GOVERNMENT OF
WESTERN AUSTRALIA

Climate Health WA Inquiry

Inquiry into the impacts of climate change on health in Western Australia

Inquiry Lead:
Dr Tarun Weeramanthri

Witnesses:

Ms Learne Durringon
CEO, WA Primary Health Alliance

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[14:00:27]

HEARING COMMENCED

PROF WEERAMANTHRI: Ms Durrington, I'd like to thank you for your interest in the Inquiry and for your appearance at today's hearing. The purpose of this hearing is to assist me in gathering evidence for the Climate Health WA Inquiry into the impacts of climate change on health in Western Australia. My name is Tarun Weeramanthri and I have been appointed by the Chief Health Officer to undertake the Inquiry. Beside me is Dr Sarah Joyce, the Inquiry's Project Director. If everyone could please be aware that the use of mobile phones and other recording devices is not permitted in this room, so if you could please make sure that your phone is on silent or switched off.

This hearing is a formal procedure convened under section 231 of the *Public Health Act 2016*. While you are not being asked to give your evidence under oath or affirmation, it is important you understand that there are penalties under the Act for knowingly providing a response or information that is false or misleading. This is a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. You have previously been provided with the Inquiry's terms of reference and information on giving evidence to the Inquiry. Before we begin, do you have any questions about today's hearing?

MS DURRINGTON: No, thank you.

PROF WEERAMANTHRI: For the transcript, could I ask you to state your name and the capacity in which you are here today?

MS DURRINGTON: Learne Durrington, and I'm the CEO of the WA Primary Health Alliance.

PROF WEERAMANTHRI: Would you like to make a brief opening statement?

MS DURRINGTON: Only very brief, but to say we, as an organisation and on behalf of our stakeholders, really support this Inquiry and acknowledge the range of issues, both direct and indirect, for both health and primary healthcare across the spectrum. So apart from that, no. I'm sure anything I've got to add will come out over the time.

PROF WEERAMANTHRI: Great. Can you tell us about the history of the WA Primary Health Association as an organisation, your mission and values and the other groups or organisations you regularly interact with in the health sector?

MS DURRINGTON: So – and excuse me up front, I've got some extensive notes here I'm very grateful my staff prepared for me. Firstly, the WA Primary Health Alliance is today about four and a half years old. So we are a relatively young organisation.

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And we evolved through a Commonwealth process to establish primary health networks, which really have a role of working across primary healthcare with some very clear objectives. And the WA model is that we operate the three primary health networks in WA. We're the only one of our type in Australia. And we did submit to the Commonwealth to have the model that we have on the basis of both the demographics and geography of WA, and acknowledging that a lot of people actually do travel to and from Perth for healthcare.

And similarly, the boundaries of a network really are irrelevant to the individual who's seeking help or assistance. So we operate the three, which means that we are aligned to the Health Service Providers in Perth North, Perth South and Country. There have been some boundary changes in our four-year lifespan, but we've adapted to that, really, with no effect. Our primary objective, from the Commonwealth's perspective, is to improve the health status of people whose health outcomes are poor. And as an adjunct to that, to reduce what are potentially preventable hospitalisations. All of this is in recognition, as Tarun would understand, on the changing prevalence of chronic diseases versus episodic illnesses, and recognition that both primary care and the acute system are responding to chronic diseases in ways that may not always mitigate people going to hospital, who could have care close to the community.

We have taken, based on our vision – and I'll come back to that in a moment – very much a strategic view that there are postcodes in WA where health status is poorer than others. And on the limited resources that we would have available compared to either the full Commonwealth expenditure, or indeed the State, they have to be very targeted and, given the primary objectives around improving health status, they've been focused on community. So at our inception, we did a piece of work in partnership with state health, identifying those locations and those postcodes and/or smaller than postcodes, locations where health was poorest. I say that.

And our functions, on one hand, are quite simple. We support primary care, general practice predominantly, in a range of ways to better equip general practice to respond to the health needs of their community. And then we commission services to augment responses where there are gaps. So predominantly, we have a focus on general practice as the cornerstone of primary healthcare, and then commission services, both treatment services and enabling services, to start to link people with general practice or indeed improve team-based care.

I think your question, Tarun, was our vision and mission. Our vision is that we seek to have equitable health outcomes for all people in WA. That is not to say that we ignore certain population groups. There are priority population groups, whether they're Aboriginal people, whether there are people who are marginalised or residing in marginalised communities. So we focus on equity.

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And our mission, effectively, is to improve access and the continuing of care for people in primary care. I'm not giving you the words exactly, but effectively, that is it. And so we do enabling activities, as well as funding and commissioning.

To ask who do we work with most closely. As an organisation – I digress, but come back – we only have 11 members. And those 11 members are peak organisations for primary healthcare in WA. So, for example, one of our members is the State Department of Health, and they're a member organisation. Similarly, the Mental Health Commission, College of GPs, WALGA – so we see local government as key in terms of both public health… – so WALGA and WACOSS, as the Council of Social Services. But predominantly, we work with… so we work with the Guild and the Pharmaceutical Society, so we have a, sort of, a grouping there which is about pharmacy.

Mental health is another key activity of ours, so the WA Mental Health Association, the Mental Health Commission, Alcohol and Other Drugs, again, the peak bodies. But I think at the end of the day, we would say that those that we work with most closely include State Health, in the Clinical Excellence Division, and then the Health Service Providers themselves, whether that's Perth South and Fiona Stanley Hospital, or indeed it's WACHS and it's something in Kununurra. So our footprint, you know, is across the state. We have staff established right across the state so that we can dovetail our work up partnership with others.

I think the most important thing to say is we believe the changes and developments and improvements that are required, no one organisation can do on their own. And if we didn't work with State Health, or the HSPs, or indeed the Pharmaceutical Society, we probably could not leverage the sort of developments that we're seeking. So we do take a very strong partnership approach, and it's founded on improving access and targeting higher need populations. Does that go towards your answer – sorry, your question, Tarun?

PROF WEERAMANTHRI: It does. And I note particularly that your membership includes, you know, non-health bodies, if you like, like WALGA and WACOSS.

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: And they're key to this Inquiry.

MS DURRINGTON: Good, good.

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PROF WEERAMANTHRI: So WALGA has already spoken with us and WACOSS is speaking with us next week. And both have provided, you know, extensive written submissions.

MS DURRINGTON: That's good.

PROF WEERAMANTHRI: So this subject is health and other - - -

MS DURRINGTON: It is. You couldn't – and I agree, you could not treat it as a health only. People reside in communities, they live and work and play, don't they? So those other entities are very important. And, of course, with WACOSS, there is a large not-for-profit sector that we also fund, and therefore, alignment with WACOSS concerns is important.

PROF WEERAMANTHRI: Ms Durrington, as you know, this Inquiry was set up by the Minister for Health, following a specific recommendation from the Sustainable Health Review. Can you tell us about your involvement with the Sustainable Health Review process, and now its implementation phase? And as a side question, do you actually have a definition of sustainability that you work with, and is environmental sustainability a component of that?

MS DURRINGTON: Yes, so I'll start absolutely where you started. I think we would express our, I think, gratitude for having an active involvement in the Sustainable Health Review. We welcomed the direction of the Sustainable Health Review in recognising that health is much broader than a hospital. And I don't say that in any disrespective way, but health – and wellbeing, importantly – is much broader. And so we welcome the opportunity to be involved. And so much so that one of our staff is seconded into the Sustainable Health Review team, which was a great vehicle to link primary health and other sub-components around primary health into the review.

So, Chris Kane, who's our honoured… her day job is our General Manager of Strategy and Policy. And she worked in the Department two or three days a week, for that full period of the review, and therefore was intimately involved. And so much so that, as a partner in the process, we hosted it, or contributed to quite deeply, for example, the primary care roundtable that was part and parcel of the SHR process. And similarly, the non-government communities, we were very much intimately involved. So we felt that, you know, beginning to knit together how the system, as a broader system, can behave, and how it can move forward was really a great opportunity, and therefore for us, we did commit a lot of time and resource to that.

I think you're right to tease out what do we mean by sustainability. And to be fair, up until very recently, we probably haven't defined that in a particular way.

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Because in the first instance, our approach to sustainability was thinking about particularly general practice, and how do we sustain good contemporary modern general practice in a changing environment with systemic issues sitting around them. And really, sustainability was key. So from our perspective, it was sustaining vibrant, viable general practice. So when you see 'sustaining' in our words, originally it was about, how do we ensure that all general practice doesn't become corporatized, and provide, you know, a different motive, or potentially different motives for how they provide care.

And secondly, sustaining meant for us team-based care, enabling general practice to work with, let's say, the dietitian, the exercise physiologist, whoever that might be, in a much more robust manner than they may today, because the health needs that GPs are often working with, with their patient group, require team-based care if they are to improve and get well. So from our perspective, we probably had a narrower version, rather than climate, as we started our journey. I think, increasingly, though, in accepting the chronic diseases, for example, which are predominant in general practice, are in and of themselves, directly and indirectly, to a whole range of climate-related issues, particularly where they're exacerbated.

So if you think of food security, for example, and obesity… you know, there are a whole range… I mean, I could go on, but I won't wax lyrical – but it has taken us some time in working with the community we do to start to say there are bigger issues here at play. All we're trying to do is adapt the system to respond better, but we need to also start to recognise the drivers. So we haven't formally adopted, but we accept the Commonwealth Department of Health's national vision, given that we're a totally Commonwealth funded entity. And we also recognise, in doing that, that the needs of communities differ. So what's a need for, you know, Geraldton might be quite different to Albany, to Mandurah. So we absolutely recognise there's not one size fits all issues here. But we also recognise the link. So we work, for example, quite closely with the Cancer Council and the 13 recognised… 13 cancers that have a relationship to obesity. And so therefore, what's our role around diet, exercise, healthy food, the community.

So environmental sustainability has not been as predominant as the, sort of, economic and health outcome sustainability for us. But we've had some, I think, interesting developments of late where we know that there are at-risk communities where we need to start to prepare general practices. I think the fires in New South Wales have really highlighted to us there is work to do to enable general practice, for example, to better respond in their communities. And similarly, you know, that terrible dust storm in Melbourne a few years back, and asthma. So there are emerging themes for us around what is the role of general practice, how can we better equip them to respond earlier when their community is at risk.

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So I think, to add to that, because of the nature of our role as being quite facilitating, we work now in a very positive manner with the key stakeholder groups, whether that's the College of GPs and the AMA and others, to start to fashion up joint strategies where there is common interest. And I think that's the other benefit for us now, we're seen as being able to facilitate conversations that may or may not have happened in the past, for a whole range of reasons. And that's because we have no vested interest, we're just trusted partner, we can sit in the middle, and, you know, take people with us.

PROF WEERAMANTHRI: Can I take you back to something you said earlier, which is around one of your goals being to reduce preventable hospitalisations, and essentially reducing demand on the state hospital system. And part of what you do there is provide good community care options for chronic diseases, for example. So one of the written submissions we received had a memorable quote in it, which said something like, "Only do in hospitals what only hospitals can do", which suggests that, you know, there's a whole lot of things you could care for in the community with different models of care, particularly chronic diseases. And if you did that, that would actually have a major environmental benefit - - -

MS DURRINGTON: That's correct.

PROF WEERAMANTHRI: - - - by providing that care in the community.

MS DURRINGTON: That's right.

PROF WEERAMANTHRI: So I'm not asking you to talk about in general about everything to do with chronic disease care, because, you know, that would be too big an ask. But I just want to ask a, kind of, basic question, which is, we've been talking about this for a long time.

MS DURRINGTON: Yes, I agree.

PROF WEERAMANTHRI: Is the health sector actually making any progress in shifting the care from hospitals to the community, and is there any data to show that progress?

MS DURRINGTON: I think there's a long and a short answer to that, Tarun. Clearly, it takes… and I think the SHR's been important in terms of the leadership required, because really, at the end of the day, it's leadership by an individual clinician or others as a system to help or ensure people get better care in their community, rather than down the road. And I'll come to answer your question. My sense is one of the learnings we're having is the… you know, people do call it health literacy. But I do think patient behaviour is part and parcel of this topic.

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And one of the strategies we have underway at the moment is the urgent care trial, which is around maximising existing and available appointments in general practice for people who might otherwise end up at an emergency department.

And so, you know, from a sustainability perspective, we are actually trying to maximise what's already available and not introduce something new. The challenge in that is the changing patient behaviour, as much as, indeed, for general practice to go, "Okay, we could do this". So I say to you, I think it is multi-layered and quite complex. We have a range of programs that we would be able to describe having an impact in terms of reducing people's reliance on the hospital, you know, just rocking up – I don't know what – just rocking up to the hospital. And particularly those that have… and I think this is where team-based care comes in, where people are supported better to get care in their community.

We would argue there's a topic called treatment support, and it doesn't matter whether you can get a service through E-Health, whether you can get it over the phone. Unless people are supported to make those changes, they do feel like, often, they can't engage. So I think, I would say, any progress we make is good, and we do have some data around that, so I'll come back to that in a moment. But it feels like – I say this – there's always still plenty of others making the step to go to the hospital.

It looks, though, from our perspective that the curve is slowing. Now, that is actually a great outcome – it's just not going up, in those health conditions that are better suited in the community. But conversely, there are still a lot of people calling a 000 number who could actually go to the GP, and we know that there are available appointments. I mean, from our perspective, I think the other thing to note in this – different population groups in the community respond differently. So older people have a different response to getting their healthcare needs met versus younger. And we put in strategies, for example, to connect younger people with mental health and alcohol and other drug concerns to services and treatment, but very few actually want to take it up.

So, you know, there's different responses for different diseases, but also different ages. And we know that the aging population is having a demand on the health system. I think for us, the biggest changes, Tarun, to answer your question, are there things making a difference? Yes. For example, I do use this one, but there's many of them, through our work that we do in our health pathways, where you bring clinicians together with general practice, and we reduce those waitlists 55-fold, you know, down from three years to three months. And GPs feel they can call a specialist and the pathway's there, they know how to treat, they've had some CPD, they will actually make a decision to keep a person close by.

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And even when the person might say, "Well, I should probably go", "No, no, we can keep you here". So I think there are a range of means that support both the GP and the hospital clinician to help drive people to the right care in the community. I think for us, where we want to, probably, do more work is really skilling people up to help use the available E-Health options, where they are available. I'm not talking about Dr Google, I'm talking about E-Health, where you can get a consult over the phone. Or indeed, you know, self-directed patient management, patient activation. So there's a whole range of really good tools for people to help start to manage themselves without actually even having to use the system.

PROF WEERAMANTHRI: You've mentioned mental health a couple of times. Do you want to talk about WAPHA's, you know, focus or activity in that area?

MS DURRINGTON: Look, one of the… and it's interesting to say, Tarun, even in our short life, this is probably one of the areas where we're learning most, where the evidence is really interesting. So, for example, they are parts of WA where there were no services, other than acute services, for people. And so we implemented a system, that is a digital mental service, across the whole of WA, GP-referred. They've seen several thousand people now, in the time, but we task that – or we commission that service – to reach into more vulnerable and marginalised communities. The thing we're learning through that is… so therefore people can have a service in their home. Or if, indeed, they're a FIFO or they're, you know, a person travelling, they can access the service from wherever they are. They don't have to be anywhere particular, as long as they've got a phone, or indeed if they've got an iPad, or indeed if they've got a letterbox.

And it's a clinically sound clinical service operated by clinical psychologists. Interestingly enough, I think the things we're finding are several-fold in that. So people do access it. The health outcomes, in terms of the clinical outcomes, are very good in terms of sustaining the treatment. But people are more unwell than was assumed, and far more comorbid. Generally unsafe alcohol and drug use are concurrent, that's never been the presenting issue. So that's one service which, from an environmental sustainability perspective, means that people can access it where they live without having to go anywhere and, you know, use it.

So mental health, for us, has been key. I think we're learning around, as I mentioned a moment ago, we had a bright idea that we could do a warm handover at emergency departments and link people into community-based treatments. And we've found that, in fact, their readiness may not be there. Now, I would have thought, you've been to hospital, you're probably close to ready. In fact, only about 40 per cent are, because we're trying to reduce the churn of going back to and from hospital. So I think there's still a long way to go.

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And I think the other issue for us is that having available clinical services is not enough. We have to work with people to enable them to be ready to take up the service and then use it. When they do, there's great outcomes. But for many, the treatment burden, i.e. their mental health concern, is one amongst many things, then their individual capacity to take up the service is limited. So it's quite interesting, and there's not an evidence base, we can't find about how to do this better.

PROF WEERAMANTHRI: The WA Primary Health Alliance has a strong focus, I believe, on general practice support, data sharing, developing population profiles, and the like.

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: With respect, let's say, for heatwave interventions, do you have any specific data on vulnerable groups that could allow for better targeting of intervention strategies. For example, the elderly or people in aged care?

MS DURRINGTON: Yes. That's probably a short answer. Sorry, I don't mean it like that. The data is a growing and improving piece of our work. We now… about 450 general practices in WA share their data with us, which we tidy up for them and give it back to them. But you can imagine, of that, that covers all of WA. The practices that aren't sharing their data are either corporates or sole providers that aren't accredited. So I just thought I'd say that. The general General Practice share their data, and so we will have a repository which we can then start to match against what our other population health data is. So what AIHW would say at a higher level, what our prevalence data would say.

So in terms of older people, yes, I think we are much closer to the suburbs where people are. And as we move forward, we're able to also, with the over-75 enrolment of patients into general practice, really be able to nail where the most vulnerable older people are. And then, of course, there are other groups with respiratory illness, which we will start to be able to say, here's where there are higher pockets than other pockets, because again, what we find is, you know, there are hot spots – you know, you can map that. So data is important. And we feed the data back to general practice because really, up until now, there'd be data in their own practice they may not have known. And conversely, they wouldn't have seen that data inside – what is the health of your community, and what is going on. And so starting to join that up is an enabler for general practice.

Sorry, just going to add to that. The other thing that… and there is no secondary use, as you know, but I think My Health Record, going forward, will also be another input to understanding where health risks are for people, and

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how to better access them. But we have the capability, today, to contact every general practice in wherever and say, there's a dust storm. I don't mean it like that, but you know, there's a dust storm, and these are the things you might need to be thinking about. So to be fair, it's taken us… you know, you can imagine the work involved, you know. But it's taken us some time, but we can now effectively… and we have a IT portal for all general practices to use, which also can push out alerts to practices. But I think, for us, the next piece of work is starting to develop up what you'd call some of those crisis response plans are, in partnership with general practice. So they start to acquit themselves from what might need to happen.

PROF WEERAMANTHRI: And we have heard from other experts that some of those systems are perhaps a bit better developed in other states. So there may be something we can learn in Western Australia.

MS DURRINGTON: Yes, that's true. We, for example, learnt from one of our colleague primary health networks – so it was the Blue Mountains, Nepean Blue Mountains – and they had bad fires a few years ago. They did the work with general practice, developed the response plans. And, of course, then in the last series of fires, all those plans were enacted, which made a huge difference.

PROF WEERAMANTHRI: WAPHA also stresses the importance of quality improvement - - -

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: - - - to evaluate outcomes and drive new approaches to patient care. Are you aware of any exemplar practices using such an approach to improve environmental sustainability or reduce waste?

MS DURRINGTON: Apparently there's a couple in WA. And, I think, to be fair to general practices, while they're now moving into quite formalised processes of quality improvement inside their practices, the environmental topic has, you know, not always been top of mind, albeit we know that there is grey advocacy on behalf of the groups of GPs. So I think there are some exemplars. We would say that there are exemplar practices who are very – what's the word – who are very committed high performing practices, who we could see adopting an environmental mindset. So we have about 100 practices in our comprehensive primary care who have very strong leadership and are much more thoughtful. I don't mean that disrespectfully, but about how do we better respond, and take that sort of leadership approach. So I would say, while I can't name those practices, but I do know where there's a couple, I think we've got a platform that can be leveraged and an engagement piece, which I think is probably different to not that long ago, to engage practices.

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PROF WEERAMANTHRI: And we have heard a little bit about those practices. I would say the probably the biggest benefit from a whole system's point of view is if you could shift care from, you know, the intensive hospital setting into the community and into primary care. That's the big game in terms of reducing environmental impact. Having said that, the primary care system might only be, you know, four or five per cent of the whole health footprint.

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: But everyone has to do their bit.

MS DURRINGTON: Yes, that's correct.

PROF WEERAMANTHRI: And though not all primary practices could probably reach the level of commitment that certain exemplars can, if the sector, as a whole, was to do something more - - -

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: - - - in this area - - -

MS DURRINGTON: Yes.

PROF WEERAMANTHRI: - - - it would set a good example and allow for the leadership role of the sector and the people within it to be evident, because people are also looking to primary care and doctors and others to talk about this as a health issue, and the issue of trust comes in. And if the sector itself isn't doing things right across, then people will say, "Well, you're saying that, but you're not doing it". So I think there's probably a bit more the sector could do.

MS DURRINGTON: There is. And having read some of the literature and had some of the experiences elsewhere, we applied the principle of, if we can have 10 per cent of practices stand up and do this, we'll get a snowball effect. And so we've taken that view. We took that view with our comprehensive primary care practices. We only aimed for 10 per cent of all practices. We're probably up to 25 per cent… you know, we're up to 100 now. And we'd have more if we could cope. So my sense is also, it's about having the target and the readiness.

Just going to your point around health, we think, apart from trying to reduce people going to the emergency departments, the big gain's to be made in outpatients. A few changes to be made in outpatients in terms of the hospital system and enabling GPs to keep people well and close to home. So that's another piece of work that we're undertaking with the Department.

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But I agree with you. I'd say let's go for 10 per cent of GPs, which would only be 65 practices, and then you'll see the ground swell. So if we go to places now, people talk to us about comprehensive primary care. So you're right.

PROF WEERAMANTHRI: Is there anything further you'd like to say about either the aged care, where you can contribute, or the disability sector? We've had someone from People with Disabilities talk to us today, and she gave us a whole range of examples about how climate change might be impacting on people with disability. How much interaction do you have?

MS DURRINGTON: Very little with people with disability. Aging, of course – and given its recent attention, is a high-profile topic. We do a number of things in aged care which we believe are important. But again, it's about system-wide. And from our perspective, trying to improve better care for people inside a residential aged facility, if they're already there, improve that care, is key. But secondly, the other thing we are working on is for people who are older but receiving home-based care, isolation is another key factor that seems to see greater deterioration in people's health and well-being. So we're also working on aged care providers to look at the mental health benefits of keeping people well at home, getting their home-based aged care, but not being so socially isolated that they deteriorate.

One of the other interesting things we're doing, which I think is just a beginning leverage footprint, is we provide mental health services in residential aged care. That's new and different, but again, there's lots of work we're doing there that's about, again, better in situ care that's appropriate for the needs of that group. So we're a little bit silent on physical disability and intellectual disability, but of course, we're actively involved in psychiatric disability. So we do a lot in that environment.

PROF WEERAMANTHRI: So we're just into the last few minutes. I've just got one final question, also. Please feel free to offer any other final comments. Do you see a role for WAPHA in partnering with the Health Department, health services and Government following completion of this Inquiry and consideration of its recommendations, and what would you like the Inquiry to recommend around future governance and leadership?

MS DURRINGTON: Well, I think, briefly, we would absolutely welcome the opportunity to be involved, given the fundamental link with our core business and the work that we do with primary care and primary care providers, more generally. So our experience has been, where there's some shared governance, it's just an enabler, to help fashion up a much stronger network and points of accountability. I do think, though, having some early targets that are achievable is really the way to go. This is a big change program.

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And if we think of general practice and indeed, many of the organisations we work with, while they might appreciate the issue, their capacity or engagement in it's been low, just for, "Well, what do I do and what can sit inside my workflow, and it's not going to be too hard?"

And I think, therefore, having the shared governance enables you to knit together the strategies that will engage that broader community. So yes is the short answer, Tarun. We would welcome involvement. We can see the inextricable links to a whole range of strategies we already have underway. So, for example, we have a state-wide heart failure and a state-wide obesity strategy. You know, you can sort of see how they can knit. And I think part of the solution in these sort of processes is leveraging what else is going on, not having something new come in, people think it's just another thing. And I think, from our perspective, our learning is now leverage. And it's a little bit like GPs, for example, now receive a payment to do quality improvement cycles. Good, let's build up the menu of what's possible to use, create that for them so they can apply that in their practice. So in a sense, it's just leveraging what's available rather than seeing it as something different.

PROF WEERAMANTHRI: Ms Durrington, thank you very much for your attendance at today's hearing. A transcript of this hearing will be sent to you so that you can correct minor factual errors before it is placed on the public record. If you could please return the transcript within 10 working days of the date of the covering letter or email, otherwise it will be deemed to be correct. While you cannot amend your evidence, if you would like to explain particular points in more detail or present further information, you can provide this as a submission to the Inquiry when you return the transcript. Once again, thank you very much for your evidence.

MS DURRINGTON: Thank you. And I'm bound to read it and think, "I didn't say that bit".

HEARING CONCLUDED