

# TRANSCRIPT

## PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

### Inquiry into the Victorian Government's Response to the COVID-19 Pandemic

Melbourne—Tuesday, 11 August 2020

*(via videoconference)*

#### MEMBERS

Ms Lizzie Blandthorn—Chair

Mr Richard Riordan—Deputy Chair

Mr Sam Hibbins

Mr David Limbrick

Mr Gary Maas

Mr Danny O'Brien

Ms Pauline Richards

Mr Tim Richardson

Ms Ingrid Stitt

Ms Bridget Vallence



**WITNESS**

Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association.

**The CHAIR:** Good afternoon and welcome to the Australian Healthcare and Hospitals Association. Welcome to the second series of public hearings for the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's Response to the COVID-19 Pandemic.

The committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. Members are attending these hearings remotely from home or from their electorate offices, so we ask you to note that members are not required to wear a face covering if they are working by themselves in an office under the stay-at-home directions of 6 August, part 2, section 7(i).

We advise that all evidence taken by this committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you repeat the same things outside this forum, including on social media, those comments may not be protected by this privilege. As a witness you will be provided with a proof version of the transcript for you to check. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

We invite you to make a 5-minute opening statement. We ask that you state your name, position and the organisation you represent, for broadcasting purposes, and this will be followed by questions from our committee. Thank you for joining us.

**Ms VERHOEVEN:** Thank you. I am Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association. Thank you for the opportunity to provide evidence to you today. I would like to acknowledge the enormous efforts being made at every level of our health system, from healthcare staff to our public health and our political leaders. They are confronting one of the greatest health challenges of our era and having to respond to new information and research in a constantly changing environment.

The low COVID case numbers during the initial months of the pandemic enabled capacity to be built up in the system—for example, the supply of personal protective equipment and ventilators and coordinated data about intensive care bed capacity. There have been innovative models of care being rolled out at every level of the system, not just via telehealth but also using virtual care models, such as remote monitoring. Importantly the lockdown measures which have been instituted in Victoria in recent months are absolutely critical to containing COVID-19.

But there are certainly areas which have not worked too well and which require urgent attention in our opinion. Infection control is particularly important, given we are sending workers into high-risk environments for an infectious disease where we are yet to understand the long-term health implications. An example of this is information that has been recounted to us by nursing staff in a private hospital that has just been converted to a COVID unit, where they have reported that they have received minimal infection control training, an online module which covers basic donning, doffing and swabbing procedures and which is the same for experienced theatre nurse staff as it is for ward nurses and inexperienced new graduates which are being deployed on that ward. There was no isolation or staff testing when staff moved from the COVID unit to work in other units—posing a risk—and an offer of access to isolation hotels was withdrawn if staff did not have family members with significant chronic disease.

We are aware also that there are a small number of nursing students who have contracted COVID-19 while on clinical placements, possibly because of the lack of infection control training that they have had, and hospital staff who have been deployed to aged-care facilities in Victoria to manage COVID outbreaks have reported to us very significant concerns about infection control practices and staff training in those facilities. In aged-care facilities we are aware of delays in testing of staff and patients. We have had reports of delays of up to four days between a staff member being diagnosed with a positive COVID-19 test to other staff and patients being tested and then a further 48-hour wait for results. During that time there was very limited change in the way residents were cared for other than to confine them to their rooms.

Workforce, as you would be aware, has been a particular issue in aged care. One thing we do want to acknowledge is the importance of paid pandemic leave and restrictions on staff movement across facilities, which has assisted in containing some of the transmission issues. We remain concerned, though, that staff shortages will result in potentially preventable hospitalisations out of aged care, which is not optimal either for the residents from aged care or for hospitals stretched to capacity.

With regard to personal protective equipment, our members have told us that there is an oversupply in some hospitals, an undersupply in other hospitals, and in some parts of primary care, allied health and aged care, supply has been extremely limited. There is growing evidence that airborne transmission is problematic, yet we know many healthcare workers, who are working with people who have tested positive or where there is a high risk of exposure, do not have access to P2/N95 masks or have not received appropriate training in their use or have not been fit tested.

We have heard from our members that it has been very difficult for them to implement some DHHS directives, and particularly that has occurred when advice has not been clear, timely and consistent. We are aware also that sometimes advice has been changed at very short notice—for example, requiring organisations to work around the clock to adjust their responses, including rostering staff at very short notice. There has been limited engagement with some community groups who may have supported DHHS in its communication efforts, and we are also aware that in some instances offers of assistance from community groups with high-risk populations have actually been turned down by the department.

Just to finish off, I would like to highlight a couple of issues in primary care, and particularly the lack of information about infection location beyond LGA data and the lack of discharge information that has been provided to GPs. Up until recently the assessment clinics, which have largely been run by the hospital services and have done most of the testing, were not collecting usual GP information, and nor were pathology results being sent to the usual GP. That is now being addressed through the implementation of a COVID-positive case management pathway co-designed between the department and primary health networks. Also the development of regional public health units might help that, but it was slow to get off the ground.

**The CHAIR:** Sorry to interrupt you there. The time for your presentation has expired. Perhaps some of the questions will explore these issues further. I will hand to Ms Richards, MP. Thank you.

**Ms RICHARDS:** Thank you, Ms Verhoeven. I would like to thank you for appearing this afternoon and also ask you to pass on to your members our great appreciation. It has been an extraordinary time for so many people, but I am very conscious that particularly your members must be really feeling the strain.

**Ms VERHOEVEN:** Thank you.

**Ms RICHARDS:** I am going to start with a broader question—perhaps a global question—and even give you the opportunity to unpack some of what you touched on in your initial presentation. Of course we have a world-class system in this state, something that I know I am incredibly proud of and that I know is something that is really important, but I am interested in, if you could perhaps explain and enter into evidence, how having a strong and universal public health system is so crucial to a response to this pandemic.

**Ms VERHOEVEN:** What we have seen internationally is in countries where there have been really significant problems and very high death rates—for example, in the United States—that has particularly occurred in areas where there has been very inequitable access to health care. One of the, I guess, advantages for Australia is that not only do we have a strong public hospital system but we also have primary care that is funded through Medicare and that provides opportunities for people to access care at a relatively affordable price. Clearly that is not always the case, and there are always some groups within communities that find it difficult to access care for various reasons, not least of which might be communication challenges, but compared with countries like the United States we have done very well because of the strength of the universal healthcare system.

**Ms RICHARDS:** Thank you for actually entering that into evidence. I think it is going to be really important for us to have that additional insight. Of course the Victorian government has made significant investments into hospital preparedness since the beginning of the pandemic; I think it is something in the order of \$1.9 billion in ensuring that our hospitals are prepared. From your perspective, and perhaps again unpacking some of that initial evidence that you gave, how prepared are Victoria's public hospitals to respond and,

importantly, how has our level of preparedness changed throughout the course of the pandemic? I am interested specifically, I suppose, in having some reflections on that surge capacity—you know, bed numbers, ICU—and that type of insight that perhaps you in particular are able to provide.

**Ms VERHOEVEN:** Thank you. I think it is important to recognise that the COVID-19 pandemic started to impact us in February, and that was at the tail end of the bushfire season and the really significant impacts that that had not only on workforce and on the capacity of hospitals and primary care but also on the supply of personal protective equipment in particular. In particular, regions like Gippsland had been impacted by that, and that needs to be taken into account as we understand the state of readiness for the health system to respond to the pandemic.

I think right at the start of the pandemic, because the numbers were fairly low, there was an opportunity right across Australia to work collectively to address some of the shortfall in personal protective equipment, to build up the supply of ventilators, to support commercial providers to start to pivot some of their production towards increasing mask production, for example, but also to do some structural work, which is long overdue in our health system. And, importantly, I would like to recognise the development of the intensive care bed data, the national database on that, which has been developed in partnership between the commonwealth and the states and territories and now allows us to understand what intensive care bed capacity is like, not only within a state but across the country. And then the other initiatives, again carried out in partnership between the commonwealth and the states and territories, around private hospitals and their ability to work together with public hospitals in this period and some of the reductions in elective surgery have been really important in ensuring preparedness. So I think we have actually done quite a good job in that space.

Potentially we could have done better around some of the preparedness for infection control, and I highlighted some of the issues with infection control training, which is available but maybe does not cater for the depth of knowledge needed by some staff. Potentially there may also have been some issues around contact tracing and testing where we could have invested in better preparation. But hindsight is a wonderful thing, and when you are dealing with something which is completely unknown in the way it is going to play out, it is very difficult to anticipate every possible outcome and to cater for that. I want to acknowledge, I think both at commonwealth and at state level, there has actually been pretty significant effort gone into preparing us for circumstances for which it has been very hard to predict how they would evolve.

**Ms RICHARDS:** Thank you again. Just segueing from some of those comments, I am interested in understanding and perhaps you providing some evidence of where we have had innovation in the system—and it is great to hear that you are seeing perhaps the effect across sectors and across the not-for-profit sector as well. I am interested in understanding how our public hospital system has adapted and innovated in this particular context where things are moving so fast.

**Ms VERHOEVEN:** Yes. Some of this has focused in on substitution activity, so substitution for face-to-face care through telehealth models of delivery—so outpatient services, for example, from some of the public hospitals being delivered by telehealth if that has been appropriate. Certainly in primary health care you would be aware that there has been a very large number of general practices that have availed themselves of MBS telehealth items and used that.

Increasingly there has been a focus on remote monitoring and the capacity to actually use telehealth in a more transformative way, so not just substituting what might have been face-to-face care but actually keeping people out of hospitals and doing things like remotely monitoring temperature, blood pressure and the like. That is something which we probably will as a country, I think, want to pursue with more vigour as time goes on. We certainly have seen many organisations coming forward with potentially innovative solutions which can be deployed very rapidly. So I think there are lots of opportunities to do that. I would also highlight the innovative way that industry has responded to things like shortage of mask supply, for example, and done really interesting things with both their workforce and their machinery to start to meet some of those supply shortages.

**Ms RICHARDS:** I am glad you mentioned workforce because actually that is where I would like to take you next. As part of the Victorian government's hospital preparedness response, or just the preparedness response, to the pandemic, I know that there has been some really significant investment in training and upskilling our existing and new clinical workforces. We are fond of calling them our last line of defence, and that seems to be a really important message—that we are so grateful to have them—but they are the last line.

How important do you think this additional training has been for our dedicated healthcare workers working on the front line of the public hospital system?

**Ms VERHOEVEN:** That has been really critical, and I guess particularly as we have seen some of the issues relating to infection control. It is where we cannot afford to drop the ball. There is really emerging evidence, both internationally and nationally, about some of the challenges related to COVID-19 like airborne transmission, for example. What we know about that now in August is quite different to what we knew about it in February and March. So to respond to that you have to ensure staff have access to training, staff have access to equipment, staff have access to support to be able to maintain the best practice standards in the care that they can offer.

And I think something else which we probably need to recognise is that this has been a very difficult year for staff at all levels in our health system. Coming off the back of the bushfires we have had staff in really high-risk circumstances, and some of the mental health stresses, the physical stress of working in this way—and you will have seen photos of staff with injured faces and hands that are covered in dermatitis—people are really struggling to manage both the physical and mental challenges of working in a best practice environment. We have to be really conscious that staff are going to need not only training support but also support to maintain their capacity in the system.

**Ms RICHARDS:** I am grateful you took us to mental health because that is actually one of the places that I also wanted to explore a little bit more, and the effect of having that training capacity—we have got the Victorian Doctors Health Program—and how important it is that we do support our workforce. You have identified that they have come off the back of the bushfire season and straight, with almost no break, into a response to a global pandemic. I am interested in hearing a little bit more about the importance of supporting our healthcare workers and their capacity to be able to respond in light of those additional drains on mental health, in addition to what you have provided there in terms of the insights into their physical health as well.

**Ms VERHOEVEN:** It is really critical to ensure that staff are well supported, and I think both the Victorian government and the commonwealth government have invested quite substantially in mental health supports for the broader community as well as for the health workforce. That has been really important. We cannot let our effort drop in that space, so this is going to be important long after COVID-19 has been managed. There will be ongoing impacts. But there are some other really practical things I think that have been done which have been important too. The isolation hotels, the Hotels for Heroes program and the like have been important. Paid pandemic leave and some of the restrictions around movement of staff between facilities has been really critical. You cannot downplay the stress that a person has if they do not have paid leave and they know they are feeling unwell but they feel that they have to work because they rely on that income. That affects not only them but also potentially their families as well. So these are really practical supports, and we have to consider how we manage these going forward.

The other issue I would raise is that for many staff they have been working at a very intense level now for nearly six months. Many of them have not had access to paid leave in the way that they might have done in normal circumstances, or indeed the opportunity, particularly now that Victoria is in lockdown, to actually go away and get away from work and enjoy that time off, and that is relevant both in the health system and elsewhere in the economy as well. So we have to be conscious, I think, that workplace stress is going to be an issue which we are going to have to manage, just as the stress of unemployment will be an issue.

**Ms RICHARDS:** Thanks again for having that global insight as well. It is really important to hear your evidence. The federal government has made a number of changes to telehealth. You touched on that before and other people have given evidence as well at this hearing about the importance of that, and it is something that has been very much welcomed by the Victorian government. Can you please explain why greater access to telehealth through this new and expanded MBS item is so important for people needing to access a GP during the pandemic?

**Ms VERHOEVEN:** It is really important that people continue to manage their health and wellbeing—not only their mental health, but to have their routine checks for things like cancer screenings, for example, and also people who have got chronic disease who may need to see a doctor regularly. They should be pursuing those opportunities notwithstanding the pandemic. I think the one challenge with the changed items, the telehealth items, is the requirement to have seen a GP in a particular practice at least once in the previous 12 months.

While I can understand the interests of GPs and patients in terms of managing continuity of care, that is a limiting factor for people who do not have a regular GP or who do not regularly need to go to a GP. It is an issue particularly for people who might need sexual health and reproductive health services—so we know that they are particularly impacted by that—and it can be an issue in regional and rural areas. So while it was a well-meaning reform that was instituted in July by the commonwealth government to the MBS telehealth program, it has placed some important limitations, and particularly for vulnerable people I think that is an issue. And the other thing is—

**The CHAIR:** I am sorry to cut you off there, but the member's time for their questions has expired, and I will give the call to Ms Bridget Vallence, MP.

**Ms VALLENCE:** Thank you very much, Chair. Thanks, Ms Verhoeven—I hope I am pronouncing it correctly—for your time and appearing at this inquiry. I just wanted to go back to some of the comments that you made during your presentation. You touched on it quite a bit: it is about infection control practices. You referred to healthcare personnel previously being untrained in infection control practices and needing rapid training. What training was provided and on average what was the time, would you say, for someone who was untrained to then commence working in an outbreak setting?

**Ms VERHOEVEN:** So generally they are not untrained, but their training may be limited, depending on the roles that they have previously occupied. So you would expect, for example, that a theatre nurse would have more knowledge about infection control than a ward nurse or a graduate nurse. So typically there have been a couple of ways of managing the training. One is the commonwealth government very early in the piece contracted to have developed an infection control module, which was made available free of charge to healthcare workers across the country. That is a short module that teaches basically donning, doffing, swabbing procedures and the like. Some hospitals have complemented that with training onsite. It varies from hospital to hospital, so there has not been a particularly standard approach. Obviously in aged care there has been significant variability. We understand from what our members have reported to us that there are some staff who may not even have accessed the infection control online training modules yet being put into positions where they are having to manage infection. So it really does vary from one organisation to another.

**Ms VALLENCE:** Okay. You mentioned there was a commonwealth quick program. Was there anything from the state government in terms of infection control practices protocols?

**Ms VERHOEVEN:** There may have been. I do not have knowledge of it though. There may well have been though.

**Ms VALLENCE:** So with your members, I think you mentioned in your presentation that there was the offer to access hotels for some of the health personnel, and then it was withdrawn for some members. Can you provide the committee an estimate of how many members that was withdrawn for?

**Ms VERHOEVEN:** I do not have an estimate of the number of organisations where it was withdrawn, but I can tell you that where it was reported to us from was private hospital settings where they had been asked to set up COVID units. Staff had initially been offered access to that program and then it was withdrawn. I do not know whether it was withdrawn by the hospital management or by the state government. I do not know who withdrew the offer.

**Ms VALLENCE:** Thank you. You mentioned as well some delays that were concerning to you in aged care. I think you mentioned up to four days to be tested before getting a result, and then a couple of days for the results. Do you know if they were working in the aged-care setting whilst waiting for that up-to-four-days to be tested?

**Ms VERHOEVEN:** I know that the staff members who had tested positive initially were isolated and communications were provided to residents and their families accordingly. But there was not testing happening in that aged-care facility for up to four days, and then it was a further two days before test results were available. During that time, the residents in that aged-care facility were confined to their rooms. There were ongoing care services provided to them, as you would expect. But according to those who have reported this to us, there was not a visible change in the way the services were operated in that time of confining them to their rooms.

**Ms VALLENCE:** So on that, is it fair to say that for potentially up to four days there might be a healthcare worker who was infected but working in the facility for those four days?

**Ms VERHOEVEN:** Yes, that could well have been, and there could have been residents as well.

**Ms VALLENCE:** Residents, yep. Okay, I just wanted to touch on the PPE. I note some of your members are also involved in the supply of goods and services to the public health sector, so they would obviously have a lot of expertise in this area. You mentioned an uneven supply of PPE. I am just wondering whether your organisation raised that at all with the government, and if so, what sort of response did you receive?

**Ms VERHOEVEN:** We have not raised that specific issue around specific organisations, but we have certainly raised issues very publicly around supply issues across different types of organisations and amongst different types of workers and also for different types of equipment. It has been uneven. Some of that is to be expected. It is difficult to manage a system and have absolutely even supplies available, but it is something that we need to do better with.

**Ms VALLENCE:** Okay. Do you have any recommendations for the committee that you can provide in terms of addressing the unevenness of supply?

**Ms VERHOEVEN:** The very first recommendation is I think it is really important to acknowledge the emerging evidence around P2 and N95 masks and airborne transmission. We need to see very urgent action from governments but also from health services and health managers to ensure that staff that should be being provided with access to P2 and N95 masks get that access and also that they get appropriate training to use it and that fit testing takes place as well.

**Ms VALLENCE:** Okay. I just would like your views and any insights perhaps regarding surge capacity of health personnel. What are you hearing from your members around surge capacity and any prospective challenges, and have you raised these issues at all with the state government?

**Ms VERHOEVEN:** We understand that generally surge capacity is manageable within the Victorian health system. You know, there are sufficient ICU beds available and there are sufficient ventilators available to manage expected cases. The particular area which is going to be challenging will be the ability to roster staff. Particularly if this current outbreak continues with significant numbers for a longer period, there will be difficulties to maintain the staff who need to have time off for leave and so forth. This is going to be a challenge going forward. At the moment, we understand that it is manageable, but it is not something that we can afford to drop the ball with.

**Ms VALLENCE:** No. So your understanding is that there are sufficient ICU beds. We heard earlier today in an earlier session of the hearings that we have around 400 ICU beds available. We have got well over 600 people in hospital at the moment. Is that a concern for you?

**Ms VERHOEVEN:** Look, I think the modelling suggests that that is manageable, but that is not my area of expertise, so I cannot comment other than what I understand to be—

**Ms VALLENCE:** That is okay. Just in the time that we have left—you just mentioned as well that it has been a very challenging year for healthcare personnel, and we would like to shout out to say thanks to everyone involved in health care. We in the coalition, we certainly would like to convey that. From the bushfires through to the pandemic—people are infected obviously with COVID, but there are lots of other health issues across our communities. What are your members telling you about other people needing care, other than for COVID, and what are the challenges there?

**Ms VERHOEVEN:** I think there are particular challenges for those with chronic disease and also challenges around potentially people who are not undertaking cancer screening, for example, because of their fears around attending doctors. That is going to be a challenge not only in Victoria and Australia, but it is a challenge internationally. We can see the data in other countries, and we are seeing, for example, cancer screenings going down—and potentially what that impact might be overall. I think one of the areas—

**The CHAIR:** Sorry to interrupt you again and to cut you off there, but the member's time has expired. I will pass the call to Mr Sam Hibbins, MP.

**Mr HIBBINS:** Right, thank you, Chair. Thank you for appearing at today's hearing. If I could just clarify, I understood that you were recommending that N95 masks be supplied or be available for all frontline workers. Is that correct?

**Ms VERHOEVEN:** No, not for all frontline workers—for frontline workers where airborne transmission is an issue.

**Mr HIBBINS:** And you mentioned fit testing, which is obviously important because the N95 mask is not fully effective unless it is properly fit tested. From your understanding, how widespread is fit testing of the N95 masks being supplied now?

**Ms VERHOEVEN:** I do not have information on how widely that is being undertaken, but I am highlighting that it needs to be undertaken. We need to have those masks available where they are needed, but it also needs to be complemented by training and testing.

**Mr HIBBINS:** Yes, okay. You mentioned students on placements earlier, in your opening statement. Was that around a concern that they are having to be used to plug the holes or to fill the gaps in our current health system? I know there are concerns around their understanding and their knowledge of PPE.

**Ms VERHOEVEN:** I think there have been some challenges with student nurses and student doctors, both in terms of their access to clinical placements and then how they are being used in the services, but equally to graduate nurses as well. You know, when you are new to a professional role and you do not have the level of training or expertise that others have but there is an expectation that you do have it, that is when we are likely to see potential problems.

**Mr HIBBINS:** So in terms of a solution to that, is it an issue of training?

**Ms VERHOEVEN:** Yes, and I think certainly being aware if we are going to use student and graduate workforces at the front line of the pandemic, we have to ensure that they receive the level of training appropriate to the skills that they have.

**Mr HIBBINS:** What is your understanding of the extent that they are being used on the front line in response to the pandemic?

**Ms VERHOEVEN:** I do not have details on that, sorry.

**Mr HIBBINS:** You mentioned earlier in your opening statement about offers of assistance from organisations being turned down. Could you elaborate on that?

**Ms VERHOEVEN:** We have been advised that there have been community groups, particularly where there have been groups with high-risk populations, that have made some offers of assistance to DHHS around communications and communication strategies to those groups and that there was not a particular interest in taking up those offers. And I highlight that because one of the weaknesses we have seen is the capacity to communicate directly with groups for whom English may not be a first language, whose health literacy may be low and who may not have access to IT services and particularly groups where there may be a highly casualised workforce. So that has been a challenge, I think.

**Mr HIBBINS:** So are you referring specifically to groups from multicultural backgrounds?

**Ms VERHOEVEN:** But also groups with diversity issues where there is potentially a requirement for different forms of communication to that which is traditionally provided, so homeless people, LGBTIQ people and so forth.

**Mr HIBBINS:** Would you like to be seeing more of those offers taken up by DHHS?

**Ms VERHOEVEN:** Look, I think it is really important that community groups are engaged, particularly with hard-to-reach populations. We need to think really carefully about the way we communicate generally to the population but also to those hard-to-reach populations in particular, being aware that not having access to IT services, poorer health literacy and low levels of literacy—perhaps even in their own language—can be impediments to good communication.

**Mr HIBBINS:** Just finally, you mentioned some reports of, I think, healthcare workers. They were offered that they would be able to quarantine themselves in a hotel or stay in a hotel, but that offer was rescinded. Could you elaborate more on that circumstance?

**Ms VERHOEVEN:** That is some information that was provided to us from staff members working in a private hospital where a COVID unit was set up. Where they were not able to demonstrate that they had family members with a significant level of chronic disease, the offer of being able to access isolation hotels was withdrawn. I do not know whether that was withdrawn by the state government or by the hospital management or by a particular supervisor, but that is information that has been provided to us by some staff.

**Mr HIBBINS:** Would you like to see that offer of being able to isolate be made standard for healthcare workers who are working specifically with COVID patients?

**Ms VERHOEVEN:** Absolutely. I think if you are making these offers, they need to be made standard to all who are potentially in scope.

**Mr HIBBINS:** All right; terrific. Thank you, I have no further questions.

**The CHAIR:** Thank you very much. That concludes the time for questions. If this discussion has raised any issues for anyone, the Lifeline number is 13 11 14 and Beyond Blue is 1300 224 636. Ms Verhoeven, we thank you very much for appearing before the committee today on behalf of your organisation. The committee will follow up on any questions which were taken on notice in writing, and responses will be requested for receipt within five working days of the committee's request. The committee will now take a 15-minute break before its consideration of the next witness. We declare this hearing adjourned. Thank you.

**Ms VERHOEVEN:** Thank you.

**Witness withdrew.**