNSW), Stephen Pidgeon (NSW Police), Cheryl Callanan (Rep. Hon Wendy Tuckerman MP), Meryl Hinge (RSO Officer – YVS) & Trish Reynolds (YVC – minutes)

2.0 Apologies:

Sharon Horner (TfNSW)

3.0 Declaration of Interest:

Nil

4.0 Public Participation:

Nil

5.0 Confirmation of Minutes

That the minutes of the Traffic Facilities Committee Meeting held on 16 March 2022 be taken as read and confirmed.

6.0 Matters Arising From Minutes

Nil

7.0 Matters for Information

Nil

8.0 MATTERS CONSIDERED BETWEEN MEETINGS

8.1 CAPITAL REGION MASTERS CYCLING CLIB 2022 CYCLE EVENTS

SUMMARY

To consider a request for cycle events on roads within Yass Valley.

DECISION:

That the approval be noted.

9.0 ITEMS DELEGATED TO COUNCIL

9.1 SAFETY CONCERNS INTERSECTION RED HILL ROAD AND BOWNING ROAD BOWNING

SUMMARY

To consider a request to install a stop sign at the intersection of Red Hill and Bowning Roads Bowning to improve road safety.

RECOMMENDATION:

That the Committee give in principle support to install a 'stop sign' & any required line-marking, at the intersection of Red Hill Road and Bowning Roads, Bowning.

9.2 SUTTON MARKETS

SUMMARY

To consider a request received to hold country markets at Sutton.

RECOMMENDATION

That the Sutton Country Markets be approved subject to the following conditions:

1. The organiser is to supply Council with a copy of the current Public Liability Insurance for the event with a minimum $20,000,000 indemnity. Transport for NSW, NSW Police and Yass Valley Council are to be identified on the insurance document as "interested parties" or equivalent.

2. The event organiser is to arrange for an appropriately certified Traffic Management Plan (TMP) and associate Traffic Guidance Scheme (TGS) to be prepared;

***Note:** Information shall be provided on any signage, detours and traffic changes, specifically how the traffic management will actually work.*
***Note:** Management of vehicles exiting Majura Lane and turning onto Bywong Street shall be addressed.*

3. That the event organiser implement the TMP and associated TGS;

4. The event organiser is to arrange the supply and installation/removal of appropriate signs etc. identified in the TMP and associated TGS. All personnel involved must be appropriate accredited;

5. The event organiser is to provide safe pedestrian access plan;
***Note:** This shall demonstrate the safe pedestrian access for people who have parked near Sutton Primary School, crossing the Bywong Street.*

6. The event organiser is responsible for directly notifying all residents that may be affected by the approved events as soon as possible;

7. Event marshals, event participants etc. will at all times obey the provisions of NSW Transport Legislation;

8. The event organiser is to ensure any local traffic, emergency services vehicles etc can safely and efficiently access/egress any property impacted;

9. The event organiser is responsible for ensuring that car parking and traffic movements are to be monitored and supervised for the safety of pedestrians and other vehicles.

10. Event organisers, event marshals, volunteers, event participants etc. are to take all possible actions to minimise the effect of the event on the non-event community, throughout the event;

11. Event organisers shall comply with the above conditions and the undertakings. Failure to comply will immediately void this approval.

3.5 COMMITTEE MEMBER UPDATES

SUMMARY

To provide each Committee member an opportunity to provide the Committee with an update on traffic matters as it relates to their area of responsibility.

NSW Police - NSW Police had a busy two weeks with long weekends.
Last week the area had visiting highway patrol cars, they were patrolling the area due to the logging trucks accidents.
Anzac Day road closures went well, no reports of any traffic issues.
An accident occurred at Gundaroo, across from the school, no serious injuries.

TfNSW - If anything progress or any request from the Gundaroo School Principal in regard to the safety of the site following the accident at Gundaroo, Mel will available to assist.

Council- Mt Carmel School upgrade to start as soon as the works have finished at Berinba School, it is anticipated in about two weeks.

Cr Adrian Cameron - Mulligans Flat Road has been receiving a lot of comments from residents in regards to speed and traffic on the road. Terry (YVC) explained the improvements that have occurred and that will be occurring to the road to improve the safety.

Office of Local Member – A health and safety officer will be onsite this week at Gundaroo following the accident.
A safety inspection will be carried out on the Hume High turn off onto Burley Griffin Way, after a constituent has raised concerns.

RECOMMENDATION

That the information be noted.

7. Next Meeting

Wednesday 3 August 2022, at 10.30am in Foyer Room
Yass Valley Council
209 Comur Street, Yass

The meeting closed at 11:06am

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Minutes of the Rescue Committee

Thursday 12 May 2022
10.00am
Council Chambers, 209 Comur Street Yass

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Minutes of the Rescue Committee held on 10 May 2022

Present

Dave Cowell – LEOCON (NSW Police), Paul Vasey (VRA Rescue NSW -Binalong), Nicholas Whiting (Fire Rescue NSW), Dianne Gordon (NSW SES), Superintendent Paul Condon (Hume Police District Commander) – 10.20am

Also Present

Shirree Garland (Yass Valley Council)

1. Apologies

Apologies were received from Peter Alley, George Shepherd NSW RFS, Ben Hutchinson (NSW Ambulance)

2. Confirmation of Minutes

COMMITTEE DECISION

That the minutes of the Rescue Committee held on 22 February 2022 be confirmed.

(P Vasey/N Whiting)

3. Correspondence

4. Delegate Reports

Fire Rescue NSW

Nicholas Whiting advised that the service had attended nine MVAs, one animal rescue. A joint familisation exercise with hybrid/electric cards will be arranged within the next couple of weeks. Heavy animal rescue training has been undertaken. Training to assist with flood rescues is also being arranged, enabling assistance to be provided to the SES.

SES

Dianne Gordon advised that there were discussions within the Zone taking place in relation to increasing flood rescue capabilities and whether there is a possibility of getting another Arkangel inflatable at Yass. Current priorities are to increase capabilities on both land and water. Working on improving cross-agency capabilities. Additional training will be scheduled coming into spring. Yass SES Controller to attend future meetings.

Rural Fire Service

Report tabled – copy attached.

VRA Rescue NSW - Binalong

Paul Vasey spoke to report as provided. Mark Spencer recently received an Emergency Services Medal, Mark has served the VRA for 40+ years.

Driver Reviver

Action: Paul to confirm with Dave Cowell, week prior, when VRA are running next Driver Reviver.

David Cowell advised that he has spoken to Jessica Holloway, Region 5 Coordinator, in relation to Binalong VRA not being called to attend MVA's, further discussions will be held outside this meeting.

Police

Dave Cowell advised that the Police were currently being over represented at MVA's, particularly in the Yass area. There was a large response required for the recent accident on the Barton Highway involving a log truck. This incident required a multi-agency response as well as cross-border response–working arrangements were good.

Dragon Dreaming to be raised at the LEMC.

5. General Business

Large Animal Rescues

Nicholas Whiting advised that during recent training on large animal rescue they were advised that there is a need for a vet to be in attendance at all incidents. This is to ensure the welfare of both animal and crew. The question was raised as to who is then responsible for payment of vet services if the owner is refusing to have a vet in attendance. Chris Harris advised that funds are available from LLS for rescue if on public land, if rescue is on private land owner is required to pay.

6. Next Meeting

10.00am, Thursday 11 August 2022

The meeting closed at 10.34 am

Minutes of the Rescue Committee held on 10 May 2022

NSW RURAL FIRE SERVICE

REPORT TO
Yass Valley Local Emergency Management Committee

NSW Rural Fire Service
Report Period: 22/02/202 to 12/05/2022

1. **ACTIVITY** - within the Southern Tablelands Zone during this period there has been a total of 129 incidents, for the Yass Valley there have been a total of 40 incidents – 13 fires, 14 MVA's and the remaining 13 were others (Hazard/Service Call/False Alarm/ Good Intent & Not Classed).

   Southern Tablelands have had a number of crews assisting in various positions with flood relief to Northern NSW

2. **CAPABILITY** – Operationally, business as usual with the Zone. Still awaiting replacement Opo 1 to start.

2. **PLANNING** – Southern Tablelands Bushfire Risk Plan is being reviewed and workshops have been conducted with relevant stakeholders reviewing the draft, work will continue for months to come. Bush fire Danger period has ceased with notifications required, this can be done on line or by contact with your local FCC

4. **TRAINING** – Planned RFS courses continue as per STZ Training plan and calendar.

5. **OTHER** – National Emergency Medals and other service medals are being presented to eligible volunteer personnel at planned events and Brigade AGM's.

6. **ACTION** – Nil

Submitted By: George Shepherd Date 11/05/2022

Minutes of the Rescue Committee held on 10 May 2022

VRA RESCUE NSW Limited
Binalong Rescue
Email: Binalong.president@vrarescue.org
Phone: 0499 030 252

08.05.2022

VRA Rescue NSW - Binalong LRC & LEMC Report

VRA Rescue NSW - Binalong are looking forward to being presented by the Minister their new Twin Cab Rescue Truck fully equipped before the end of this financial Year

4 members from VRA Rescue NSW – Binalong completed a Swift Water Course at Gundagai on the 19th & 20th Feb 2022. 2 Swift Water Technicians & 2 Land Based Operators are now situated at Binalong.

VRA Binalong continue to train once a week with 4 trainee members going through their mandatory training starting with ROM before progressing to GLR operators' status – they are all progressing quite well

VRA Binalong continue assisting Warby Motor sports trials at Tumut a trial run is scheduled for August 2022 with an attempt in October 2022

Cross training with NSW Police Rescue based in Goulburn took place on the 6th April 2022, a very good evening was had by both PRS & VRA Rescue NSW Binalong Members. More training evenings are being organised for the future.

On Wednesday 11th May 2022 Members from SES Harden will be training with VRA Rescue NSW – Binalong, a meet & greet has been organised along with some training – this was a request from SES Harden

On Wednesday 13th April 2022 - VRA Rescue NSW Binalong were call out for a lighting job recently – 2 members dropped the lights off to the location with instructions and collected them from Yass Police Station the next day

Binalong opened Driver Reviver at Bookham over the Easter Weekend; it was a very busy time

If members are called by a member of the public or another emergency service to an incident they will respond accordingly

Again, VRA Rescue NSW - Binalong are not been responded to MVA's that they are the nearest and most appropriate to attend

This has now been handed to VRA Rescue NSW Ltd & Region 5 Coordinator Jessica Holloway to follow up as this has been ongoing for far too long with no outcomes.

The Community Based Volunteer Emergency Service
PROUDLY SERVING THE COMMUNITY PROUDLY SERVING YOU

A few more examples: (different to the previous LRC & LEMC report):

- 03.04.2022 – approx. 1533hrs – Car rolled several times and hit 2 trees – Gilberts Grave - Binalong
  The driver got himself out of the vehicle – collapsed with head injuries etc. VRA Rescue NSW – Binalong were only 5 minutes away? No one in attendance for approx. 15mins?
- 12.04.2022 – 04.02hrs - Truck through medium strip - Obese driver with broken ankle – extrication required from cab over truck - Bookham cross of Whitfields Lane
  NSWFR Yass attended and assisted?
- 29.04.2022 - Loose wheel hit the side of a parked vehicle on the side of the Hume Highway – Driver trapped by confinement –
  NSWFR Harden drove through Binalong to attend this accident?
- 06.05.2022 – 10.44am - Car towing a trailer - persons trapped – Illalong Road, Bookham Hume Highway

There have been other MVA's but still the list grows and nothing seems to be being done to have this corrected

Members understand that persons may not be trapped in all of these accidents, however members can offer reassurance, first aid etc. whilst other services are on route if we are the first on scene.

In most places VRA Rescue NSW and other services are called out and work together to assist those in need. In some cases, an emergency service may be stood down and they then return to base.

This is not happening in the Yass Valley local area?

We look forward to working alongside all emergency services, working together to assist those in need at any time.

Members would be happy to do any cross-agency training and welcomes anyone that would like to visit us, just send us an email or call the number above to organise

Thank you and we look forward to a response

Report prepared by Debra Scanes ESM
VRA Rescue NSW – Binalong President/ Secretary

Submitted by Paul Vasey
VRA Rescue NSW - Binalong LRC & LEMC Representative

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Minutes of the Local Emergency Management Committee

Thursday 12 May 2022
10.30am
Council Chambers
209 Comur Street, Yass

Minutes of the Local Emergency Management Committee held on 22 February 2022

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Minutes of the Local Emergency Management Committee held on 22 February 2022

Present

James Dugdell - Chair, Tony Stevens – LEMO (Yass Valley Council), Dave Cowell – LEOCON (NSW Police), Superintendent Paul Condon (Hume Police District Commander), Paul Vasey (VRA Rescue NSW - Binalong), Nicholas Whiting, (Fire Rescue NSW, Dianne Gordon (NSW SES), Paul Lloyd (REMO – NSW Police), Chris Harris and Fiona Leech (Local Land Services), Ben Hutchinson (NSW Ambulance) (Teams), Sinisa Mrdalj (Transport) (Teams), Jessica Holloway (VRA Region 5) (Teams)

1. Apologies

Apologies were received from Julie Venables (DC&J), Peter Alley and George Shepherd (RFS)

2. Confirmation of Minutes

COMMITTEE DECISION

That the minutes of the Local Emergency Management Committee held on 22 February 2022, be taken as read and confirmed.

3. Matters Arising from Minutes

Access to Transgrid

Tony Stevens advised that Council has now been issued with an access card to Transgrid.

Internet Access – Council Chambers

Tony Stevens advised that improved internet access has been provided via Resilience NSW funding and the installation of a SkyMuster satellite.

Dragon Dreaming

Dave Cowell advised the following in relation to the recent Dragon Dreaming Festival:

- There was the maximum amount of attendees – around 4,000
- No major issues – number of overdoses dealt with on-site, one person required transportation to Goulburn
- Difficulties were experienced with access in and out of venue
- There were communication issues
- Event is again planned for September 2023 – this is the last year of the current DA approval.

Police will continue to object to the running of the Festival due to access issues, communication, location and the drain on resources. Agency debrief is scheduled for 17 May 2022.

Chris Harris raised a concern of residents that participants at the festival appeared to not be aware that Wee Jasper Road was a two way road. Agreed that a VMS may be required to have road safety messages.

4. Correspondence

Correspondence listed in report noted.

5. Delegate Reports

Police

Dave Cowell advised that there had been an increase in the number of crashes on both the Hume and Barton Highways. Multi agency and cross-border response worked well for the recent serious accident on the Hume Highway. Police were currently being over represented at MVA's, particularly in the Yass area.

Looking at re-commencing 'Coffee with a Cop' events, targeting heavy vehicles and fatigue. Looking at arranging for a nurse to be in attendance, undertaking basic health checks if drivers agree.

Ambulance

Ben Hutchinson advised that Dragon Dreaming had put a significant strain on resources, crews from Gundagai and Wagga were called in to assist. Ambulance Service would be supporting Police in Dragon Dreaming not continuing.

Work load has increased due to COVID being out in the community. Services looking to be impacted with the upcoming snow season, Perisher Medical Service have currently not secured a doctor. Meetings are ongoing with Health. Ben to provide any further information to the committee.

Fire Rescue NSW

Nicholas Whiting advised that the service had attended 15 incidents. There are currently two fire fighters in the recruitment process. Open Day is scheduled for this Saturday (14 May).

Rural Fire Service

Report tabled – copy attached.

State Emergency Service

Dianne Gordon advised that there were discussions within the Zone taking place in relation to increasing flood rescue capabilities and whether there is a possibility of getting another Arkangel inflatable at Yass – with increased training. Current priorities are to increase capabilities on both land and water. Working on improving cross-agency capabilities. Additional training will be scheduled coming into spring. Yass SES Controller to attend future meetings

VRA Rescue NSW - Binalong

Paul Vasey spoke to the attached report.

Local Land Services

Chris Harris reported that locally there has not been much activity. Assistance has been provided during recent floods on the South and North Coast. Planning has commenced for an in-house evac for small animals.

Aerial control operations, targeting pest animals, have been successfully undertaken.

Transport for NSW

Sinisa Mrdalj advised that the contraflow on the Federal Highway will finish 26 May.

Communities and Justice

Julie Venables provided a write advising that it was business as usual for the Department and that they were fully prepared and resourced (COVID requirements) should they be required to manage an evacuation centre.

Minutes of the Local Emergency Management Committee held on 22 February 2022

6. Region Emergency Management Officer Report

Paul Lloyd advised that:

- Peter Cotter APM has been appointed as Assistant Commissioner Southern Region
- NSW Resilience Training is scheduled for 24-25 May at the Harden Fire Control Centre – register on line
- REMC meeting will be held on 25 July

David Cowell left meeting at 11.12 am.

Paul Condon – advised that he has asked REMOs to prioritise LEOCONs and Deputy LEOCONs to attend NSW Resilience training (those that have financial and delegated authority). The last three years have been difficult but this region is going well and has a lot of stability.

Council

James Dugdell advised that the new Council is up and running. Integrated Planning & Reporting (IP&R) documents are currently out on exhibition. An Audit on Yass Dam has been undertaken. It has been noted that there hasn't been a desk top exercise undertaken in relation to the dam failure, we have until December 2023 to complete.

Action: Dianne Gordon and Paul Lloyd to arrange dam failure exercise.

Wendy Tuckerman announced last week that $1M has been provided for Binalong safety improvements (Stephen/Fitzroy/Richmond Streets). Plans for these works will be developed next financial year (22/23).

Resilience Blueprint Project for South East NSW – coordinated through the Canberra Region Joint Organisation, working with all levels of government, emergency services, researchers, risk analysts, businesses and communities to embed resilience in decision making. Workshop to be held 31 May 2022.

7. General Business

8. Next Meeting

Thursday 11 August 2022 , at 10.30am in Yass Valley Council Chambers.

The meeting closed at 11.23 am

Minutes of the Local Emergency Management Committee held on 22 February 2022

REPORT TO

Yass Valley Local Emergency Management Committee

NSW Rural Fire Service

Report Period: 22/02/202 to 12/05/2022

1. **ACTIVITY** - within the Southern Tablelands Zone during this period there has been a total of 129 incidents, for the Yass Valley there have been a total of 40 incidents – 13 fires, 14 MVA's and the remaining 13 were others (Hazard/Service Call/False Alarm/ Good Intent & Not Classed).

   Southern Tablelands have had a number of crews assisting in various positions with flood relief to Northern NSW

2. **CAPABILITY** – Operationally, business as usual with the Zone. Still awaiting replacement Opo 1 to start.

2. **PLANNING** – Southern Tablelands Bushfire Risk Plan is being reviewed and workshops have been conducted with relevant stakeholders reviewing the draft, work will continue for months to come. Bush fire Danger period has ceased with notifications required, this can be done on line or by contact with your local FCC

4. **TRAINING** – Planned RFS courses continue as per STZ Training plan and calendar.

5. **OTHER** – National Emergency Medals and other service medals are being presented to eligible volunteer personnel at planned events and Brigade AGM's.

6. **ACTION** – Nil

Submitted By: George Shepherd Date 11/05/2022

Minutes of the Local Emergency Management Committee held on 22 February 2022

VRA RESCUE NSW Limited
Binalong Rescue
Email: Binalong.president@vrarescue.org
Phone: 0499 030 252

08.05.2022

VRA Rescue NSW - Binalong LRC & LEMC Report

VRA Rescue NSW - Binalong are looking forward to being presented by the Minister their new Twin Cab Rescue Truck fully equipped before the end of this financial Year

4 members from VRA Rescue NSW – Binalong completed a Swift Water Course at Gundagai on the 19th & 20th Feb 2022. 2 Swift Water Technicians & 2 Land Based Operators are now situated at Binalong.

VRA Binalong continue to train once a week with 4 trainee members going through their mandatory training starting with ROM before progressing to GLR operators' status – they are all progressing quite well

VRA Binalong continue assisting Warby Motor sports trials at Tumut a trial run is scheduled for August 2022 with an attempt in October 2022

Cross training with NSW Police Rescue based in Goulburn took place on the 6th April 2022, a very good evening was had by both PRS & VRA Rescue NSW Binalong Members. More training evenings are being organised for the future.

On Wednesday 11th May 2022 Members from SES Harden will be training with VRA Rescue NSW – Binalong, a meet & greet has been organised along with some training – this was a request from SES Harden

On Wednesday 13th April 2022 - VRA Rescue NSW Binalong were call out for a lighting Job recently – 2 members dropped the lights off to the location with instructions and collected them from Yass Police Station the next day

Binalong opened Driver Reviver at Bookham over the Easter Weekend; it was a very busy time

If members are called by a member of the public or another emergency service to an incident they will respond accordingly

Again, VRA Rescue NSW - Binalong are not been responded to MVA's that they are the nearest and most appropriate to attend

This has now been handed to VRA Rescue NSW Ltd & Region 5 Coordinator Jessica Holloway to follow up as this has been ongoing for far too long with no outcomes.

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A few more examples: (different to the previous LRC & LEMC report):

- 03.04.2022 – approx. 1533hrs – Car rolled several times and hit 2 trees – Gilberts Grave - Binalong
  The driver got himself out of the vehicle – collapsed with head injuries etc. VRA Rescue NSW – Binalong were only 5 minutes away? No one in attendance for approx. 15mins?
- 12.04.2022 – 04.02hrs - Truck through medium strip - Obese driver with broken ankle – extrication required from cab over truck - Bookham cross of Whitfields Lane
  NSWFR Yass attended and assisted?
- 29.04.2022 - Loose wheel hit the side of a parked vehicle on the side of the Hume Highway – Driver trapped by confinement –
  NSWFR Harden drove through Binalong to attend this accident?
- 06.05.2022 – 10.44am - Car towing a trailer - persons trapped – Illalong Road, Bookham Hume Highway

There have been other MVA's but still the list grows and nothing seems to be being done to have this corrected

Members understand that persons may not be trapped in all of these accidents, however members can offer reassurance, first aid etc. whilst other services are on route if we are the first on scene.

In most places VRA Rescue NSW and other services are called out and work together to assist those in need. In some cases, an emergency service may be stood down and they then return to base.

This is not happening in the Yass Valley local area?

We look forward to working alongside all emergency services, working together to assist those in need at any time.

Members would be happy to do any cross-agency training and welcomes anyone that would like to visit us, just send us an email or call the number above to organise

Thank you and we look forward to a response

Report prepared by Debra Scanes ESM
VRA Rescue NSW – Binalong President/ Secretary

Submitted by Paul Vasey
VRA Rescue NSW - Binalong LRC & LEMC Representative

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