REPORT OF PROCEEDINGS BEFORE

PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO AUDITOR-GENERAL'S FOLLOW-UP REPORTS

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At Sydney on Wednesday 5 May 2010

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The Committee met at 11.00 a.m.

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PRESENT

Mr P. B. Gibson (Chair)

Mr V. Dominello
Mr P. R. Draper
Mr. N. Khoshaba

Mr J. H. Turner

PETER CHARLES ACHTERSTRAAT, Auditor-General, New South Wales Audit Office, 1 Margaret Street, Sydney,

MARK ANTHONY RONSISVALLE, Deputy Secretary and Financial Management, New South Wales Treasury, 1 Farrar Place, Sydney,

MARK PELLOWE, Senior Director, Budget and Infrastructure Management and Reporting Branch, New South Wales Treasury, 1 Farrar Place, Sydney, and

ANTHONY THOMAS WHITFIELD, Deputy Auditor-General, New South Wales Audit Office, 1 Margaret Street, Sydney, sworn and examined:

CHAIR: I welcome and thank the representatives of New South Wales Treasury and the Auditor-General for appearing to brief the Committee on issues relating to financial reporting in New South Wales. In what capacity are you appearing before the Committee?

Mr PELLOWE: My team is principally responsible for producing the whole-of-government accounts, and as a senior accountant I am responsible for the accounts. I actually sign them off.

Mr RONSISVALLE: My area of Treasury is the budget and financial management. I look after the production of the budget papers.

Mr ACHTERSTRAAT: I am the Auditor-General and I appear in that capacity.

Mr WHITFIELD: I am the Deputy Auditor-General and I appear in that capacity.

CHAIR: I draw your attention to the fact that you are covered by parliamentary privilege at this hearing today. Any deliberate misleading of the Committee may constitute a contempt of Parliament and an offence under the Parliamentary Evidence Act 1901, which I am certain you are aware of. The Committee has asked you to brief us on issues relating to financial reporting in the New South Wales Government. This issue has also been highlighted in Volume 4 of the 2009 financial audit which raises concerns relating to the quality and reliability of financial reporting. I therefore ask Mr Achterstraat and Mr Ronsisvalle to outline these issues for the Committee before we begin questions.

Mr ACHTERSTRAAT: Imagine you are playing a game of cricket. Imagine if, while you are playing, you do not know the score. You do not know the score until after the match is finished. It may affect the way you play; it may not. Imagine you do not know the score until three months after the game finished. That may be somewhat disconcerting. That is the first issue. This is the second issue. Similarly, imagine in the game of cricket when you put your score in you have been allocating five runs for every boundary. When you put it in someone comes along and says, "It wasn't quite right. Your score is not X but Y" because you should only be allowing four runs per boundary. That would be disconcerting. Finally, imagine they said you have a certain budget to run this cricket team and you are not allowed to go over the budget. Imagine if after the game, sometime later, someone were to say to you, "I'm sorry, you have overspent. You have spent too much on the team." Again, that is disconcerting.

I guess those similar three issues can arise in the public sector. We have made Treasury aware of that and we have been able to go a long way forward. We recognise the complexity of the issues, but as we have indicated in our reports we come across a situation where we do not know the score. In June in one year we will think the budget surplus is going to be X for that year—$1,000 million or whatever—but then come 30 June, three weeks later, the budget result is very different. So we do not know the score during the year. We do not find out until the end of June. Similarly, when the Audit Office gets a series of accounts there are often some significant errors—we call them errors; some call them misstatements—and we need to discuss that with the preparers and we will say, "On this one we don't think you should have given five runs for the boundary; it should have been four runs for the boundary". So there is a bit of work in that, four runs for the boundary, and we come to an agreement in relation to what the value is. So that happens as well, and we have referred to that in our report.

Also for the last couple of years we have found that a number of departments have exceeded their budget by roughly the same amount as they did the year before. We have listed those as well. Those are the

three issues. With the assistance of this Committee and Treasury, we are already making some good inroads, and we can come up with solutions which will make it a lot easier for the people of New South Wales to know what the score is, to know what the rules are and to know how the budget is travelling. I can go briefly through those things in the report, but I think the members have read them in the various reports so I will take them as read. I would like to thank Treasury for following up on many of the issues, particularly in relation to the hard close, as it were, and what that is about is our suggestion is rather than wait until 30 June and then us getting a set of books at the end of July and then discussing the anomalies with them, if each of the major departments could do a hard close or a set of accounts as of another time, say, 31 March, that would be a good trial run, as it were, to iron out the big issues. That would make it a lot easier for us when we get the final set of accounts because all the big issues would have been ironed out. It would also make it a lot easier for the departments because they have a better handle on how their spending is going because they would have an understanding of where we are travelling.

It may well be that the figures in the June budget then might be a little more robust so there is not a big discrepancy between the figure in the June budget and what happens on 30 June. We commend the Department of Health for the initiatives they took last year. Sometime ago the Department of Health merged from 17 area health services down to eight and that caused a change in the accounting system, et cetera. It was a big issue. As a result we tended to get accounts from the Department of Health which needed a bit of polishing up. They were not entirely complete; there were issues there. So for the first couple of years after that amalgamation we were not able to sign off until close to Christmas and we were not able to finally report to Parliament until February. My concern is that in relation to the amalgamation of many departments it will be similar to what happened with Health a few years ago. If we have a large number of departments going down to 13 we do not want to be in a situation where we are running around just before Christmas and I do not issue things until early 2011. I want to avoid that, and I have made that known. I have liaised with Treasury, which has been quite responsive to come up with initiatives to streamline that.

The Department of Health, after Mr Whitfield liaised heavily with them and their audit committees, refocused their approach and they did a hard close last year. That enabled them to give us a much more robust set of accounts at 30 June and we were able to not only sign off but report on them much earlier than we had in the past. So the Department of Health, we believe in this respect, is an early adopter and we are very pleased with it and we would encourage other departments to do the same.

Mr RONSISVALLE: Firstly, we welcome the Public Accounts Committee's interest in this improved financial reporting. I think we would all agree that we would like to improve the quality of financial reports, but we also bear in mind that there are risks associated with actually doing something else. The Government prefers to put money into front-line services. Sometimes that means that other things have to be not as well done as they should be done. We also need to understand that in the public sector we often deal with very complex accounting issues, things like the valuation of land under Roads or parks, things that do not have an alternative use. There is also, as Mr Achterstraat has already alluded to, the complexity of agency amalgamations. Some agencies will be challenged by that this financial year. We also hope to report on a harmonised GFS accounting process that introduces some significant complexities into the accounts. Also, we adopt fair value of accounting in the public sector, which again is introducing a degree of subjectivity into the valuation of assets.

It is also important to note that the significant errors or misstatements—or whatever word Peter Achterstraat and I agree on—while they are large in dollar terms, they are immaterial in the terms of the total State accounts. The total State accounts were not qualified by those misstatements. In the scheme of things they are large in dollar terms, but not large in terms of the State's account. In terms of revenues they were about 0.3 per cent and in terms of expenses they were 0.1 per cent. That is not to say that we should not be improving. It is important, and Mr Achterstraat and I probably agree that agencies do not see the submission of their accounts to the Auditor-General as an opportunity to go back and check the accounts that they have provided to the Auditor-General. The full checking process needs to occur prior to giving it to the Auditor-General.

It is, in my opinion, not acceptable for significant changes to occur in accounts after they have been given to the Auditor-General. That says something about the process the agencies go through. It is also important that while we introduced accrual accounting many years ago, in the mid-1990s, you might argue that some agencies still do accrual accounting at the end of the financial year rather than on a progressive basis. That is another reason why things pop up at the end of the financial year that cause complexity with the agencies' accounts.

Mr Achterstraat has already mentioned a couple of things we are trying to do; one is the hard close. The Government also endorsed a new risk management policy, which increases the level of scrutiny on the agencies' operations, in particular on their accounts. We have also, through those audit and risk committees, written to audit and risk committees to alert them to the pilot of the hard close and asked them to keep an eye on that. We have asked the audit and risk committees to put in place an internal audit program that will provide assurances as to the data that is being provided to Treasury and the Auditor-General. That is asking CEOs for certification of the systems and the processes that they go through to produce their accounts. That certification will not be done until March next year because we need to allow the internal audit process to allow the audit committees to put in place a process that allows them to get assurances and then allows them to say the CEO should be able to sign the certificates. These are some of the things we have put in place to improve the production of accounts.

CHAIR: Mr Pellowe, do you wish to make a statement?

Mr PELLOWE: No, Mark Ronsisvalle has summarised it all.

CHAIR: I ask a layman's question. I have been here almost 23 years and am yet to see a budget with any accounts that come in anywhere near close to that budget. Sometimes there has been a very small surplus budgeted for and it turns out to be a fairly big surplus. Sometimes a big one turns into a little one. There are events during the year that influence it. The private sector does not seem to be the same with their predictions. Am I right in that? Is there a reason for that?

Mr RONSISVALLE: All budgets are based on assumptions. If you take last year's budget, it was predicated in an environment where the world seemed to be collapsing through the global financial crisis. Commonwealth receipts were well down and the transfer duties were well down. This year those things have turned around much more quickly than what people anticipated. That is not just what the New South Wales Treasury has anticipated, it is what is seen in the estimates at both the Commonwealth level and in the national accounts—the growth in the economy. Those things have a very significant impact on the State's finances.

On the expenditure side, governments do respond to community needs and they decide that they need to address community needs. Often, not in all cases, that involves a change in the expenditures that the State incurs. Does it happen more often than it should? Perhaps that is a question that should be directed to the Treasurer. Certainly we put forward the best estimates we can at the time. I point out that those revenue estimates are usually based around last month; that is when we lock in to basing revenue estimates. Regarding the expenditure estimates, the agencies provide it around this time. They provide them about early April. The estimates that we put in the budget papers, even at budget time, are somewhat dated. So the production of the budget papers needs to go through a process and you need to lock it in at a certain point in time. Estimates can change.

CHAIR: I am a new boy to the block, but if we have 12 out of 24 departments with mistakes of over $20 million, how can we put an accurate budget anywhere?

Mr RONSISVALLE: Firstly, you need to understand that that is a small amount of money relative to the total State account.

CHAIR: I understand that, but tell Mr and Mrs Ordinary on the street that $240 million is a small amount.

Mr RONSISVALLE: Often those errors that were just referred to are differences in the valuation of assets and they do not actually affect the budget, the operating of the budget result. They are just changes in the valuation of an asset. Yes, they affect the balance sheet of the State, but it is not the operating statement, which is the key focus of government.

CHAIR: My point is: Would that happen in the private sector?

Mr WHITFIELD: I will answer that. Prior to joining the Audit Office I spent 30 years with one of the big four auditing the private sector. The difference between the private sector, large listed companies, large private companies and government departments is that out in the private sector they apply accrual accounting on a regular basis. They generally have monthly accounts that they prepare and each month they apply the same disciplines that they use at the year's end. So, within three or four days of the month's end they have all their

accruals that have an estimate of expenditure that should be portrayed for that period, so they have more accurate information.

As Mark Ronsisvalle indicated earlier, our view is that a number of government departments apply only accrual accounting at the year's end. They work on a cash basis, then they get to the year end and they realise they have a lot of accruals of expenditure and the like and all of a sudden, the result for the year changes because they have not been monitoring it closely enough on a monthly basis. Not so much with the State-owned corporations [SOCs] because the SOCs are required to prepare a set of financial statements at 31 December. So there are six-monthly accounts. They are doing it twice a year, so they get into the habit. The more often you do something the better you get at it.

CHAIR: The obvious question is: Why do we not do it the same as the private sector?

Mr PELLOWE: I will add two points to that. The asset valuations in the private sector are almost exclusively on an historic cost basis. That is fairly objective; it is what you pay. Because of the vast holdings and size of the assets that we hold in the public sector and the age of them, we generally do those on a valuation basis. That introduces far more subjectivity into it, because you have to make assessments about current condition, useful life, all those kinds of things. So you are doing a valuation based on a number of subjective assessments. You can end up with different interpretations of a correct valuation. So I think there is one difference there.

CHAIR: Would that be for every agency?

Mr PELLOWE: More or less, yes. We have a cycle of five-yearly revaluations. You would appreciate that a lot of our assets are old, they go back a long way, so the historic cost has no meaning for those. You challenge as to what is the replacement cost or, as I said before, what is the useful life, and all those kinds of things. They are all subjective assessments. The other issue around the budget result is that often 1 or 2 per cent of our revenues are expenses. So a small change in revenues is expenses, and that can have a big effect on our budget result. The private sector might be operating at a profit margin of 10 per cent or 15 per cent, so changes in revenues are expenses. That has less material impact on the profit result than it does in the public sector. We keep saying that the budget result is a balancing number between two very big numbers; revenues and expenses. And a small change in either can make a significant change.

CHAIR: Am I correct in thinking that some departments may put more effort into the balancing situation than the profit and loss situation, or the greatest bang for your buck?

Mr RONSISVALLE: I do not understand what you mean.

CHAIR: At the end of the financial year you can say that you have balanced, you have done well, and that A equals B. But if you look at it, the value for the money that you have to balance may be way out of kilter?

Mr PELLOWE: One of the things that Treasury has been doing with the budget process is to try to get performance agreements from agencies, called results and services plans, which articulate a series of performance indicators and also measures of what they have produced and what they are trying to achieve with that for the money that has been provided. It is trying to balance the fact, as you say, that budget compliance does not mean anything in itself. It is also what has been delivered versus what was planned to be delivered for that money.

CHAIR: But if you have $20 million mistakes, those that have tried to balance have not been trying too hard.

Mr RONSISVALLE: When we talk about budgets, there is a budget that is done at the start of the year and clearly 12 months down the track things will occur, which mean that the result would be different from the budget. You would understand that at the start of the year someone says that it is going to be X. I guess the concern of the Audit Office is that often 11 months into the year we are told the budget result will be X for this year. For example, in 2008 we were told on 8 June that the budget result would be a billion dollars, and three weeks later, when the result came in, it was only $386 million—that was within three weeks.

I can understand why it changes over a year, but in relation to the shorter time I guess that is why the benefit of accrual based hard close would have clarified that first figure. As it turns out in that figure we talk

about changes in markets and changes in other things, but there was a large result in that as a result of not taking into account long-service leave or something like that, which caused a significant variance. Arguably that would have been picked up if there had been a hard close earlier on. We have to remember the complexities, because if New South Wales were a country, someone said that it would be the twenty-ninth biggest country in the world. It is a large set of books to look at and very disparate.

CHAIR: That is something I will address later. Mr Draper, do you have a question?

Mr PETER DRAPER: The Auditor-General has impressed upon the Committee many times, and especially on the member for Lane Cove, that if you do not measure it you cannot manage it.

Mr ACHTERSTRAAT: There is a trademark there!

Mr PETER DRAPER: It will stay with you for the rest of your life.

Mr ACHTERSTRAAT: One of the members for Myall Lakes said the same thing.

Mr PETER DRAPER: One of the members! I am interested in the departments that appear to be making the same mistake year after year. You said that some are over budget, or that there is a difference that is almost identical to the previous year.

Mr ACHTERSTRAAT: You are quite right, there are two issues there. There is the identical amount that they are over budget each year. That is probably, to a certain extent, a separate issue from the errors that they make. That is not necessarily a correlation. As I reported last year, the Department of Health was over budget by approximately $600 million in both 2008 and 2009. The Roads and Traffic Authority was over budget by $269 million in 2008 and $272 million in 2009. The Department of Education and Training was over budget by $176 million in 2008 and $178 million in 2009. The first point we are making is that there is a consistency between the amounts over budget. The solution to that is not necessarily wholesale review; it is more that if there is a hard close people could manage that better, and if you measure it you can manage it better.

Mr PETER DRAPER: I live by the philosophy: it is fine to make mistakes, but never make the same mistake twice.

Mr ACHTERSTRAAT: I think that is a very good point. As it has turned out, the same overrun has occurred twice. Whether it is a mistake or not would depend on the components of that overrun. In some years it may well have been in relation to excess wages; in others it may be in relation to something else. But with regard to the first point you made in relation to the errors, as Mark and Tony have indicated—I think Treasury have called them misstatements—on many occasions they are in relation to the valuation of an asset, or indeed whether an asset should be included in the balance sheet of an agency. They are some of the discussions we have had. I am not suggesting that exactly the same error that occurred one year in relation to the valuation occurs in the other.

Mr WHITFIELD: In some cases the errors are there because there has been a lack of suitable scrutiny and review of the issues. We have had instances where lines or cells in a spreadsheet have been left out of the total and that has left out $500 million worth of assets, for example. It is simple things like that, that if there were a high degree of scrutiny and if it had been done earlier, someone would have picked up that they were not adding all the cells in the spreadsheet. It is issues like that that contribute to it, but there are, in addition, issues in relation to valuation where we have had assets included in an agency's accounts that did not belong to that agency, or to which they have applied wrong valuations, or picked up the wrong numbers out of another document and transposed them. Those are things that should be picked up before they come to the Auditor-General.

CHAIR: What happens to these people—for example, the fellow that Peter spoke about who forgot that there was long service leave? Do they keep their jobs? They would not keep them in the private sector.

Mr RONSISVALLE: I think government recognises that sometimes mistakes are actually made. I am not familiar with what the consequences were for any of these particular people, but I suspect it was: "Hope it does not happen again. Let's try and put in place systems and processes so that it does not happen again."

CHAIR: We have 12 out of 24 agencies that have found discrepancies—

Mr RONSISVALLE: Yes, and I do not want to sit here and provide excuses for why that occurred, because it is obviously not an acceptable situation. I think there will always be some level of those things that occur, so it is a matter of minimising them and detecting them as early as possible so they can be corrected in the accounts. The issue of errors in the accounts and the reasons why agencies are over budget are very different subject matters. Agencies go over budget for many, many reasons. Often they can relate to simply additional Commonwealth funding coming in which shows up as a revenue in the budget that just goes out as an expense in the agency.

It can also be changes in government policy; it can even be changes in the timing of when we pay grants to people. Certainly there is an element of it that you might argue is bad management, that they have not controlled their expenditure. In those sorts of circumstances, that is something that Treasury draws to the attention of government, and government then decides what it will do to keep agencies within their budgets, or they may choose to say: The consequences of bringing someone back into budget are something the government is not prepared to tolerate, and therefore they effectively sanction the agencies going over budget.

Mr JOHN TURNER: You were saying that you work on the premise that sometimes there is a line missing or there has been some error in the calculations. Would it be true to say that the budget that the Treasurer delivers to us is, at best, a draft budget?

Mr RONSISVALLE: No, I would not say that. It is prepared with the best degree of professionalism that can be mounted by Treasury in the production of the budget. When we put the budget papers together, they go through a very rigorous process to try to detect any issues that might arise in those numbers. I cannot put my hand on my heart and say that there has never been an error in a budget paper; sometimes that does happen. But they are usually quite small—

Mr JOHN TURNER: You say it is not an error in the budget paper, but if the budget papers have been predicated on the advice given up to 30 June which has a line missing with $500 million worth of assets in it, there is quite a deal of possible error in the final budget paper given by the Treasurer?

Mr RONSISVALLE: I think Tony is talking about the valuation of assets. That is not affecting the budget result. And I suppose—

Mr JOHN TURNER: The omission of long service leave would, would it not?

Mr RONSISVALLE: Yes, but that was picked up in the final set of accounts. Effectively, agencies give us a profit and loss statement, a balance sheet and a cash flow statement, and we make sure we try to reconcile those things. Effectively, we are trying to reconcile back to the cash they have in their bank account, trying to make sure we have the right data. In the end, what Treasury gets from agencies is what agencies tell Treasury. We do not have an independent look into the agencies' financial systems.

Mr JOHN TURNER: You do, but that is the Auditor-General—

Mr RONSISVALLE: But that is in the next step; you are talking about the budget.

Mr ACHTERSTRAAT: I think Mr Turner is right we do look at that. As Mark said, Treasury relies on information given to them by the departments. If the departments had a hard close on 31 March to find out things, I am sure Treasury would get a much better set of accounts and that they would be able to prepare the early June budget based on that set of accounts, rather than what they are getting at the moment.

Mr RONSISVALLE: We are piloting the 15 agencies this year. Chair, earlier you ask me what happened to the private sector area. What we are doing is piloting the 15 agencies that are hard closed as at—they get to choose whether it is 31 March or 30 April—to see what issues actually arise. Certainly the response of one or two agencies when it was first raised with them was, "We need additional resources for this." What we are doing through the pilot is testing whether that actually is the case, so we know where we are at. We are meeting with these agencies at the end of the year to review how the hard close went, and on the assumption that things proceeded fine, we are looking to extend the hard close to other agencies. But we need to try it the first year, to see what issues arise.

CHAIR: Would the private sector tolerate that? They would be simply telling their agencies it has to be done. It is all right to say more agencies are coming on board and it is all fine. It is the biggest business in the nation. Why would we not be just telling them that it is going to happen?

Mr RONSISVALLE: Let us assume it did involve additional resources to do these monthly closes or periodic hard closes. The organisation would then be able to allocate the resources to do that. In the case of government, any resources allocated to do that comes at the cost of something else the government would have otherwise done. So we need to be very clear about what costs are involved in doing this before we say to government, "Let's spend an extra $20 million on accounting services."

CHAIR: That may be so, but we do spend less than a quarter of what Victoria spends on the Auditor-General; we spend less than half of what Queensland spends on the Auditor-General; and we spend less than what Tasmania spends on the Auditor-General.

Mr ACHTERSTRAAT: The performance audit side.

Mr JOHN TURNER: In simplistic terms, you are talking about staying with the hard close for the major agencies, which I presume includes the Department of Education. Yet, local schools, for instance—and my wife is a school assistant—are required to do quarterly reconciliations. The Auditor-General has a look at that. At the micro level you are making departments do that, but at the macro level, where the big dollars are, we are looking as though we are stepping forward to hard closes and getting some forward knowledge that something might be awry. But I am amazed that it has taken so long to get to a situation where you are really living in a void for 12 months and hoping it is all right, you give a set of figures to Treasury, and a couple of months later you say, "Well, we did not quite get that right."

Mr RONSISVALLE: We are collecting data from agencies on a monthly basis. They give us their year-to-date actuals and their projections to the end of the year. We look at that data and compare it against previous years to see whether agencies are tracking on budget. Where an agency appears to be going over budget, we raise that with the agency and hopefully we come to some sort of agreement as to whether they are. They tell us why they are going to be pulling back their budgetary balance for the year, or yes, they agree they are on budget. If they are on budget, we take it to government, and government makes a decision about what they are going to do about that. But we do monitor agencies on a monthly basis, from September on.

CHAIR: On 26 March you sent a circular out to the agencies. The second dot point simply said: "The importance of providing accurate financial statements for audit is stressed." Why would you even have to say that to them?

Mr RONSISVALLE: As Peter's report shows, maybe agencies are not paying enough attention to this, and that is the reason why they are— As I said in my opening statement, some agencies—

CHAIR: Whose fault is that?

Mr RONSISVALLE: Treasury can issue circulars, but ultimately the responsibility for the production of the accounts rests with the agency.

Mr PETER DRAPER: Does Treasury question the competency of some of the reporting that is coming to you?

Mr RONSISVALLE: As I mentioned earlier, we review the data the agencies give us and we will ask questions. If half the year has gone and they have spent 80 per cent of their budget, we will say to them, "What's going on?" They will have to give us an explanation. Ultimately that goes back to the competency of the people providing the data to us.

Mr PETER DRAPER: Having spent 16 years in News Corporation, setting budgets and monitoring expenditure, I would not have lasted 16 weeks if I had adopted the practices of some of the agencies, I have to say. If the Auditor-General's view is listened to and there is implementation of more periodic reporting, the question to the Auditor-General is: Do you have the resources at the moment, and if not, what sort of increase in resources would be required so that we can get an appropriate level of periodic reporting?

Mr ACHTERSTRAAT: Thank you for the question. The purpose of the periodic reporting would undoubtedly help the Audit Office, but that is not the primary reason for it; it is to help the transparency of information to the Parliament. If there were a hard close earlier, and we were able to do a review of that—but not necessarily issue an opinion, because we would not be suggesting that was an opinion-based thing, it was more of a review—that would reduce the workload at the end of the year, after 30 June. I do not know if there is a direct correlation between the increase in one and the reduction in the other; there may be a bit of overlap. But certainly if there were better quality data available at the end of March, it would make the audit a lot more smooth and timely—

Mr PETER DRAPER: And accurate?

Mr ACHTERSTRAAT: And accurate. But in relation to the resourcing, we would probably have to bring forward some of our resourcing from the end of the year to March. It would depend on the level of attestation the Parliament required of us, whether it was a review or an opinion. The Department of Health is a good example, where I think they were able to do the work with rearranging their priorities et cetera; there may not necessarily have been a large increase in the resourcing. I would have to take on notice how much extra resourcing would be needed.

Mr PETER DRAPER: I have sat in hearings similar to this where we have talked about best practice, benchmarking and comparisons. Are we benchmarking the quality of financial reporting coming from the different agencies with a view to getting a standard right across the whole level of government, rather than some being excellent and some being questionable?

Mr RONSISVALLE: I would accept that some agencies are better at reporting than others. Peter has mentioned that the Department of Health has gone from probably being down the bottom to being much closer towards the top. We would like everybody to improve their performance. Through the new audit and risk policy, through the use of those committees, we intend to raise everybody's standard of reporting.

Mr PETER DRAPER: So we can expect to see the standards rise?

Mr RONSISVALLE: Yes. These audit and risk committees consist of a majority of independent members. They are not departmental committees rubberstamping the actions of the department. Of a committee of five, three of them have to be independents and the chair is an independent. That is going to put considerable pressure on the agencies to improve both the internal audit risk management and, in particular, the quality of the production of their accounts. We are hoping this will improve the quality of the accounts and bring them forward.

CHAIR: I would love to have a boss like you. It is great to say, "We hope to see the other agencies improve." You are the boss. Why don't you make them do it?

Mr RONSISVALLE: There is often a misconception about Treasury being all-powerful.

CHAIR: If you have not got the power, who has got the power to make it happen?

Mr RONSISVALLE: Let us say we mandated hard close, the first thing that the Treasurer is going to ask me is, "How much is that going to cost?" He knows there will be not one, not two but many agencies that will come back and ask us for additional resources.

Mr NINOS KHOSHABA: You say you would be asked, "How much is that going to cost?" At the same time, how much is that going to save?

CHAIR: We are still talking about a balancing act. Forget the balancing act. You have to spend a quid to make a quid.

Mr RONSISVALLE: What this is doing is getting our accounts close to being accurate. Peter mentioned there may be potential resource implications for the Audit Office. There are potentially resource implications for agencies.

CHAIR: We have had 200 years and we have not got there yet.

Mr RONSISVALLE: We are doing a pilot to try to assess whether there are implications or not, and that is part of the review.

Mr NINOS KHOSHABA: I see the importance and benefits of doing a hard close. Going back to the Auditor-General's opening statement about the cricket, for which I thank him, we all know that the score is calculated correctly but there are times where the game is washed out, the goalposts have moved and changes need to be made.

Mr ACHTERSTRAAT: The goalposts moved in the cricket? Not often. Possibly the stumps.

Mr NINOS KHOSHABA: I know the difference. Mark, are you saying there is no actual reporting system; it is just done on an annual basis?

Mr RONSISVALLE: The agencies provide us with monthly financial statements.

Mr NINOS KHOSHABA: There is no checking of those?

Mr RONSISVALLE: That is right, they are not audited. They are effectively management accounts that they send to us.

Mr NINOS KHOSHABA: Apart from the costs that you mentioned earlier of employing more people or having a separate department, do you see any disadvantages in doing a hard closed?

Mr RONSISVALLE: That is the primary issue that would need to be addressed, bearing in mind the skill level of people in public sector agencies. I do not know whether you are prepared to comment on this more than I, but I suspect that the skill level is probably—the public sector does not pay substantial salaries for accountants. Therefore, if there is a correlation between skill level and pay, there may be an issue in the public sector as to the quality of the people who produce our accounts.

Mr WHITFIELD: If I could add to that, not so much in the State-owned corporations where they tend to have more private sector people on the boards and the quality of the people preparing financial statements are a lot better, but within the departments I would tend to agree with Mark. We did a study a number of years back and came up with a recommendation that people responsible for preparing the financial statements should have professional qualifications either with the Institute of Chartered Accountants or CPR Australia. The Premier of the time issued a memorandum to put that in place and then eight weeks later that got withdrawn because the National Institute of Accountants [NIA] thought it was a restriction. The requirement now is you have to be a member of an accounting body. That could be anything, quite frankly. So that requirement got watered down. What we are finding is that the State-owned corporations and some of the statutory authorities tend to provide better financial statements than the government departments. It is linked back to the quality of the people and the experience they have in the government departments and the fact that they only do it once a year. Therefore, they go through a relearning curve every time that they do it.

Mr NINOS KHOSHABA: We all agree that circumstances change, particularly with budgets. When a department becomes aware that it is going over budget or is already over budget, what does it need to do? What steps does it need to take to continue with the projects that have been promised? Does it need permission from Treasury? The department knows it is going to be over budget by $100 million or $50 million because the price of concrete has doubled, or for what ever reason. What happens?

Mr RONSISVALLE: In the end this eventually boils down to the agency needing additional funding through the Consolidated Fund, which means it needs to seek the Treasurer's approval to access additional funds either through the Treasurer's Advance or other mechanisms provided under the Public Finance and Audit Act. We control agencies in a number of ways. Firstly, by how much cash we give them. Secondly, we control by what is called net cost of services, which is effectively the expenses minus their own revenues. We control on that basis. We also control on what is called an asset authorisation, which is the total spent on capital works. If any of those variables change beyond a certain tolerance that we allow in the case of the net cost of services constraint, they need to seek the Treasurer's approval. That is the process they need to go through. Once they ask for approval, I suppose it depends on the significance of what they are asking for. If it is a few million dollars the Treasurer may make the decision to approve it. If it is $100 billion, then that is the sort of matter that would be considered by Government as a whole and it would go to the budget committee of Cabinet.

Mr NINOS KHOSHABA: At what stage would you find out that a department is going to go well over budget? Is it towards the end of the year when you are provided with all the figures?

Mr RONSISVALLE: What you need to understand is that agencies that report to us, if they start to go over budget they usually assume that they can find a way of bringing themselves back on budget. So they take a conservative approach to their budget. Treasury will say to them, "Half the year has gone and you have spent 60 per cent of your budget. How are you going to bring yourself back on budget?" They will usually give us a very plausible set of explanations as to how they are going to bring their expenditure back on budget. Often they are pretty optimistic about how they are operating. It may turn out that they eventually are on budget. What happens is as the year goes on it progressively becomes harder for them to give an explanation that is plausible for them to be coming back on budget. They may still be sending us data that says they are going to be on budget but by looking at their historical patterns and their expenditure during the course of the year we will then say to Government, "We don't believe what this agency is telling us." We will take it to Government and bring it to, for example, the expenditure review committee of Cabinet.

Similarly, it also works on the other side when an agency is underspending its budget. We will say to them, "What is happening? You are not spending your budget." They will usually give us a set of explanations as to why they think they will spend all their money during the financial year and how they are going to catch up. Again, as the year goes on that explanation becomes less and less plausible. What Treasury can do is look at their data, see if there is anything in that data that gives us cause for concern, ask them questions about the data and test the explanations they have given us. If those explanations look reasonable, then effectively we have to accept what they have told us until such time that what they are telling us becomes implausible.

CHAIR: Do you find in that case there is waste at the end? If an agency has not spent its budget and you ask why, do you find there is a lot of waste in the agency spending the money so that next year when it asks for X amount of money it is not penalised because it did not spend that amount last year?

Mr RONSISVALLE: There have been many inquiries into whether there are end-of-year spend-ups. Agencies do spend a lot of money in the last quarter of the financial year and they give us very legitimate reasons as to why they are spending that money. At the level that Treasury actually sees, we do not see necessarily that they have gone out and bought three photocopiers at the end of the year. We do not actually receive that sort of stuff. That is not the level of reporting that we get. That gets back to probably also the function where you talked about spending a lot less money on performance audits for the Auditor-General. The Treasury is the smallest Treasury in the country. There is a limited amount of—

CHAIR: With very ordinary accountants?

Mr RONSISVALLE: I would not say that accountants in Treasury are ordinary. We have some highly professional people in Treasury.

CHAIR: I have no doubt that you do but the comment was made that you were going to get top-class accountants and that was knocked back.

Mr RONSISVALLE: I was talking generally about across the public sector.

Mr NINOS KHOSHABA: If a household is earning $1,000 a week and spending $1,500 a week, at some stage someone has to pull them up and say, "You are spending too much. We cannot continue to lend you $500 a week." What is the trigger for Treasury to intervene? Is it case-by-case for every department? When does Treasury say, "Your budget was $500 million. We are six months down the track and you have already spent $700 million." When does Treasury get involved?

Mr RONSISVALLE: It gets back to the stories they tell us about why they are running over budget. In 2007-08 Health came in well and truly over budget. Treasury was saying to Government and telling the Department of Health, "All the indicators that we are looking at in your data tell us that you are going to be over budget." They kept on saying that they were not going to be over budget. As it turned out Treasury was right, they were well and truly over budget. But they kept on giving us what we considered to be reasonable explanations as to why they would come on budget. It is when it becomes totally implausible that the agency is going to somehow be on budget given what has happened during the course of the year that we then alert Government.

Mr PETER DRAPER: Should we not stop the train before the train wreck happens?

Mr RONSISVALLE: It gets back to the explanations that are given to us. If those explanations look reasonable—

Mr P ETER DRAPER: You just said that you had concerns about health.

Mr RONSISVALLE: Yes, we did and we raise them with Government.

Mr PETER DRAPER: Mr Ninos Khoshaba's point is that the flames are coming in the back door. Do we wait until that stage?

Mr RONSISVALLE: No, in the case of health we were alerting Government in January or February that it looked like they were going to be well and truly over budget. That is well before the end of the financial year.

CHAIR: Did they take any notice? Apparently not. Why alert them if they are not going to do anything about it?

Mr RONSISVALLE: No, to be fair the Government does pay attention. The Treasurer would have meetings with agencies to talk to them about their budgets and it would be a pretty robust sort of discussion.

CHAIR: Do we impose any penalties for being over budget?

Mr RONSISVALLE: I often say that I have never seen a CEO sacked for going over budget. The point is we do not have a sanction that someone gets the sack if they go over budget. To be fair, the reasons they go over budget are often outside their control. Some of them are inside their control but they are often outside their control.

Mr NINOS KHOSHABA: Again, there are always special circumstances, but can you see the benefit with a hard close? Apart from the additional cost do you see the benefits?

Mr RONSISVALLE: Yes.

Mr NINOS KHOSHABA: Also, from a Treasury point of view, knowing that well before the financial year ends you will know how every department is faring?

Mr RONSISVALLE: The hard close will clarify things in your accounts and tell us pretty clearly how they have gone for the financial year. It does not necessarily tell us what their budget outcome is for the year, but it will certainly improve the quality of the data that we actually get. So, to that extent, the budget and the total State accounts will be more accurate and I suppose what we are looking to do is, hopefully, as part of this, if we extend the pilot to all agencies and get the accounts done earlier, we will be able to bring forward the date for the production of the total State accounts.

Peter spoke about not knowing the budget result until three months after the end of the financial year. From my perspective that is not an acceptable outcome. Accountability delay is accountability denied, in my opinion, and accounts need to be brought forward. But at the moment we struggle to get them done and they are finalised and signed on the same day because the audit is not completed until that day because effectively the accounts are not completed.

Mr VICTOR DOMINELLO: Mark, how long have you been of the view that a hard close would be a good idea?

Mr RONSISVALLE: I think the Audit Office has raised this with us for a couple of years.

Mr ACHTERSTRAAT: I have been in the chair three years and I think the second year I was in the chair I raised it informally and last year I raised it formally through the report.

Mr VICTOR DOMINELLO: So for a few years. Are you aware of any other States that do a hard close?

Mr PELLOWE: No, we are not aware of any other States.

Mr VICTOR DOMINELLO: You are not aware or you do not know?

Mr PELLOWE: We have not done research, no.

Mr VICTOR DOMINELLO: Can somebody make some inquiries and get back to me or the Committee in relation to what other States do and how effective that is?

Mr PELLOWE: Certainly. Those of us who have worked in the private sector are very familiar with the concept. So I think we have taken a lot of it as the private sector rather than what other States were doing.

Mr VICTOR DOMINELLO: Other States are more efficient because they had this in place. I am just wondering why it has taken us so long to come to this point if everybody seems to think that this has been a good idea for two or three years. The wheels of progress go so slow.

Mr PELLOWE: We have done some very high-level research and we could not find any evidence of other jurisdictions doing it.

Mr VICTOR DOMINELLO: And you think if we do a hard close that will correct or weed out a lot of the errors that eventually go out to State accounts?

Mr RONSISVALLE: It should. You obviously cannot give any assurances that it will eliminate all the errors.

Mr VICTOR DOMINELLO: When you identify the errors, for example, somebody is missing a cell on an Excel spreadsheet that someone has forgot to put an asset on or one of these more subjective errors and misstatements in relation to valuations—and I will come back to that in a moment—is there a system in place whereby these errors are consistently recorded against a person or an area so that that person or that area can be more carefully monitored to make sure that these errors are not repeated again and again?

Mr RONSISVALLE: The production of total State accounts is a collection of the aggregate of the agency accounts. Treasury has a system which consolidates those. We rely on the accounts that are given to us. Where an agency has a systemic error in their accounts, what action it actually takes to fix that is something you would have to ask the agency, but through the new audit risk management policy I suppose we have upped the ante in them having to fix those problems before the accounts are sent to us.

Mr VICTOR DOMINELLO: If in another two or three years we are having the same discussion—

Mr RONSISVALLE: I hope not.

Mr VICTOR DOMINELLO: —and there are repeated errors that you see, because there is a hard close, you determine every agency is going to have a hard close because it is the right thing to do and there are repeated errors, what do you do then, as Treasury, to say, "Hold on, this is unacceptable. What is going on?"

Mr RONSISVALLE: I think you will find, and correct me if I am wrong, that while there may be agencies that have a tendency to go over budget on a consistent basis, I think the misstatements or errors in the accounts varies from year to year; it is not a consistent pattern that every year the Department of Health has the same error or the Department of Education has the same error. Each year the list of errors would vary in type and the agencies would vary.

Mr WHITFIELD: If I could help there? What Mark is saying is correct. When we finalise the audit and get ready for the following year's audit we have a planning meeting with the client and we would point out to them the areas—and it goes to the management—where the errors have occurred and it is in our planning for the audit for the next year; it is one of the areas we concentrate on to make sure they have done something to ensure that they do not repeat that same error. But that is not to say that an error does not crop up in some other area.

If I can add a little bit to what you were saying earlier about hard closes with the other jurisdictions, what we do know of the other jurisdictions, and there are a number of them, they have brought forward their reporting timetables so that they sign off on the equivalent of their total State accounts by the end of August, which is some four weeks prior to what we do in New South Wales, and also they are a little bit stricter in that under the Public Finance and Audit Act we have got to 20 October to sign off on the audits of all the agencies; they have brought theirs forward a lot more to coincide with their end of August time frame.

Mr VICTOR DOMINELLO: So it is pressure to come back?

Mr WHITFIELD: Yes. Once you do that then that forces you into doing the work earlier, which is the equivalent of a hard close.

Mr VICTOR DOMINELLO: It is a de facto hard close?

Mr WHITFIELD: That is right.

Mr VICTOR DOMINELLO: For how long have they had that system in place?

Mr WHITFIELD: A couple of years that has occurred—two years ago.

Mr VICTOR DOMINELLO: Which jurisdiction in particular are you talking about?

Mr WHITFIELD: To my knowledge, Western Australia and Queensland are doing it and I think the Commonwealth is doing it.

Mr VICTOR DOMINELLO: Do you know whether that has produced better outcomes?

Mr WHITFIELD: Certainly they are able to sign off and get information out quicker.

Mr VICTOR DOMINELLO: Did they have the same complaint in terms of additional cost of doing these things?

Mr WHITFIELD: There is when you do it for the first time because you have got to shift the work forward. But then when you come to 30 June it is easier because you have done it before; there is less work to do. If you do not do it and you find an error at 30 June you have got to then work back over 12 months to find out where the error occurred. If you are doing it early you have got less to go back to find the errors, and you get them fixed up and into the financial statements by 30 June. The issue that we have is now we come along in July and August and find the errors and then we end up getting into what we term a robust discussion with the client as to: Is it really an error? Does it have to be adjusted? Why do you not want to adjust it?

The other issue that crops up is that we may find a series of errors in different agencies at an agency level that are not material to adjust the individual agency, but because they are of the same nature and dealing with the same account line, by the time you get to a total State level they become material and then we have to adjust the total State account. So that whilst it was not adjusted down there, you are then causing an adjustment at a total State level. If the error was not made in the first place or had been found earlier and was corrected earlier you would not have the problem at the total State level.

Mr VICTOR DOMINELLO: Mark, if Western Australia and Queensland say it is effectively having a de facto hard close through the operation of their legislation, why do you not think we can?

Mr RONSISVALLE: We are doing the pilot. If the pilot is successful—

Mr VICTOR DOMINELLO: You have got some agencies reporting in as at 30 April. How did they go?

Mr RONSISVALLE: They would have provided their accounts to you guys by now, I suspect.

Mr VICTOR DOMINELLO: Do any of you have any figures in relation to those?

Mr PELLOWE: They do not report in to us; it is just part of the process.

Mr WHITFIELD: They are doing a hard close. We would expect to get those in the next couple of weeks and then we will review those. So prior to 30 June we will have done a review of those and hopefully found any material errors and got them corrected.

Mr RONSISVALLE: The objective is to bring forward the production of the total State accounts. That is what we are working towards.

Mr VICTOR DOMINELLO: I think I accurately reflect the views of the Chair or I endorse the view of the Chair that we should be more rigorous about these things, and if other States are doing it there is absolutely no excuse why we should not be doing it. It is not like we are Robinson Crusoe here or we are creating the wheel, it has been done, and those States have not fallen over. We should not languish behind. That is my personal view.

There is another aspect I want to explore and that is in relation to valuations and the subjective nature of them. If there are subjective elements to valuations, which I accept, are there not policies or guidelines in place to make sure that the subjective nature of these valuations are not repeated over and over again, or the errors in them are not repeated over and over again? Surely the guidelines would make that subjectivity less fluid?

Mr PELLOWE: We do have specific guidelines but it is more a case of applying the guidelines. For example, there is inherent subjectivity to deciding what the remaining useful life is of a building or even its current condition, unless you do a very thorough exercise. Quite often it is cost beneficial to do a fairly high-level review of its current condition, for example. So you are making a whole series of subjective decisions in applying the policy.

Mr VICTOR DOMINELLO: But we are saying that one person makes those subjective decisions and then somebody picks them up later on down here and says those subjective decisions were completely off-track and that affects the valuation. Is that what we are pretty much saying?

Mr RONSISVALLE: Often there is no decision made. People had not determined what the effective life was, for example.

Mr VICTOR DOMINELLO: How can that happen?

Mr RONSISVALLE: That can happen in, say, the Department of Health a few years ago where we found the written-down value of a lot of the assets was nil. In quite a few of the hospitals the written-down value was nil. That does not mean the equipment is not working properly. What it means is that people had not reviewed the effective life of these machines.

Mr VICTOR DOMINELLO: But why not? Why did they not do it?

Mr RONSISVALLE: We recommended that they do it in future. The next year they said they were starting and I think this year they are also starting; they are completing it.

CHAIR: Peter, it is a little bit like what you said initially about the cricket team. We come back to the cricket analogy: Once you are selected in the cricket team it is very hard to get dropped, and that is the same with a lot of these people that come up with these mistakes time and time again. If it were a Minister of the Crown he or she would be sacked.

Mr ACHTERSTRAAT: I think we have got a complicated set of accounts here. It is a big issue. Not all the mistakes are the same ones repeated each year. The reason I am pushing the hard close so much is because I think that will force people to do a solution, and, as I have said to many of the audit Chairs of the large agencies now, these amalgamated agencies, I do not want to have to sign off on any of those too late. Mark made the point that I got the final set of total State sector accounts the day before I was due to sign them off. We had seen copies of it before, we had seen drafts and there was a lot of discussion. If we have to wait until 20 October to get the final set and then I had to sign it off the next day, we have reviewed them all and it is just maybe there are changes at the margin, but it does get a little bit flustering to do it so quickly. We commend Treasury for accepting our recommendation to take it forward and we hope that this Committee can add a little bit more—

Mr RONSISVALLE: Impetus.

Mr ACHTERSTRAAT: Yes, impetus I think we would value.

Mr NINOS KHOSHABA: Can I just ask the Auditor-General one final question? Mark earlier mentioned about the main disadvantage was the cost in setting up—

Mr RONSISVALLE: Potential cost.

Mr NINOS KHOSHABA: —the potential cost of setting up more regular reporting. I think we all agree there will be some expenses incurred to set up that process. But in your opinion do you see savings? I certainly see the benefit in a hard close, but do you see that whilst it might cost, just plucking a number out of the air, say, $20 million to establish that, do you see that $20 million might actually save Treasury and other departments $200 million?

Mr ACHTERSTRAAT: In the first year there may be costs for bringing it forward. The benefits are not just direct monetary benefits in relation to the savings in doing the accounting in June, July, August, there are also benefits in having an accurate set of data. At the moment if on the monthly basis there is a cash figure that comes in, which is not necessarily reconciled, there is an issue. If we can get a more accurate set of data then I believe there will be a benefit in decision-making. I am not sure you can put a figure on that, but if you get better data you get a better decision. It may cost more in the first year, and there may even be a marginal rearrangement of costs in departments and central agencies on an ongoing basis.

Mr RONSISVALLE: I endorse that. The reason we monitor agencies on a monthly basis and give the Government revised budget forecasts is so that they can make decisions. If the data the agencies supply is inaccurate, the Government potentially makes different decisions than it would have made.

Mr VICTOR DOMINELLO: Garbage in garbage out.

Mr RONSISVALLE: Yes.

CHAIR: And the Minister gets the sack. We thank you for your time today.

Mr RONSISVALLE: Does the Committee intend to produce a report on this?

CHAIR: Yes. Do you wish to make a closing statement?

Mr ACHTERSTRAAT: I simply wish to thank Treasury for working with us to get this embedded and I thank the Committee for taking this very important topic on board. We hope we can work with members to get some benefit.

Mr RONSISVALLE: I endorse those comments.

CHAIR: Thank you very much.

(The witnesses withdrew)

(Luncheon adjournment)

PETER CHARLES ACHTERSTRAAT, Auditor-General, New South Wales Audit Office, 1 Margaret Street, Sydney, on a former oath;

TIM SMYTH, Deputy Director-General, NSW Department of Health, 73 Miller Street, North Sydney,

RAJ VERMA, Director, Health Services Performance Improvement Branch, NSW Department of Health, 73 Miller Street, North Sydney, affirmed and examined; and

GEOFFREY GREY BARNDEN, Director of Chronic Disease Management, NSW Department of Health, 73 Miller Street, North Sydney,

SEAN MICHAEL CRUMLIN New South Wales Audit Office, 1 Margaret Street, Sydney, sworn and examined:

CHAIR: Welcome and I thank the representatives of New South Wales Health and, of course, the Auditor-General for appearing to give evidence to the Public Accounts Committee about the response to the performance audit on delivering health out of hospitals. I note that everybody is accorded parliamentary privilege. Any deliberate misleading of the Committee may constitute a contempt of Parliament and an offence under the Parliamentary Evidence Act 1901. Would you like to make a brief opening statement? The Committee will then ask questions.

Dr SMYTH: We welcome the very helpful and timely report by the Auditor-General. Out-of-hospital care is nothing new in New South Wales or for New South Wales Health. For example, we have community palliative care and community mental health services and for many years we have provided services at home for people who have been in a birthing centre. That used to be called "early discharge" for women who had just given birth. It is nothing new. Each year we deliver more than 20 million community health services to the people of New South Wales.

The Auditor-General's report specifically covered the out-of-hospital care program experience of patients and their carers and it found that they uniformly love them. There is no doubt that those services, where they are able to be provided, do meet a need. The point about how we change community perceptions and, to some extent, the media perceptions—because the two are linked—is that out-of-hospital care is not substandard care. There will always be a place for hospitals—there always has been and there always will be. There is no doubt that we will need to continue to expand our hospital services to meet the growth in demand and to address the ageing of the population. One of our problems is the perception of those who have not experienced out-of-hospital care that it is substandard, it is not as good or as safe or that it is cost cutting. However, once people have experienced it, they do not want to go back to hospital for the same type of service.

Since the Auditor-General's report was handed down we have had the assistance of Ernst and Young in looking at the cost effectiveness of the services. Not surprisingly, that examination confirmed what the Auditor-General's report found; that is, it is very difficult to get very good data to do a detailed cost benefit analysis. To the extent that they were able to do that, they confirmed that the services are cost effective. The average cost of an acute hospital bed these days is about $780 and these services cost less than $300. Again I emphasise that commitment to out-of-hospital care services is not cost cutting, it is a better form of care. Looking at the subset of out-of-hospital care services examined by the Auditor-General's report, last financial year well over 60,000 people received those services across New South Wales and we continue to expand them and to invest in them.

We have a major new program underway, the Chronic Disease Management Program. Geoff Barnden is the manager of that program with New South Wales Health. As that program starts to roll out there will be a very significant expansion of our service capability to support people at home. We are looking to avoid the need for people to come to hospital. However, if they do, we want to ensure that they spend the shortest time there as possible.

Mr ACHTERSTRAAT: I endorse what Dr Smyth said. Out-of-hospital care should not be seen simply as an accounting issue; it should be seen as more appropriate care. I am heartened to hear the comment that 60,000 services have been provided, which is an increase from 45,000. I will be very interested as time goes on to get the results of the new program being introduced and I encourage the department to report on that

publicly. I commend the department for the action taken so far. However, as they would agree, 60,000 is just a start.

Dr SMYTH: Only just the start.

Mr ACHTERSTRAAT: Every one is a winner.

CHAIR: If as Dr Smyth said it has been going on for years with birthing and so on, why is it so hard to get data? It was very hard to get any information in October last year, but we now find out 45,000 patients were provided with out-of-hospital care and the figure is now 60,000. You found some data somewhere.

Dr SMYTH: I will not go into a long saga about underinvestment in IT in the health sector nationally and internationally compared to investment in IT in other industries. Suffice to say, far too little is spent. The focus and priority in Australia has been on getting better information systems in place for acute care and acute inpatient care. That has been driven by three factors. There is a significant amount of activity where information is needed to help in the actual care of the patient. It has also been driven by Commonwealth data requirements. The Commonwealth's requirements to date have been around inpatient data. It has also been linked to a number of financial issues such as billing health funds, workers compensation insurers and getting the Department of Veterans Affairs to pay. Australia recognises that there has not been enough focus on IT systems for out-of-hospital care.

Why is it more difficult to develop effective IT systems for out-of-hospital care? The first issue is the heterogeneous nature of the area. There are services run by State employees, contracted non-government organisation providers and local government and there are very small and very large services. The variety of situations makes it very difficult to find an IT system which will talk to all of those players and with which they are all happy. A practical example relates to general practice. In reality there are two major suppliers of software to general practitioners in Australia. While the technology is there to interface with our systems, the software suppliers have not been willing to make the necessary modifications free of charge. They want the State to pay them for every message to and from a GP. The cost of that is prohibitive, but I believe we will eventually sort it out.

That mixture of services is an issue, as are the technical arrangements to connect to them. I am saying this with very genuine sympathy for the sector, but it is difficult to get them to agree on the definitions, what should be reported and how things should be counted. With many of the services, because of their very nature, the mix has to suit the particular person. Very few traditional clinical services may be required; the patient may need home help, help with shopping, community transport and so on and oversight by a GP. How do you define that service as distinct from a post-acute care service where a nurse and/or doctor visits to do observations, administer medication and so on? Defining an inpatient is relatively simple, although there have been arguments about that over the years. It is much harder to get those data definitions.

The last factor is that there have been so many false starts in Australia with the national e-health agenda and we have all been waiting. It was going to be Health Connect in the 1990s, but that did not happen. Then there was the national e-health agenda and that has not happened. The National Electronic Health Transition Authority has helped by providing some standards, but to some extent everybody has been waiting before making any major investment. In terms of collecting data, we largely rely on manual systems. In the interim, before we move to a national e-health system, we are working with the two systems that we have in New South Wales now. One is the Cerner Electronic Medical Record and the other is the Community Health Information Management Enterprise. Both of those systems exist in New South Wales. The Cerner system primarily has been on the hospital side, but it has modules that allow you to gather information on out-of-hospital services. The CHIME system actually was built particularly for community health and out-of-hospital services.

We have refreshed and rejuvenated CHIME and we are expanding Cerner to go out of hospital. That will be our bridge for probably the next three or four years while we develop in conjunction with the national e-health agenda something more appropriate for out-of-hospital care. For example, the Hunter-New England Area Health Service has used CHIME for a number of years and now can provide very good data. Sydney South-West is using Cerner out of hospital and it can start to provide some good data. It is getting better. We agree with the conclusion of the report. It is not that there is an absence of information; there is an absence of easily collected information.

CHAIR: You stated that out of hospital care is the way to go but everyone has been waiting since 1990 and 2000; now it is 2010. We are 20 years down the track. My electorate of Blacktown has the largest population in the State. To get out-of-hospital care there is nigh on impossible. A day would not go by when I would not receive a complaint from people who cannot get out-of-hospital care. If we have put such an emphasis on it, as you have said we have, why have we not got it? Why is it not out there for the public to see it?

Dr SMYTH: Okay, there are three things on that. First, the services are out there but there needs to be more of them. Second, again it is this variety of services. When you say one of your constituents needs out-of-hospital care, it depends what sort of out-of-hospital care they actually require—

CHAIR: Very basic.

Dr SMYTH: —and whether that is through the Home and Community Care program, through the New South Wales health program or through a separate Commonwealth-funded program. A practical example is the interface with residential aged care. I can give you a personal example. My mother will be 87 in May. She has dementia and is in residential aged care in a hostel. She had an infected leg in February. Because that hostel could not provide intravenous antibiotics for just three days, four times a day, she had to go to hospital. She was in hospital for 10 days. The hospital does nothing positive for people with dementia, who are confused by being in different surroundings. I went up every morning to make sure she got breakfast and those sorts of things, but she actually did not need to go to hospital if that aged care hostel was able to have a nurse to provide intravenous antibiotics—tablets were not going to be strong enough—for just three days.

CHAIR: Why have we been waiting since 1999?

Dr SMYTH: They are not funded by the Commonwealth for that, so they cannot provide that.

CHAIR: Why have we not moved that way before now?

Dr SMYTH: One of the things has been the Commonwealth-State divide and getting high priority for out-of-hospital care services, and this is where I come back to community perceptions and the media again, emphasising that hospitals are important—they always will be. If you ask people what do we need more in health, immediately they say beds. They will not say more ComPacks or more CAPACs for out-of-hospital care services. We have to change that perception so that it gets a higher profile with the community. For example, we put another $11 million this financial year into the CAPAC services and will continue to invest more in those services each year. Geoff Barnden can tell you more about the chronic disease management program. That has a budget of over $20 million going up to $26 million over the next two years.

CHAIR: An MRI machine will cost you that anyway. You are not talking about big bucks as far as that is concerned, surely?

Dr SMYTH: For the amount spent on general practitioner services, on the Home and Community Care program and on community health services you are talking billions across Australia. It is not an infant industry. It is actually quite a big sector of health already, but it just does not get that focus. It is sort of out of sight, out of mind. Out of hospital is almost out of sight.

Mr VICTOR DOMINELLO: How much are you spending in promoting it and educating people?

Dr SMYTH: Clearly not enough. We put a lot of effort into—

Mr VICTOR DOMINELLO: How much was the figure?

Dr SMYTH: I could not tell you.

Mr VICTOR DOMINELLO: Can you get back to me on that?

Dr SMYTH: Yes, but as the Auditor-General's report would show, it is probably going to be hard to come back with an answer for you because, again, it depends on what you mean by promoting.

Mr VICTOR DOMINELLO: How much money do you spend on educating doctors, the public, whomever you want to educate, about the benefits of this program? Surely there must be a figure somewhere?

Dr SMYTH: I can certainly get back to you about the hours spent on that, but we have not gone into a mass media campaign, television ads and that sort of stuff.

Mr VICTOR DOMINELLO: Looking at these figures, in the past two years you have saved close to $100 million?

Dr SMYTH: You raise a good point. We have not saved it. What we have done is reduced the rate of increase that needs to be put into the health budget. You have raised a very important point. These programs do not save money in the sense of generating spare cash. When we say that the average cost of the out-of-hospital care program from the Ernst & Young study was about $258 per day compared to $780 in a hospital, that does not mean we have saved $500. To save $500 you would have to close the bed behind the person. The population is growing and ageing.

CHAIR: But you would save the difference?

Dr SMYTH: No, you do not save the difference. You reduce the rate of increase of the health budget. It saves the taxpayer and the community money; it is a more cost-effective way of care, but you do not save the $500—

Mr NINOS KHOSHABA: The bed is still there.

Dr SMYTH: —unless you shut the bed and say goodbye to the nurse who was on the payroll for that bed. The benefit of the program is threefold. First, It is better for the patients—better care in safety, quality and comfort. It is much easier to be at home than in a hospital. Second, It allows us then to bring another patient into that bed so that we are able to have shorter waiting times for surgery. That patient will be more expensive than $258 a day. If anything, it increases the expenditure. Third, is the effectiveness of the program. An example would be that in the New South Wales public hospital system we have reduced the total number of bed days occupied by people over 75 years of age over the last couple of years against the projected increase. That has meant that the amount that has to be invested in acute hospital beds for people over 75 is not as great as it would have been, but we are still spending more on acute hospital beds for people over 75.

Mr VICTOR DOMINELLO: What are the projections for this new program? How many patients will be using patient care?

Mr BARNDEN: In relation to the new chronic disease management program?

Mr VICTOR DOMINELLO: Yes, what are the projections? You received 60,000 last year.

Mr BARNDEN: No, what we are aiming to do is achieve a gradual growth program as we build the infrastructure. We are aiming to proactively enrol 6,000 patients in the first year, moving up to 43,000 patients by the end of the fourth year.

Dr SMYTH: It is an additional program.

Mr BARNDEN: This is additional to the 60,000.

Mr ACHTERSTRAAT: It might be helpful if Dr Smyth broke down the 60,000. Just to clarify, on page 30 we have broken down what they were. It might be helpful if Dr Smyth could update that.

Dr SMYTH: Yes, in the last financial year, the number of persons who received CAPAC—the hospital at home service—increased. When I first started back in the Department of Health in late 2008 I was told that one of our hospital's older people was taken to the OPERA. I thought, well, that is very nice of public hospitals to do that, but I found out that is the Older Person's Evaluation and Rehabilitation Assessment Service—acronyms are funny things in Health. So, 40,900 people received a CAPAC service, 11,800 received a ComPacks service, 1,200 received a service from the three pilot Healthy at Home—hospital in the home—services and approximately 15,000 people received a cardiology or respiratory, lung or heart disease, rehabilitation program.

Mr VICTOR DOMINELLO: What about rehabilitation for chronic disease?

Dr SMYTH: That is the 15,000, and that was up 20 per cent on the previous year.

Mr NINOS KHOSHABA: The 60,000 are those patients who received treatment or out-of-care services last year?

Dr SMYTH: Yes.

Mr NINOS KHOSHABA: I assume that many of those would have received ongoing treatment or out-of-care service from a hospital?

Dr SMYTH: Yes. There was a mixture. Some people just need the service related to that particular event. Other people are going to need a continuing service. They then get into the other programs through our community health services or the Home and Community Care program. Then with the severe chronic disease program, the focus is that there are groups of people, obviously with chronic disease, hence the name of the program, who either are frequent attendees to our emergency departments or have frequent admissions to hospital in relation to their chronic disease. The evidence from clinical trials is quite clear that if you have a targeted program to help those people better manage their chronic illness themselves—part of it is coaching and helping them understand their care plan, medications and nature of their disease—and then early intervention, if they need to come to the hospital they are identified quickly in the emergency department.

People who are skilled in the program can quickly work out, "Well, actually we don't need to keep you in the hospital, but what we're going to need is to increase the service that you're getting at home. I'll get that organised and we'll get you home" sort of thing, or if they need to be admitted, they are only admitted for a shorter period of time. That program is looking to then progressively enrol over the next four years 43,000 people who would be largely an age group over 65—except for Aboriginal and Torres Strait Islander people where chronic disease hits them much earlier and much harder. The target group there probably would be over the age of 45.

Geoff and his team, in conjunction with the health services, have been working on how we can, from existing emergency departments and hospital in-patient admissions systems, identify a target group of people. We have been able to successfully identify that. Now we are going to concentrate in the first tranche on the people who are frequent attendees in emergency departments or have more than three unplanned admissions a year and get them enrolled in the program, offer them the healthy coaching service, make sure they are connected into a care plan with a general practitioner, have someone nominated as their care coordinator and progressively roll that out to the next group so that over time we will have the 43,000 people enrolled. Out of the recent COAG announcements is that the landscape is probably going to change in the Commonwealth involvement and role in relation to primary care. That is still a little bit of a moving feast, but the New South Wales Government and the New South Wales Department of Health are committed to rolling out the program, but obviously we need then to make sure that it interfaces with whatever changes the Commonwealth makes.

CHAIR: What is your budget for that?

Dr SMYTH: It is $23 million going up to $26 million.

Mr BARNDEN: It is $21.5 million going up to $26 million.

CHAIR: Is that for four years?

Dr SMYTH: It is per annum.

Mr BARNDEN: Yes.

CHAIR: Is that enough?

Mr BARNDEN: At this stage we have enough for next year confirmed, but the projected estimate for next year is $26 million.

CHAIR: If you reach the 43,000, by the fourth year you have $23 million for 43,000 people?

Dr SMYTH: Our program will go up to $26 million over the four years. It is $21.5 million this year going up to $26 million. That is to run the program, which is basically the coaching services, the enrolment process, making sure the care plans are in place. Obviously, on top of that would be whether the person actually needs an admission to hospital. Obviously, there will still be the expenditure on the acute hospital admission, but it will be a shorter stay. Coming back to the point about savings, the program will reduce the rate of increase that would have had to happen to the health budget. That is the point I am making. It is not that cash comes out of an exhaust pipe that you can then spend on something else.

CHAIR: How do you pick up the 6,000? How is that advertised?

Mr BARNDEN: We can find them quite easily because we have excellent data systems in this respect and in respect of inpatient health data. We apply an logarithm and we have our experts identify, using all the existing data, those patients who in the past 12 months had more than three unplanned admissions covering the disease categories that are part of the program. They have identified the patients and they can do that using the area-unique identifier number. We have been able to identify each patient and provide patient details to each of the areas so that they can start looking at these patients with a view to enrolling them.

If I could just mention some of the statistics which I think are quite interesting. We have identified, using that algorithm over the last 18 months, because we did two applications, more than 7,400 patients had three or more unplanned admissions within a 12-month period. Of those, 1,114 had four unplanned admissions, 653 had five unplanned admissions and so forth. It builds up, but the bottom line is of those 7,000 patients over 220,000 bed days were involved and each of them stayed an average of about 28 bed days unplanned each year in an acute bed. So it is a very significant cost.

CHAIR: So those over 7,000, they are now in this program, are they, or you have nominated them?

Mr BARNDEN: We have nominated them. We have asked the areas to look at them. These are people with severe chronic illness and some of them have since died, but what we are doing is now assessing them in each area with a view to enrolling them in the program.

CHAIR: So do we have any in the program at this stage?

Mr BARNDEN: We have not got any in at this stage but we expect that by the end of this financial year we will have a significant number enrolled. What we have been doing is actually working with all the stakeholders in the areas, all the area health services and all the GP divisions across the State because the GPs are a key part of this and we want some of the services, if appropriate, to actually be delivered by GPs and GP divisions assisting the health system, because what this does is actually start to establish a core of primary care services.

CHAIR: But it is a bit misleading to say we have 6,000 people this year in the program when we have got none.

Dr SMYTH: It is a question I ask Mr Barnden every week is that, "When will you have the first people enrolled in the program"—

CHAIR: So we have zero at the moment.

Dr SMYTH: We are pushing him hard to get them in.

Mr BARNDEN: What we have done is we are approving plans, which will all be approved this month. All the funding will be going out to the areas and then areas will be able to work with GPs who will also get funding, the GP divisions that is, to actually start enrolling.

CHAIR: Why would we not have had this sort of program before?

Mr BARNDEN: This was a program recommended by the Garling report and that is actually why we are doing it and also by the Auditor-General. So this is a program—

CHAIR: What was the Garling report?

Dr SMYTH: A special commission of inquiry.

CHAIR: Yes. When was that?

Dr SMYTH: At the end of 2008, November 2008.

CHAIR: That is right, 2008, and we still do not have anyone in the program.

Dr SMYTH: Your concern is shared by many in the department but the rate limiting steps are that you need to identify the patients. You then obviously cannot enrol patients without asking them, and they obviously want to know, "What am I being offered?" and those things there. There have been quite a number of difficult issues to work through with general practitioners in terms of "no, this is not a takeover of your practice", "no, we are not going to take over the patient", who owns the patient type of issue. And then getting in place the elements of the program about the coaching services, the telephone coaching line, for example, identifying who the care coordinators would be. But there have been services already on the ground and out in Sydney west and actually at Blacktown Hospital is where they identify the people coming, frequent attenders to Blacktown ED. When they arrive in the ED, if they are on that program, a pager goes off to the coordinator, the coordinator comes down to ED and actually sees the person, talks to them, sees whether they actually need to be in the hospital. If they do they then fast track them to organise a bed. There are 4,000 people on that program at Blacktown Hospital alone.

CHAIR: Have we written to any of those 6,000 that we are talking about? Do they know about it yet?

Mr BARNDEN: Not yet, no, because we cannot approach them until we have got their GPs involved.

CHAIR: So we really do not have a program.

Mr BARNDEN: What happens is that a lot of these patients who are involved are already enrolled in some of our chronic rehabilitation programs and some other individual programs.

CHAIR: That is fine. That still does not help the patient because it is a program but no-one is in it.

Mr BARNDEN: Yes.

Dr SMYTH: The elements are there. It will become live very soon, but I take your point.

CHAIR: When you say "very soon" give us an idea how long?

Dr SMYTH: Three months.

Mr BARNDEN: I would say we would be enrolling the patients in June because we have approved the plans this month.

Mr NINOS KHOSHABA: How will it be broken up? Will the hospitals be managing it, or does the Sydney South West Area Health Service look after the whole area or will it be the responsibility—

Mr BARNDEN: It will not be the hospital managing it. In each area we have issued some comprehensive guidelines because one of the things that all the stakeholders said was, "You can't just impose this. It has to come from the bottom up". So we went to work with all the area health services and particularly the directors of community health, the community health strategy, and then they in turn have worked with their local GP divisions to build partnerships so we actually get ownership because the program is essentially out of hospital. So it is about identifying these people.

People constantly go to hospital and then putting them in a program which will actually give them a connected care pathway within the community and connecting them to many of the existing services, because whilst you are looking at only four of the out-of-hospital programs there are over 25 different programs out in the community and part of the problem is that these patients and their carers, and half the time their clinicians as well, cannot navigate the system. It is really complicated. What we want to introduce is a shared care plan that

each patient will have a care coordinator. That care coordinator will then be able to assist the patient in managing the journey, assisting them with not only clinical issues but non-clinical issues as well.

So we want to make sure they are connected to all the HACC programs and all the services the Commonwealth provides as well because there are many services that are not only run by the State but also by the Commonwealth as well as NGOs. So this is a connected care program and it is quite new in that sense because we have not done this to this extent before. We have involved the Commonwealth in it so we have actually got the Assistant Secretary of Chronic Disease and Mental Health on our clinical reference group. So they are very keen to make this program work and to work with us. We have put in these regional guidelines and we are hoping that in each area there will be a governance committee which will involve community health people, the hospitals, the GP divisions, the ADHC people so we will actually get some regional cooperation and regional strategies which connect all the many programs because there is so much going out there but what we have got is lots of individual things. If you can connect them, then the patient will be better looked after. They will not go to hospital; they will stay in their home with their carer.

Mr NINOS KHOSHABA: I guess my question is: when the program is up and running I am assuming there will be a certain amount of spots allocated to every region or area?

Mr BARNDEN: That is right.

Mr NINOS KHOSHABA: And you are talking about this governance committee. How does a patient know who to go to? Let us say that a patient meets all the requirements, ticks all the boxes and should be on that list. How does the patient know where to go? Is he referred to by the hospital or how will he be contacted?

Dr SMYTH: Under the program, we will actually be approaching the patient to enrol them in the program and then if they agree to be enrolled—and it is entirely up to the patient and carers whether they do; it is voluntary—once they are enrolled in the program they will have a nominated care coordinator, a contact point. They will have their GP. There will be a shared care plan. That will be much clearer to the patient, irrespective about whether they are at home or they arrive in an emergency department or they need to be admitted into hospital. A lot of the elements of this new program are actually already in place across New South Wales in different parts of New South Wales. There are some great programs on the North Coast. There is that program at Blacktown emergency department. There are some really good programs out in other parts of rural New South Wales.

So it is not as if it is a greenfield site and there is nothing there, but what has been missing is a proactive assertive process of going to the people to enrol them in the program, rather than waiting until we or their GP find out that they have a chronic disease and need to get better services, putting the coordination in and making it easier for the patients and, importantly, for their carers so there is less navigation they have to do. We do that for them. And, thirdly, trying to integrate the various service elements, not just the health element but the home care and support, the community transport, all the other things that people need to stay healthy at home. That will be the major benefits out of it. Supported by good IT but we do not need the IT to start it.

Mr VICTOR DOMINELLO: How long have you been aware that out-of-hospital care is economically a good thing to do?

Dr SMYTH: Probably the third year I was a doctor. I started as a doctor in 1977 in the New South Wales health system. If you look at the attitudes towards children, and I think this is an example, and that was led more by parents than by paediatricians and health departments, is that—I mean, I am old enough to remember back to the 1960s where the visiting hours to the children's ward was restricted to three to four and mum and dad could not stay with their kid and all those sorts of things. That whole thing revolutionised, and parents drove that. And so now it is very rare to have a child admitted to a hospital that does not need to be admitted, and when they are admitted they stay in hospital for as short a period as possible. Everybody knows it is better—

Mr VICTOR DOMINELLO: So you have known for decades that this is a good thing to do and you have realised at least since September 2008 that it was a good thing to do, as the Auditor-General noted in his report. Why then did you require an economic evaluation to be communicated to you before you ensured that the health professionals were informed about out-of-hospital care?

Dr SMYTH: Because there are still a lot of doubting Thomases out in—

Mr VICTOR DOMINELLO: But you are not a doubting Thomas—

Dr SMYTH: I know.

Mr VICTOR DOMINELLO: —and you are one of the people in charge. You are one of the leaders and you have known for so long. Why would you delay such an important program? Forget the doubting Thomases, they do not get a say in terms of leadership. Why did you delay this?

Dr SMYTH: I have not delayed the programs. I ran the Hunter area health service from 1991 to 1997 and we implemented the programs in the Hunter-New England area health service.

Mr VICTOR DOMINELLO: I draw your attention to page 9 of your submission and it says, in relation to 3.6 of the recommendation of the Auditor-General, to ensure that the health professionals are informed of how out-of-hospital care will affect them and their patients, your response was, "delayed, as detailed in recommendation 2, following the completion of the economic evaluation a communication strategy will commence in 2010". So it has been delayed.

Dr SMYTH: That is in relation to those specific programs.

Mr VICTOR DOMINELLO: Precisely.

Dr SMYTH: There has been no delay in having health services to support people at home.

Mr VICTOR DOMINELLO: But those programs would no doubt increase the amount of out-of-hospital care, would they not?

Dr SMYTH: Yes.

Mr VICTOR DOMINELLO: Then why were they delayed?

Dr SMYTH: We have expanded them. We have not delayed them.

Mr VICTOR DOMINELLO: Then whey did you say they were?

Dr SMYTH: Delayed the communication has been because part of the problem, and I came back to the Department of Health in late 2008, so in early 2009 it was pretty evident to me that we actually have a lot of these programs. They all have different acronyms, they have different eligibility at entry pathways and doors in and doors out. So I think we do need to really review and refresh how we actually badge these and I think from the community's point of view I think hospital in the home sounds like the right terminology.

Mr VICTOR DOMINELLO: With great respect, Dr Smyth, I talk from personal experience. I was in Royal North Shore and there was a stuff-up in an operation. I do not know whether I should disclose this. I had a cyst. It turned out to be a brachial fistula. One thing led to another. I had an abscess. I went back into North Shore emergency and they had to drain it. I was in hospital for three or four days and I was climbing the walls because I was in one of those 23 hour and I was climbing the walls and I said, "You've got to get me out of here. This is crazy. All I am doing is getting a drip." I had to make that many inquiries before somebody somewhere higher up in the food chain said, "We could do this for you." But it took me days of complaining, of what am I doing in this bed. That happened in circa 2008. I have no doubt that if the Auditor-General's recommendation to ensure that health professionals are informed of how out-of-hospital care will affect them and their patients was implemented two or three years ago they would have approached me rather than me approaching them. Is that a fair observation?

Dr SMYTH: And if you had been to Bankstown Hospital they would have, and if you had been to another—

Mr VICTOR DOMINELLO: I was in Royal North Shore.

Dr SMYTH: I know, but the point I am making is that those programs are in place—

Mr VICTOR DOMINELLO: It was not in place in Royal North Shore.

Dr SMYTH: I know but they are in place in New South Wales and what we do need to do is we do need to expand them so it is not as if we are starting from a greenfield zero base, and secondly we need to get more of the health professionals committed to them and that it actually is not something that they are going to lose the patient, that they are going to be taken over by somebody else. There is also a philosophical debate about whether you have a specialty, you have a lung community service and you have a heart community service and a leg community service. Hopefully I think everyone in this room would say, "Wait a minute, have I got a heart problem, a lung problem or a leg problem? Why do I have to have three different services?" So it is building commitment from health professionals that in fact this form of care is not going to diminish the training.

It is not going to impact on their practice. It is not going to be the end of their careers. And there are a large number of health professionals, particularly allied health but strongly now more medical and there has been a very strong commitment from nurses to this. I think we have virtually reached the tipping point where there will be so much momentum now that we have solved that problem. We have indeed got to work on making sure that it is a more organised program and easy to navigate. Then we have to work on the community, particularly the media, perception that out-of-hospital care is not substandard care.

CHAIR: What has been done to change that? You say that we are there now, so what have we done to change that opinion?

Dr SMYTH: We have had a range of health professionals that have been championing it, have actually done it, and have proved to their colleagues that it works. That is a lot of how you get change, particularly in the medical profession. The department can issue policy directives until the cows come home, but the medical profession responds much more to example and what they regard as their peers and their leaders. Also there has been a lot of innovation in places where the population has been growing. They have to build new hospitals in big lumpy pieces, as you know, in the north-west corridor. We are going to have to do more for the north-west corridor of Sydney as well as the south-west corridor. They have to be more innovative, and so they have developed these services and they show that they work and the patients like it. So you get a pull factor from the patients and carers, and you get a push factor from the clinicians.

CHAIR: To change it that way is a little like instead of using Telstra you start using the Pony Express again. Is that not the slowest way to change things?

Dr SMYTH: No, I would not use the Pony Express as the alternative; using the Internet instead of Telstra might be a better analogy.

CHAIR: It seems a very slow, cumbersome way to change something that is so imperative to health care.

Dr SMYTH: Some things change in health care almost overnight. Some do not, that is one of the things in health in terms of how you get change in how health professionals work. It is quite a difficult agenda. There are tonnes of research about what makes doctors tick, what makes them change what they do. We have been very successful with surgery. The percentage of surgery done on a day-only or extended day-only basis is now up to 80 per cent. When I started as an intern, a person undergoing a cataract operation in a hospital was in for a week. It is now only hours for a cataract operation. In some orthopaedic units, after a hip or knee replacement for appropriate patients, they could go home, with support, within three or four days. It used to be two weeks.

CHAIR: But the urgency of using their beds changed 90 per cent of that. Not what the doctors had done.

Dr SMYTH: That was partly a factor. It was partly a factor of where it shows that it works and is safe, so the doctors have confidence in doing that. Also, if you take diabetes and asthma, the majority of people with diabetes do not get admitted to hospital for stabilisation of their diabetes, like they did in the 1970s; they are admitted for complications of the diabetes such as eye, vascular, or whatever. The management of diabetes is so much better now, people know how to manage their diabetes. The same with asthma. Some of it is patient factors and some is health professional factors. But I am not resiling from your point about why we are not going faster, and should we be going faster. I agree with you.

CHAIR: You mentioned a few times the super-duper 4,000 people program at Blacktown. What is that? I have been there for a long time and I thought I knew everything that happened at Blacktown.

Mr VERMA: It is called care navigation. Essentially it is what Mr Geoff Barnden described earlier; identifying those patients who have chronic heart or lung problems or diabetes conditions and proactively going and getting them and flagging them on the system as soon as they appear, whether in the ED or the outpatients or in community health. The care navigator, their contact person, goes and gets them.

CHAIR: Has that started at Blacktown?

Mr VERMA: Yes, it has been going for a year and a half.

CHAIR: I have pushed for years and we got a catheter laboratory out there in the past few months. More people die from heart attacks in Blacktown than in any other part of Australia. I do not know about the care navigation there.

Mr VERMA: It has been going for a year and a half and they have shown that it has reduced hospitalisation of the people they have enrolled. They are being managed.

CHAIR: It has been reduced because we have not had a catheter laboratory. A lot of people have died while waiting to be transported to Westmead hospital for the catheter laboratory facility.

Dr SMYTH: Yes, and as you say, the cardiac catheter laboratory will be operational at Blacktown Hospital in September. The first lot of equipment is there, this month.

CHAIR: And it has taken me 22 years to get it there.

Dr SMYTH: Also we have been working with the Ambulance Service on the early thrombolysis program. We are now rolling out new technology into ambulances so the paramedic can take an ECG and electronically transmit that, not by Pony Express but through the Internet, to a hand-held device to a cardiologist at home or in the hospital, or wherever. The cardiologist can read that and say that the person has had a heart attack and give permission to give treatment. That is world-class treatment.

CHAIR: World-class. I opened a nuclear medicine section at Blacktown Hospital about five or six years ago. In the past few months I went and inspected it. And do you know what is there now? Not even a pencil! Nothing! We had nuclear medicine in the old hospital before the new one was built in 2000. Blacktown has the fastest growing population in Australia, with not one extra bed in its hospital. The Prime Minister came out there the other day and I asked for 110 beds, and he gave me 18.

Dr SMYTH: The first instalment, it will not be the last.

CHAIR: Yes, the first instalment. It is like asking your dad for a motor car and when you get up the next morning he has a pushbike for you.

Mr JOHN TURNER: Following on from your comments at Blacktown with the care navigation and Mr Dominello's problems, we are not islands. A pass system is not needed. If you can do that at Blacktown, why can you not do it at Royal North Shore?

Dr SMYTH: Exactly.

Mr JOHN TURNER: I appreciate your problems with health professionals. One easy way to fix that: money. That would sort them out very quickly, and not give them more but take it away if they do not want to be part of the system. I find it amazing that you have been very proud about what is happening there, yet 20 kilometres down the road as the crow flies there is nothing. It is like going across the border into another country.

Dr SMYTH: I agree and that is one of the drivers to get a more comprehensive, integrated program, but also to learn from what has worked and what has not worked, and how we can build on that. Plus, rural has different needs from urban. A number of programs have been able to recruit and retain allied health

professionals. That is very important to those programs. There are pockets of New South Wales where we have not won the heart and soul of every GP in the area, so there are a number of roadblocks there. I agree with you. It is about how to find the balance, without going into the politics of letting a thousand flowers bloom in various countries, and about how you maintain creativity and innovation so you do not stifle them by saying that everybody has to do it this way.

However, at the same time, you need to make sure you learn from all those projects and then roll it out. We have done that with planned surgery and now we are doing it in terms of organising the acute emergency surgery. We have learnt a lot from the projects we have done about improving the processes within emergency departments. I accept that there is still more we have to do on how to get that spread across a State so that everyone has access to the program. In some parts of rural and remote New South Wales logistically it is not possible, but we still want to provide them access to the service.

Mr VICTOR DOMINELLO: Please keep your answers as short as possible, we are running short on time. I am new to this, so forgive my training wheels. When I came here I saw one of my responsibilities as to hold you to account, because the public need that, particularly in relation to things that have been delayed. Recommendations have been put in place. Can you explain in short compass the explanation for the delay to implement recommendation 3.6 on page 9 of your submission?

Dr SMYTH: I will defer to my colleague.

Mr VICTOR DOMINELLO: Why was it delayed?

Mr VERMA: A lot of these programs start with an enthusiast who uses research money to start a little program. Hospital in the Home started in two or three places with one doctor who got some research money and ran the program. It looked really good, so we started seeding some other programs. Hospital in the Home started at Prince of Wales and at Campbelltown. They convinced the doctors in the hospital that it was a good idea to refer. So we then funded some more programs and started funding it statewide. But the economic evaluation we did to try to make a case across the State, because there was no hard evidence—

Mr VICTOR DOMINELLO: Dr Smyth just said about 10 minutes ago that he was aware that this is an economically efficient way of going about it.

Mr VERMA: But we have no numbers, there were no dollar figures for us to say that it cost so much.

Mr VICTOR DOMINELLO: On what basis did Dr Smyth tell the Committee that it was economically efficient?

Dr SMYTH: Practical experience, from running hospitals and health services.

Mr VICTOR DOMINELLO: Exactly. Then why were you waiting?

Dr SMYTH: Because some health professionals want to—

Mr VERMA: A lot of doctors like their patients in hospitals.

Mr VICTOR DOMINELLO: In September 2008 the Auditor-General published a report that showed, and I am looking at the figures, that economically it is a good way to move forward.

Mr VERMA: That was on three sites.

Mr VICTOR DOMINELLO: Precisely. So why was there a delay, notwithstanding this report?

Mr VERMA: There is no delay in rolling out the money. We put out another $11.9 million this year.

Mr VICTOR DOMINELLO: But the delay in implementing the recommendation, you were waiting for another report from Ernst and Young. That was the basis on which you were doing it.

Dr SMYTH: Yes.

Mr VERMA: The programs are rolling out. They are already being used.

Mr VICTOR DOMINELLO: I still do not have an explanation as to why there was a delay.

Mr VERMA: The delay was in one communication strategy for all clinicians. We have not done one communication strategy for all clinicians, but every service that we set up has done local communication with their doctors who refer. But we have not done a one-off, which is what this says.

Mr VICTOR DOMINELLO: Why?

Dr SMYTH: I recognise the time constraints. There are a couple of reasons why. The National Health and Hospital Reform Commission had been established and we were waiting to see what its report would do to reorganise the Australian health care system, particularly in relation to primary care. Secondly, if you have ever tried to engage consultants and actually organise a consultancy and make sure that it is to time, that is another factor as to why it took a long time to get it done. The third factor was getting the study done, which we regarded as part of the ingredient we needed to go out to the doubting Thomases in health professional land to say that it does work. It was not just looking at economics; it was also trying to look at outcome indicators and other things.

CHAIR: Are you sure that the doubting Thomases were not at the top?

Dr SMYTH: No, definitely not at the top.

Mr VICTOR DOMINELLO: You had the Auditor-General's figures in September 2008. I would have thought you had enough to move on that.

Dr SMYTH: We have.

Mr VICTOR DOMINELLO: No.

Dr SMYTH: That is the answer to your question.

CHAIR: The first point you gave about the changes federally, that is only recent. That was not there in 2008.

Dr SMYTH: Exactly. The commission was set up in 2008 and it did not deliver its report until late 2008, or early 2009. I cannot remember, the years blur.

Mr NINOS KHOSHABA: For the record, I support the Out of Hospital Care Program. I guess it will be an option; patients do not have to take it up. For most patients it will be an option. I can see many patients benefiting from it rather than having to go to hospital. Better to have someone come to the home and administer. You spoke about doctors and health professionals and some have been doubting Thomases and some have championed for the program. Earlier you mentioned that there is a fear or concern of them being taken over. What exact concerns do they have? When you talk about them being taken over, how will you impact on their practice or the doctors or health professionals? What are the benefits to the health professionals? Are they getting compensated for their services, their assistance? How does it work exactly?

Dr SMYTH: Again, I have a couple of points. There is a constellation theme about the type of practice and how that particular health professional works. For those who are largely hospital-based for their practice, they basically prefer the patients to come to see them at the outpatients or the hospital. Part of the exercise there is an understanding that you are not going to lose the patient, that the service is actually going to go out to them. Within general practice, there is concern about who is going to be looking after, or ultimately controlling at a clinical level, the care of the patient. There have been some inter-professional tensions about the role of a care coordinator or a nurse versus a doctor. I think we have largely worked our way through that in Australia.

In terms of payment, by and large there is no real negative impact on payment systems. There is a little bit of Commonwealth-State sort of thing, about who pays the GP in these services, but they are things we can work through. Private health funds are authorised under the Private Health Insurance Act to get into out-of-hospital care. They have been exploring some of these models, with a mixed degree of success. I do not want to overemphasise that as a problem going forward, but it has been an issue in the past.

Mr NINOS KHOSHABA: Surely the patient's health care should come first?

Dr SMYTH: Absolutely.

CHAIR: What quality indicators will we have for out-of-hospital care?

Dr SMYTH: A combination of people having to be readmitted or come back into the emergency department; that is one set of indicators. We have a system where, if there are any adverse events, they are reported to us. We have very few adverse events reported for persons on out-of-hospital care programs. That is almost logical: Because they are not in a bed and in a confused space, they are less likely to be having multiple treatments, they are largely on a care plan that is protocol driven, and those sorts of things. An important ingredient of safety and quality is satisfaction. The feedback we get from surveys, the feedback we get from letters and compliments, and the feedback we get from the staff who say what the patients and carers have said, is uniformly positive.

Mr VICTOR DOMINELLO: I hear from a lot of my friends who are doctors that you do not want to stay in a hospital because of the risk of infection and the like. Is there any data in terms of how many people have to stay in hospital for an extended period due to secondary infections—which would be preventable had they exercised out-of-hospital care?

Dr SMYTH: There are a number of studies. There was one released last year, which is a national research study about the number of bed days associated with healthcare associated infections. Across Australia, that is hundreds of thousands of bed days. That is a very significant problem—

Mr VICTOR DOMINELLO: Is that being factored into the Ernst and Young report, in terms of a cost benefit analysis?

Dr SMYTH: Those studies have basically looked at the patients in hospitals; they have not separated out people who could have been on an out-of-hospital care program—

Mr VICTOR DOMINELLO: But by extrapolation, surely that would then add to the bottom line in terms of how valuable this program would be?

Dr SMYTH: Yes.

Mr VICTOR DOMINELLO: Is it possible to provide us with figures on that?

Dr SMYTH: We will have a look at some of those studies. We would probably have to apportion it on the basis of the case mix. But the challenge here is not an argument about whether these are good programs; it is how to get them out there in the public—

Mr VICTOR DOMINELLO: To use your words, we want to convince the doubting Thomases?

Dr SMYTH: Yes.

Mr VICTOR DOMINELLO: No doubt, if you extrapolate those figures and throw them in with the Ernst and Young figures, I think the case would be unanswerable?

Dr SMYTH: Yes, I agree.

CHAIR: Is there anything else you would like to say, gentlemen?

Dr SMYTH: No.

CHAIR: I would like to see if you can come back in three months time, to see whether we are on course with the starting of the program, how many people we have signed up, and so on, if that is all right with you.

Dr SMYTH: That would be fine.

(The witnesses withdrew)

(Short adjournment)

CATHERINE BURN, Deputy Commissioner, Corporate Services, New South Wales Police Force, 201 Elizabeth Street, Sydney,

MARK JENKINS, Assistant Commissioner and Commander of Corporate Force, New South Wales Police Force, 201 Elizabeth Street, Sydney,

JULIE ANITA WILLS, Director, Safety Command, New South Wales Police Force, 151 to 241 Goulburn Street, Darlinghurst, and

JANE TEBBATT, Director, Performance Audit Branch, Audit Office of New South Wales, 1 Margaret Street, Sydney, sworn and examined:

PETER CHARLES ACHTERSTRAAT, Auditor-General, New South Wales Audit Office, 1 Margaret Street, Sydney, on former oath:

CHAIR: I note that all witnesses have the benefit of parliamentary privilege here today. I also point out that any deliberate misleading of the Committee may constitute a contempt of Parliament, an offence under the Parliamentary Evidence Act 1901. I invite Ms Burn and the Auditor-General to make a brief opening statement.

Ms BURN: I know we are here in respect of the Auditor-General's report "Managing Injured Police" and that a number of recommendations came out of that report and we had been reporting on those. I am aware that the Public Accounts Committee has also sought information from us and that we have provided some information. Generally speaking, we welcomed the report when it first came out and we accepted many of the recommendations. There was really only one—and that related to permanent restricted duties officers and positions—that we gave an explanation to. All those other recommendations we have taken on board.

I think that the New South Wales Police Force definitely is in an improved position, probably since 2006 and then since the Auditor-General's report. I note from the work that both these two people do that the amount of strategic work that has gone into managing injured officers has really excelled, as has the amount of operational process-driven work—which is really important to get the front end of the process and systems right, but to also focus on some of the more strategic issues, like the causes of our injuries and why our officers get injured, so that we try to prevent it. Prevention and early intervention is definitely our priority.

Most of our injuries are physically related. We say that about 20 per cent are psychologically related. They are the ones that probably cause us the most concern and are our problems, and we have done a lot of work on that. I can expand on that if you like, or wait to be asked questions. There are a lot of organisational, strategic things about trying to address psychological injuries. We have also recently had announced a realignment in the New South Wales Police Force. The parts of the injury management command under safety that were focused on workers compensation, death and disability—basically post-1988 injured officers—have now all been amalgamated into one, so that we now have a coordinated, improved and holistic management of our injured officers, regardless of when the injury occurred. Although we understand there were different schemes and different insurance issues, we now have better, coordinated case management, which we think will add another nice dimension to it. That has very recently happened also.

There is one other issue, I guess, and that is the death and disability scheme. We negotiated a police award, which expires at the end of the 2011 financial year. Part of that award and what is written into that award is that the death and disability scheme as it exists will remain until after the completion of that award. There is nothing we can do with the current scheme at the moment, but we will be entering negotiations with the association as part of what we wrote into our memorandum of understanding to commence a process of seeing how we can review the scheme.

Mr ACHTERSTRAAT: I would also like to thank the Police Force for the way they have approached this audit. The reason I chose to do this audit was that when we compared some of the New South Wales figures with some of the other States' figures there was a suggestion that it was an area where there could be improvement. I am pleased that my discussions with the commissioner and the others in the Police Force have got a commitment to improving this area, to get police back to work quicker and to manage the area. I am certain there is a strong commitment to do that. I will be interested, with the questioning, in the progress

involved. Recommendation 9 understands where the police are coming from. Recommendation 14, in relation to the scheme, is a very complex and significant area to go through.

CHAIR: I note in the report on page 33, exhibit 15, a part that says that about 60 per cent of officers who are hurt get medical retirement. If you compare that to other agencies, they rate around the 13 per cent. Is there any reason why the New South Wales Police Force medical retirement rate is three or four times higher than in any other jurisdiction?

Ms BURN: There are a couple of reasons that we could suggest. With the two schemes, the death and disability scheme is an interesting scheme. In some ways it could be interpreted as being more conducive to having a retirement from the Police Force, rather than coming back to work. I think it was alluded to in the report that there might be some sort of disincentive in relation to a lump-sum payment that is there, that was part of that scheme. Potentially—and this is one of the things we are having a look at—there are people who do not come back to work but who retire because of that perspective. That is one possibility. The other thing is that policing is quite a dangerous job and people do get injured, unfortunately, and people do have to exit. As I said, a lot of our injuries are physically related and they do have to exit the organisation.

CHAIR: I accept that. It is a very dangerous job; there is no doubt about that. But it is also dangerous in every other State, and their medical retirement rate is 13 per cent, compared with about 60 per cent for New South Wales.

Mr JENKINS: I think one of the key things there is that the schemes interstate are not the same as the schemes we have here in New South Wales. We have a pre-1988 scheme in place for police officers, and it is a very good scheme. We also have a death and disability scheme, which is for police officers who are working on the street. If they do become disabled, if they are hurt, it is a very good scheme. I have talked with some of my counterparts around Australia, and they do not have similar sorts of schemes in their jurisdictions. Sometimes the alternative to medical retirement in some of those areas is simply resignation, because the awards just are not the same as they are in New South Wales.

CHAIR: What about post 1988?

Mr JENKINS: Post 1988 is exactly the same. It is quite generous in New South Wales, if I could term it in that fashion. However, the interstate schemes are not as generous as we have in New South Wales and they do not have the same characteristics as we have in New South Wales.

CHAIR: Could it be a factor that we do not rehabilitate as well as we should? When we look at the figures, we are losing people who have had years of experience. Rather than rehabilitate them and get them back to work, we are putting them on the bench and sending them off to early retirement.

Ms BURN: That is a very good point. That is why, especially with the better coordinated unit, our focus is on return to work under pretty much all circumstances. It definitely is a push. There is a whole range of units and processes in place now. We can even speak to the medical practitioners who are dealing with these injured officers. We can say, "We have a position for them. We can place them somewhere." The number of officers now who could be cleared for suitable duties is getting increasing and we are placing them a bit better. There are difficulties in placing some officers who are injured, without doubt, especially if they are injured in country areas where there are not a lot of positions. You cannot have 50 police all in one place injured. So there are difficulties, but we are working on it. If we can get them back to pre-injury duties that is a fantastic achievement. If we can get them back to what is called permanent restricted duties and find them a position that is much better. That is exactly our focus now. I think there once was a time where probably the option was it was easier to go out, but not any more. There is a whole range of reasons for that. Especially in the metropolitan areas, they are extremely good at getting their officers back as soon as possible in any capacity now.

CHAIR: From the point of view of the police officers, if the powers-to-be care and want them back at work, that is an incentive for them to get back to work.

Ms BURN: Absolutely. We used an example recently. There was an experienced officer who, unfortunately, was diagnosed with cancer. The officer went through an operation and started chemo. Everybody was doing everything they possibly could to accommodate this person. They said, "Of course you can come back even if it is only one day." This officer had cancer and you would do everything for the person. We are saying, "This is the culture we want for all injured officers: Of course we will get you back into the workplace.

Of course we want you back even if it is only for four hours a week." They are the sorts of messages we are talking about with our commanders.

Mr JOHN TURNER: You mentioned the culture. Has the culture changed? In the past the culture was, "If we get hurt let's get out, go off and do something else." It was not all officers, of course, but that seemed to be the culture. Is that culture coming out of the system?

Ms BURN: I think so, I really do. As the Chair showed with those figures and not having police officers available to do the work, it impacts on every other police officer. It is better to have the people in the workplace because everybody benefits from that. It is more cultural in some areas than others, and we have a lot of work to do. One of the issues that we are working on with the Police Association—and this is focusing on some of the causes of psychological injuries—is rolling out a leadership program to our sergeant level supervisors. Normally with this group of people we train them but it is about the process, the outcome, the form to fill in. But with the Police Association and other partners we have put in place now a leadership course for them. It is a one-day course about identifying those leadership and cultural issues on the front line. They are the ones who influence the officers. I can say what I want and that I want them to do it but it has to go all the way down. It is the supervisors who are at the front line. We are hoping that will have a big cultural change.

Mr JENKINS: It starts on 8 June. I was at Richmond this morning opening a session for the trainers in relation to that particular program. We are rolling that out to about 3,100 sergeants who, in real terms, lead 11,500 of our troops. It is a critical part of our organisation to ensure that we get the right sorts of behaviours and leadership behaviours in that particular area. We are working on that very hard.

Mr NINOS KHOSHABA: Ms Burn, the department is receiving funding in the 2010-11 financial year to set up an electronic data system to monitor the effectiveness and efficiency of injury management practices. When will the new system be set up and running? What will it allow you to achieve?

Ms BURN: We have funding for the financial year 2010-11, we have put the business case through, and we also have funding for the following financial year. That system will not be operational until probably 2012 in its full capacity. In the interim we have databases. It is more manual; it is not integrated. It will definitely be an improvement. It was one of the issues raised in the report. We definitely agreed and we have taken that on board. The technological solution has taken a bit of time. Unfortunately, it seems to take time. It will be better. I can get Julie to talk more about it. Even since the Auditor-General's report, even though they are manual systems now, we have improved them and we have more electronic systems. It is just not as coordinated and integrated as we would like. We have introduced forms for investigation and reporting. We can get the statistics and information from there and identify a trend. I am not overly panicky that we are waiting till 2012. It will be better then, but it is much better now than it was.

Ms WILLS: The injury management advisers carry reasonably high caseloads. The system will provide them an easy to-do list as to what they need to do every day. It will prompt them. They will get to their desk, they will open up their system and it will prompt them, "You need to make your fortnightly check with the following officers", "You need to ring the doctors on the following officers". It will basically guide them through the stages of the return-to-work process. At the moment they manage that through spreadsheets, to-do lists and other systems that they have. It is effective but it creates a greater pressure on these staff, who are already quite busy. The system will alleviate a little bit of pressure on the staff. It will also allow us to get some better data around certain time frames. At the moment we monitor key performance indicators [KPIs] for time frames that the organisation has deemed important to monitor. If a new request came in that we have not looked at before we would have to generate that manually. The system will be able to tell us all sorts of data about compliance, time frames, average time for interim measurement staff to undertake a certain action, all those things that we need to do manually at the moment.

CHAIR: It was supposed to start in March this year. Has it started?

Ms WILLS: The case management system?

CHAIR: Yes.

Ms WILLS: We have developed detailed user specifications for it and the business case. We have been awarded the money. The next stage is to move into the initial development aspects.

Mr NINOS KHOSHABA: Does the Auditor-General have additional comments on this matter?

Mr ACHTERSTRAAT: A manual system is always the more difficult to do. We are pleased that there is funding and a commitment to the electronic one. More fundamentally, we are pleased there is a commitment to actually doing things as well as measuring them. I think we are on the right track there. When the Deputy Commissioner mentioned culture, it all comes down to that to a certain extent. It is not helpful when we have articles in newspapers and so on that suggest other things. It is a difficult area to manage.

Mr VICTOR DOMINELLO: I refer to exhibit 15 on page 33 of the report. Do we have updated figures? The last figures we have are for 2006-07. Do we have figures for 2007-08 and 2008-09?

Ms BURN: We do not have the comparison with Victoria.

Mr VICTOR DOMINELLO: I am not so much worried about Victoria as I am about our figures.

Mr JENKINS: The total police separations in 2008-09 were 655 and of those 351 were medically retired.

Mr VICTOR DOMINELLO: Has someone done the percentages?

CHAIR: It is around 55 to 60 per cent.

Mr VICTOR DOMINELLO: Do you have the figures for 2007-08?

Mr JENKINS: I do not have those figures in front of me, I apologise.

CHAIR: The injury management guidelines was also a recommendation by the Auditor-General. I note that it was going to start in March 2010. Has that been implemented?

Ms BURN: We have a number of standard operating procedures, policies and guidelines. They have definitely been implemented. We did have a delay on some of them whilst we were doing our award negotiations with the Police Association through the Industrial Relations Commission. A lot of our focus has been on injury management reform. In relation to some of the things we agreed to we have had to put operating procedures in place. For instance, we have introduced an independent medical panel—this is post-88ers—that we can refer officers to if they have been off on sick report for 26 weeks or more. In this way we can get independent medical advice on how we can get them back to work and so on. We only agreed on that a couple of months ago. There are a few of those procedures that we have been updating. We do have guidelines. Ideally what we are going to be able to do now is incorporate them into one holistic injury management guide. We do not want it to be too big and complicated because we want people to read and understand it. We will be able to have it more integrated now with recent standard operating procedures.

Mr NINOS KHOSHABA: Ms Burn, you mentioned earlier that the current agreement for the Police Force expires in June 2011. Your department is engaged in discussions with other agencies and the Police Association as to what a financially viable death and disability scheme should look like. What model are you advocating and how does it differ to the present scheme?

Ms BURN: There is not a model we are advocating at the moment. We realistically have not commenced that consultation with the association at this point. What we have been trying to do is take the recommendations on board, utilise the injury management reforms that we have recently agreed to with the association, put them in place and see if they are going to work. What will not be very helpful is if we have a new scheme but we still have the same problems. It might be a different scheme, it might have different incentives in it, but we need to make sure that we are doing everything we can internally. That is one of the reasons we are working very closely with the association on all these injury management reforms. If we get to the point where we say we have done all that we can, we have got the systems in place, we have got the compliance, we are trying to address the culture, then the rest is the scheme and the rest is what we want to work at. We are confident that we can now start to look at possible scheme changes, whatever they might be. At this point I do not know what that might look like. I do know that we have to start those negotiations and come up with something. It has been documented that there is probably that disincentive in the scheme that we need to address.

Mr VICTOR DOMINELLO: In response to the Auditor-General's recommendation to develop protocols for processing medical discharge applications, your submission stated that the proposed legislative amendments would assist you to reduce administrative delays. What legislative amendments were you seeking and have they been enacted yet, to your knowledge? Secondly, what other steps are you taking to reduce the administrative delays?

Mr JENKINS: There are two parts to that quite obviously identified there and one is the administrative delays in relation to medical discharge. One of the historical things that we have found, particularly in relation to the pre-1988 area, which is what this is addressing at the moment, is that people will wait until they have an approved hurt-on-duty claim before they will submit their papers to the superannuation authority to be able to discharge. We have put a lot of processes in place within that pre-1988 administrative area to quicken those medical assessments and to quicken the approval process in relation to whether somebody's sore back or psychological injury is attributable to their work circumstances or whether it is not attributable to their work circumstances. We have streamlined the administration of that, we have streamlined the way that we get advice in relation to our legal opinions in relation to those particular aspects so that we can quicken that process up.

The other part of it is something that whilst it is out of our control at the moment the legislative changes that we are requesting, and also other changes that we are requesting through the Privacy Commissioner, will give us a little bit more control over whether somebody remains within our organisation or not. The fact is that at the moment we are unable to submit an officer who was sworn in pre-1988 for medical discharge; they have to make that application themselves. The superannuation authority will not take an application from us as the employer in relation to that because it is an individual who is accessing their own superannuation benefits.

Mr JOHN TURNER: This is pre-1988?

Mr JENKINS: Pre-1988. We have a lot of work being done at the moment through what was the ministry, the law enforcement branch, and also through elsewhere, to try and strike some regulation change, some legislative change, some work through the Privacy Commissioner to allow us to initiate in an appropriate fashion with the appropriate medical evidence a medical discharge to the superannuation authority. If we are in a situation where somebody has been off work for 12 months and it is clear that they are unable to perform police duties, that we are unable to redeploy them within our organisation somewhere and that step has to be taken, then we will need to try and regain some control about whether that person remains within the organisation or not.

Mr VICTOR DOMINELLO: What steps have you taken to put these amendments before the Parliament?

Mr JENKINS: We have made application to the Privacy Commissioner for an exemption under the Privacy Act.

Mr VICTOR DOMINELLO: When did you do that?

Mr JENKINS: That was a number of months ago, which I think is working its way through the system at this stage. That was a result of discussions that we had during the award negotiations. We have also commenced some work in relation to having the parliamentary draftsperson draft some regulation of legislative change so that we can do some finetuning around the negotiation process.

Mr VICTOR DOMINELLO: The impression I get, and I could be wrong, is that a whole lot of this was delayed due to the award negotiations. Everything was put on ice until we saw how the cards fell as a result of the negotiations.

Mr JENKINS: I think that a number of these aspects were subject to the negotiations during the award, and that was the issue. I do not know that the term "put on ice" is probably right. It is more about the fact that these were parts of the negotiation process that we were going through at the time in relation to the award and trying to generate savings within the organisation to be able to utilise as wage rises, and so these were absolutely the subject of the negotiations.

Mr JOHN TURNER: So the concept that you could initiate the application to the superannuation was not agreed to during the award proceedings, is that the bottom line?

Mr JENKINS: That is the bottom line. We have still got a lot of work to do in relation to that, yes.

Mr JOHN TURNER: So if it was to become a legislative change we could expect some conflict between yourself and the association—between the commissioner and the association?

Ms BURN: Not necessarily. I think one of the issues is the privacy issue. Regardless of the association's opinion, we have got it pretty black and white that it would be a breach of privacy for those details to be passed between agencies. So that is what we are trying to seek.

Mr JOHN TURNER: It is a privacy legal issue rather than a job issue?

Ms BURN: Yes.

Mr JOHN TURNER: As a matter of interest, how many pre-1988ers would there be as a percentage, just roughly?

Mr JENKINS: There are around about 2,200 left in the organisation.

Ms BURN: Of us.

Mr JENKINS: Of us—growing smaller.

Mr NINOS KHOSHABA: Ms Wills, regarding recommendation 7, your submission states that the safety command had been working with the police association to identify barriers to returning to work for those with psychological injuries and that a template has been developed for June 2009 appointments. It is not clear from your submission whether these two initiatives are linked. My question is a two-part question: What barriers to returning to work did you identify and, secondly, what strategies have you adopted as a result?

Ms WILLS: The work that we were doing with the police association was a research project that they had some WorkCover grant funding for. At this stage I am not in receipt of a final report for that. Nevertheless, we were clearly getting progress information throughout the study. In regard to barriers to returning to work from the psychological injury perspective, generally the sorts of things we end up needing to medically discharge officers with a stress-related condition, include the fact that they are unable to be exposed to certain things within the workplace that is fairly unique to police—that could be police radios, for example, it may be reports about dramatic incidents, it may be dealing with the public, aspects such as those.

In regard to strategies for overcoming barriers, the key areas that we focused in on are two-fold. Firstly, we focused in on barriers that exist within organisational processes and, secondly, barriers that exist in regards to the traumatic processes. It is a lot harder to control for the traumatic aspects of the job than for the organisational aspects of the job. Ms Burn has already spoken about the sergeants training that we are implementing to assist sergeants in dealing better with the injury management processes. There has been education and training with superintendents and inspectors from the Black Dog Institute looking at stress and depression, anxiety signs and symptoms and how management styles can impact on those. We have also made significant improvements to a number of other standard organisational processes, such as changes to the complaints handling systems, changes to the promotion systems. There have been changes also to the way that we engage from an early intervention perspective, so when people are injured the sort of contact they get from their commands and the support that they get from their commands.

In the area of the trauma, we have invested significantly with a three-year research project, in partnership with the police association, looking at resilience of police officers and seeing that there are ways that we can build resilience or, indeed, identify and select for resilience within our organisation, and, of course, we have all of the processes in place that we did at the time of the audit in regards to supporting officers that have been exposed to trauma. I can go through those if you like, but I will not revisit them if everyone is aware of those.

CHAIR: Roughly how many would that include that have been affected psychologically out of the 60 per cent that medically retire?

Ms BURN: Out of all those claims that are submitted we would say about 20 per cent would be psychologically related.

Mr VICTOR DOMINELLO: So 20 per cent of those medically retired would be on a psychological basis?

Ms BURN: That is of all claims. It might actually be a bit higher. We can find that out. It is a figure that I would say would be more than 20 per cent of psychological injuries.

CHAIR: It is a wonder it is not higher.

Ms BURN: Yes. It is interesting. Because of that we also focus a lot on the physical aspects of it and we have been doing a lot of work at the moment around the wearing of our appointments. We are trialling a thigh holster to get some of the weight off the hip and the back. We have now got a load-bearing vest that we are about to put everything up around the chest and carry it up there rather than around the waist. We have had some good feedback with people with back injuries who are now able to come back into the workplace. It is a focus also on the physical injuries. The issue with the psychological ones is that people tend to be off work a lot longer with a psychological injury and it is a lot harder to get them back into the workplace. Our average cost of claims and our time lost is impacted greatly by the 20 per cent of those that are psychologically injured.

Mr VICTOR DOMINELLO: Is it fair to conclude that most of the people who are psychologically retired would be at a pretty young age or people who have recently gone into the force, that is, they have not been exposed to a trauma and they get a shock?

Ms BURN: No. That trend is not there. It can be a single incident or it can be an accumulation of—

CHAIR: Over years.

Ms BURN: Exactly, over years, and something over 25 years that is just it and then everything sort of comes out. That is that traumatic side of it. So what we do there is for every traumatic incident now there is welfare availability, peer support. It is not an easy thing to keep going and seeing horrible things, but we have that sort of intervention and we have a well-check program in place in the higher risk areas where we know that people will come across horrible things all the time, like child sexual assault. That is in place for those and what was referred to, a lot of the major organisational change that we have tried to do is to impact on those things—conflict in the organisation, all those other things that people get sick and there is conflict—

Mr VICTOR DOMINELLO: How much as a percentage, if you know, would represent conflict within the organisation as a stressor?

Ms BURN: We have looked at it. It could be anywhere between 40 per cent and 70 per cent.

Mr VICTOR DOMINELLO: Of the 20 per cent?

Ms BURN: Yes.

Mr VICTOR DOMINELLO: That high?

Ms BURN: It could be. A lot of the claims, however, are secondary claims as well. You might have a claim that says, "I am having trouble in the workplace but I also went to a traumatic incident". So which is which? Which caused which or which has led to it is a bit difficult. But whatever the cause is we are trying to counter all those potential ones and that is why organisationally we are rolling out better leadership. We changed our complete management system and we are now reaping the benefits of that because a lot less officers are now formally investigated. That causes stress and trauma if you are subject to a criminal investigation or a complaint. So we have less of those. We also had the Ronalds inquiry into bullying and harassment in the workplace and we have put in a recommendation, so we now have an equity unit looking at grievances. So it is looking at the physical side, it is looking at the traumatic causes of the psychological injury and the organisational causes.

Mr ACHTERSTRAAT: Mr Dominello, I think the deputy commissioner's statements are supported on pages 27 and 28 of the report. Page 27 gives a bit of a breakdown of not so much the medically retired but the reasons why people are off. For every 100 employees you can see the physical, being hit by a moving object, is the most common and that the stress there is the third most common. But I think, as the deputy commissioner said, the final paragraph there about recent research of psychological injury lodged indicates the vast majority of the claims are related to workplace interpersonal issues and not exposure to operational trauma. Over the page I think the statistics are there, which suggest that 71 per cent were in relation to performance management or disciplinary matters, exactly as the deputy commissioner has said.

Mr VICTOR DOMINELLO: I would have thought, given what the police are exposed to on a day-to-day basis, just in terms of psychological trauma that would be the higher figure by a long shot.

Ms BURN: That is why one of the areas we are investing in at the moment is about resilience and researching the resilience with our university partners and the association.

Mr VICTOR DOMINELLO: Is that testing people before they get into the force?

Ms BURN: It depends what the research shows. It is a three-year project. The issue with that is the causes. It might be that traumatic incidents make you more susceptible to conflict in the workplace. So we do not know what the actual causes are. They are good correlations and it is good trend information, but we have to go further and that is what we are now doing.

Mr VICTOR DOMINELLO: Do you do any testing now before people come into the force to see if they are an eggshell-skull type person that may be exposed to—

Ms BURN: There is a very stringent standard and it involves physical and psychological testing.

Mr VICTOR DOMINELLO: Is that working? Are you preventing emotionally vulnerable people from entering the force in the first place?

Ms BURN: I do not know. Anecdotally I think the quality of the recruits is outstanding and that it has improved. Since 2003 especially, they have been improving. There could be some relationship there.

Mr JOHN TURNER: Why 2003?

Ms BURN: Only because I went to Burwood Local Area Command and paid a lot of attention to it.

Mr NINOS KHOSHABA: The Committee is always interested in feedback on the conduct of performance audits and investigations. It is aware that these come at a cost to the agencies under review and it is keen to maximise the benefits from the process. However, you indicated in your submission that you thought the audit process was not as efficient as it could have been. Can you comment?

Ms BURN: I do not think we said it was not as efficient as it could have been. First and foremost, we welcome any audit that may be done. This was a completely relevant and timely one and I am glad it was done, as I am glad about all the other audits that are done, and I have been subjected to a few. The one issue that might relate to this audit is that it is a complicated area and it took some time. It took some of our senior people in the units out of their normal work for extensive periods of time. I do not know how we can overcome that, but that was the observation.

Mr NINOS KHOSHABA: I refer to the letter we received from Assistant Commissioner David Owens on 29 January 2010. I am happy to read it out.

Ms BURN: I have read that letter and I am aware that comments were made. I think it related to the time that the senior people in the safety command needed to take out of their normal day. There is no reason other than the time.

CHAIR: Do you have any comment about the Waverley magistrate's decision? It is astounding.

Ms BURN: I think that if I said the word here everyone would be shocked.

CHAIR: If he was called that I am sure we would all be behind bars.

Ms BURN: Absolutely.

Mr VICTOR DOMINELLO: In contempt of court—it is a ridiculous decision.

CHAIR: The world has gone mad.

Ms BURN: That sort of decision does nothing for frontline police because they do not feel they have support.

Mr VICTOR DOMINELLO: Is that being reviewed?

Ms BURN: Yes, it is being referred.

Mr VICTOR DOMINELLO: Is there going to be a challenge?

Ms BURN: I have not heard.

CHAIR: There has been no announcement. Thank you for your attendance here today and please pass on our best to the commissioner.

(The witnesses withdrew)

(The Committee adjourned at 4.18 p.m.)