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GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 13 September 2010

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 9.15 a.m.

MEMBERS

The Hon. R. M. Parker (Chair)

The Hon. A. Catanzariti
The Hon. M. A. Ficarra
Dr John Kaye
The Hon. S. Moselmane
Reverend the Hon. G. K. M. Moyes
The Hon. C. M. Robertson

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PRESENT

The Hon. C. M. Tebbutt, *Deputy Premier, and Minister for Health*

Department of Health
Professor D. Picone, *Director General*
Dr R. Matthews, *Deputy Director General, Strategic Development*
Ms K. Crawshaw, *Deputy Director General, Health System Support*
Dr K. Chant, *Director General, Population Health*
Dr T. Smyth, *Deputy Director General, Health System Quality, Performance and Innovation*
Mr J. Roach, *Chief Financial Officer*

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

Corrections should be marked on a photocopy of the proof and forwarded to:

Budget Estimates secretariat
Room 812
Parliament House
Macquarie Street
SYDNEY NSW 2000

CHAIR: I declare this hearing for the inquiry into Budget Estimates 2010-11 open to the public and welcome the Minister and other officials from the Department of Health. We will be talking about the proposed expenditure for the portfolio of Health. I need to make some comments about procedural matters, with which many of you will be familiar. For those who are not, according to the Legislative Council guidelines on the broadcasting of proceedings only Committee members and witnesses may be filmed or recorded. People in the public gallery will have to have their 15 minutes of fame at some other time, because they should not be the primary of focus of filming or photos. In reporting the proceedings of this Committee, you must take responsibility for what you publish or what interpretation you place on anything said before the Committee. The guidelines are available on the table by the door.

If anyone in the public gallery has messages they wish to pass to the Committee, they should be passed through the Committee clerks or Chamber staff. Obviously, Minister, you can have notes passed directly you. Please turn mobile phones off or to silent. If they are receiving data, keep them away from the microphones because they interfere with the recording equipment. The House has resolved that answers to questions on notice must be received within 21 days. Transcripts will be available on the web tomorrow morning.

DEBORA PICONE Director General, and

RICHARD MATTHEWS, Deputy Director General, Strategic Development, affirmed and examined:

KAREN CRAWSHAW, Deputy Director General, Health System Support

KERRY CHANT, Director General, Population Health

TIM SMYTH, Deputy Director General, Health System Quality, Performance and Innovation, and

JOHN ROACH, Chief Financial Officer, sworn and examined:

CHAIR: We do not have provision for opening statements, so we will get straight into questions. We will try to take the morning tea break as close as possible to 10.30 a.m. The Committee has approved filming by students from the University of Technology Sydney. No doubt this will be interesting for them.

Minister, you told Parliament on 2 September that your Government provided quarterly performance data for emergency departments and planned surgery. You said it would give the people of New South Wales the most comprehensive and accessible hospital-based information in the country. I do not know whether you are familiar with the Western Australian Department of Health's website, but it reports, among other things, real-time waiting periods for each hospital emergency department, and available hospital bed reports are updated every Thursday. Given that, how can you justify your claim?

Ms CARMEL TEBBUTT: Thank you for the question. The performance report that was released last week was the first time that the quarterly performance reports have been undertaken by the Bureau of Health Information. This is very important because the Government gave a commitment that there would be independent reporting about performance data and having the Bureau of Health Information undertake that reporting gives the community greater confidence in that reporting process, and the report is a more extensive report than has been the case in the past. We have also released our health website, which provides a whole range of information to the community. I am confident the way we are reporting to the community is providing useful, valuable and up-to-date information for the community.

CHAIR: I know you are confident about that, but how can the public be confident, because on Friday you updated that, and that information in September was only from information in June. Western Australia, for example, can do that hourly. Are you aware that this situation has deteriorated markedly in the Hunter and Illawarra hospital emergency departments since June and that that information was only put up there on Friday?

Ms CARMEL TEBBUTT: That is right, we have always given a commitment to provide quarterly performance data. It usually takes about six to eight weeks to ensure that the data is properly collated, audited

and checked. So it usually takes about that long for quarterly performance data to come up. I might point out that the quarterly performance data demonstrates that despite the fact there is significant increase in demand both on our own emergency departments and for planned surgery, our hospitals are doing very well. Once again we have met four out of the five triage categories with regard to our emergency departments, and again with our planned surgery we see similarly about 87 per cent of people are getting their planned surgery on time. When you look at the interstate comparisons you once again see that New South Wales performed better than other States and Territories with regard to emergency departments, for example, the most recent Our Public Hospital report—

CHAIR: The question was about the Hunter and the Illawarra. Are you aware that has gone backwards?

Ms CARMEL TEBBUTT: Obviously when the performance data is released you see some hospitals that go forward and you see some hospitals, for a range of different reasons, go backwards. I am just giving some broader data and I might ask the director general or the deputy director general to respond to specifics.

CHAIR: Your information takes some time to get on the website. I am able to obtain and have in my hand the sustainable access weekly plan that shows that the number of potentially life-threatened patients seen within the 30-minute benchmark has dropped from 73 per cent in June to 60 per cent in August. I am able to have that information. I do not understand why you are not able to put that information on the website.

Ms CARMEL TEBBUTT: Obviously it is important when we are providing information to the community that that information is properly checked and validated. That is why—

CHAIR: But this is one of your own documents—Greater Metropolitan and Individual Metropolitan Area Health Services.

Ms CARMEL TEBBUTT: And that would be a document that is used. I do not know; I do not know what the document is that you have in your hand—

CHAIR: I am happy to table it.

Ms CARMEL TEBBUTT: Sure, but that would be a document that would be used in order to drive performance improvement throughout the system. There is a range of different ways we use this performance data and I will get the director general or deputy director general to talk in a bit more detail. But regular reports are generated for the surgical services task force, which meets monthly. That task force has been extremely successful in driving improvements with regard to elective surgery performance. It looks very closely at what is happening in every hospital across the State, so probably the data you have is data that may well be prepared for the surgical services task force. But that has to be distinguished from data that we make available to the public and properly checked and validated—

CHAIR: No, you have to put your spin on this, is what you are saying.

The Hon. CHRISTINE ROBERTSON: Point of order—

CHAIR: Western Australia can put that up there every day, it can put it up in real time. What you mean is not checked, but the spin has to be right.

Ms CARMEL TEBBUTT: That is not right at all. Obviously we are very transparent and the data is produced—

The Hon. CHRISTINE ROBERTSON: Point of order: Please allow the witness to answer the question.

CHAIR: I am just clarifying the answer.

Ms CARMEL TEBBUTT: The data is produced every quarter and it is done in a way that the community can rely on its accuracy. I point out that with the Bureau of Health Information now taking on its role we are going to see independent reporting of performance data and the capacity for the Bureau of Health Information to do some extra analysis, like, for example, in the report it released last week that had an analysis

on emergency department performance—patient satisfaction in our emergency departments. In its next report, which will come out approximately eight weeks after the end of the quarter—so that will be the end of the September quarter—it intends to have a focus on elective surgery and our performance with regard to elective surgery.

I think this is far more beneficial for the community. The community wants data that it knows is verified, that it knows it can rely on and that is giving them a true and accurate picture of what is happening in our health system. If you look at a whole range of other government agencies or big institutions, it is not that often you get data that is that readily available so quickly. We report the data within eight weeks of the time period ending. I will ask the deputy director general to—

CHAIR: On Friday you put up June's information. This is data that is given to your staff. If your staff has this information, why can the public not have this information?

Ms CARMEL TEBBUTT: I did explain that, because that is about improving performance. I will ask the deputy director general to respond to the detail of the report you have.

Dr SMYTH: In relation to emergency departments in metropolitan Perth, the Western Australian public health came over to New South Wales and met with my staff for advice on what we have been doing in New South Wales to help them lift the performance of their emergency departments in Perth and the reporting of waiting times in the Perth emergency departments, as part of their strategy is to lift the performance of their emergency department. Queensland does that for its major emergency departments, but they are the only two States in Australia that do it. Victoria has a six-monthly performance report. The level, content and frequency of reports vary around Australia. I, as part of my role, in terms of performance, look at what happens around the States and pick up their good ideas, and one of the things we have been looking at is what other States and Territories have been doing.

For example, we report healthcare-associated infection data for public hospitals. We are the only State that does that, so it varies from State to State. In relation to your question about particular emergency department issues, yes, Wollongong Hospital has been under pressure. It is one of the major emergency departments now. It sees more than 1,000 people a week, along with other major emergency departments. We put in a psychiatric emergency care centre there. We have recently completed building works to expand the size of that emergency department. Staff members are now moving into that area and the area health service has advised me that they expect the performance of Wollongong to improve.

In Newcastle, it is a very local specific issue and as a former chief executive of the Hunter Area Health Service, I know Newcastle really well and it basically is the flow-on effect from issues as the Calvary Mater campus at Waratah and the Calvary Mater campus at Waratah emergency department are not performing well—it has a flow-on effect at John Hunter Hospital.

CHAIR: Are you saying Calvary Mater is not performing well.

Dr SMYTH: When Calvary Mater Hospital at Waratah is not performing, its emergency department has a flow-effect to the John Hunter Hospital at Rankin Park. Also, Maitland Hospital is undergoing a major upgrade and refurbishment of its emergency department. That process has affected the performance of Maitland Hospital and that flows into the figures for Newcastle. They are Maitland-specific issues.

CHAIR: That is just about the entrance to the emergency department, though. That is not about improvement for patients.

Dr SMYTH: It has reduced the number of treatment spaces temporarily and it has also increased the number of movements from the ambulance to the actual emergency department. It has affected performance there and once that work is completed, Maitland will come back to being a top community.

The Hon. MARIE FICARRA: My question is to the Minister or whichever staff member wishes to answer it. Data currently on your website suggests that only 49 per cent of patients in potentially life-threatening conditions at Westmead Hospital were seen within the 30-minute benchmark, but according to our report showing August figures, the number of life-threatening patients at Westmead seen within 30 minutes in August has dropped to an alarming 42 per cent, clearly a deterioration in one month from 49 per cent to 42 per cent. What have you got to say about this and what are you doing about this situation?

Ms CARMEL TEBBUTT: I make it very clear that patients who have an immediately life-threatening condition are always seen immediately in our emergency departments. With regard to Westmead Hospital emergency department, it is one of Australia's major emergency departments. It sees about 55,000 patients every year. Demand during winter months has certainly risen and so the figures you are reporting would be taking into account some of the winter period. We do see demand increase in the winter period. The Council of Australian Governments [COAG] agreement with regards to additional beds will see significant additional beds come on stream at Westmead. More than $18 million has been allocated to Westmead Hospital to fund additional bed capacity. This includes 20 acute beds, 12 trauma rehabilitation beds and additional intensive care beds, and 12 rehabilitation beds.

The Hon. MARIE FICARRA: Can you put time frames on those?

Ms CARMEL TEBBUTT: I might ask the department to respond to that when I have finished with a bit more information. A major refurbishment of the department is currently in planning stages to provide a more functional configuration of the beds, with an increased number of resuscitation bays. I am also advised that a trial of a new urgent care centre on the Westmead Hospital campus to stream patients who do not require complex emergency department care will get underway in early 2011. These improvements will help address access block, but we also know that access block is not just about what happens in the emergency department; it is also about having a whole-of-hospital approach to bed management.

This requires all clinical units to work very closely together. I had an opportunity to meet with the Westmead doctors just two weeks ago to talk through some of these issues. I think that they are confident that there is significant change that is underway at the hospital. I know that the chief executive officer of the area health service is establishing a taskforce to work with doctors and other clinicians—nurses as well—to make sure that we can improve patient flow throughout the whole of the hospital because if you just focus on what is happening in the emergency department without looking at the whole of the hospital, you are not necessarily going to get the sustained improvement that you are looking for.

The Hon. MARIE FICARRA: I point out that the information that we get from the staff—the doctors and nurses—is that they are not happy. I am talking about 42 per cent, which is alarming—only 42 per cent of patients presenting to Westmead Hospital emergency department are seen within 30 minutes. I would like to know in the answer you gave about the increase in beds, are you talking about a similar situation to Sutherland Hospital where they were recliner chairs? Your department is touting that as an increase in beds? Are you talking about Westmead Hospital having recliner chairs? Is this where your increase in bed numbers are coming from?

Ms CARMEL TEBBUTT: I am very glad that you raised that because it gives me an opportunity to clarify some of the misinformation that has been circulating with regard to Sutherland Hospital. As part of the COAG funding, Sutherland Hospital is going to receive 17 new beds; that is five acute care beds, five emergency medical unit beds, six general subacute beds and one bed for the adult intensive care unit. I had the opportunity prior to making the announcement of these additional beds to visit Sutherland Hospital and I talked with the emergency staff, amongst other staff. They made very clear to me that their key priority was to have an emergency medical unit—an EMU is what it is called. They were very keen on having that.

I was very pleased, when I was able to go back, to be able to say that of the 17 COAG beds, we would use five to establish an emergency medical unit. If you actually look at the local reporting in the local paper from that visit, it makes very clear that I said at the time that the extra funding would start, but some beds will take some time to come on stream because there would need to be some building work or some reconfiguration of existing units, and that is not surprising. When you announce 17 extra beds at a busy hospital, it is not always possible to just immediately insert all of those beds without doing some building work.

The Hon. MARIE FICARRA: With all due respect, the announcement is when you actually have beds?

Ms CARMEL TEBBUTT: No, I made it very clear, and if you go to the local paper—

The Hon. MARIE FICARRA: It is all spin?

Ms CARMEL TEBBUTT: The honourable member would be well aware that the *St George and Sutherland Shire Leader* is not a paper that is known to necessarily embellish things in favour of the Government, so I think you could probably be fairly confident that the way the Leader has reported this was the way that it was presented without any embellishment. I made it very clear at the time that there needed to be reconfiguration work but in the meantime the hospital has put in place the chairs so that there is a benefit to the emergency department. I congratulate the hospital on doing this because it means that while the work is underway to reconfigure the emergency department to get the EMU, which the staff specifically requested me to provide, the chairs are being used to treat lower acuity patients.

The Hon. MARIE FICARRA: As a constituent who lives in the area serviced by Sutherland Hospital, I can tell you that the public are not happy.

The Hon. CHRISTINE ROBERTSON: So you have never been on a trolley in a hospital?

The Hon. MARIE FICARRA: I would not like to be there and be sitting in a recliner chair if I needed acute care.

Ms CARMEL TEBBUTT: There were an additional 17 beds for the hospital there at the time that I was there making the announcement, making it clear that there needed to be some reconfiguration, and it is a shame that that was not reported today because we did provide that information to the Herald, including a copy of the *St George and Sutherland Shire Leader*, but at the time that I was there, the staff welcomed it.

The Hon. SHAOQUETT MOSELMANE: It is good news.

The Hon. MARIE FICARRA: It is good news. I move on to the Central Coast area because we have lots of constituents there with concerns. At Gosford, your website shows 67 per cent of potentially life-threatened patients were seen in 30 minutes but we have August figures that again show only 60 per cent were treated within the benchmark. Are you cheating the people of the Central Coast? What exactly is happening on the Central Coast? Why can we not see better improvements in these waiting times? I am talking August figures of 60 per cent.

The Hon. CHRISTINE ROBERTSON: Point of clarification—

Ms CARMEL TEBBUTT: Are you talking about emergency department figures or—

The Hon. MARIE FICARRA: Emergency waiting times; patients with life-threatening conditions being seen within 30 minutes.

Ms CARMEL TEBBUTT: That is triage category 3?

The Hon. MARIE FICARRA: That is right, life-threatening category 3.

Ms CARMEL TEBBUTT: I might ask the deputy director general to provide some more detail with regard to what is happening on the Central Coast.

Dr SMYTH: The Northern Sydney Central Coast Area Health Service and the general manager of Gosford and Wyong hospitals have been doing a great job. They have been working closely with my team in the Department of Health about the operations at Gosford and Wyong hospitals to improve emergency department access as well to reduce long-waiting periods for patients for surgery, and they have been successful on both fronts. With regard to the discussions with the Ambulance service locally, the Ambulance Service will confirm that performance on the Central Coast has lifted significantly over the last 12 months. Wyong is another very busy emergency department. People tend to think that it is the Prince Alfreds that have busy emergency departments, but Wyong and Wollongong also have very busy emergency departments. Wyong also has a young, growing population. Wyong also has a significant deficit in general practitioners and a particularly significant deficit in access to after-hours general practitioners.

Reverend the Hon. Dr GORDON MOYES: But does it have dialysis?

Dr SMYTH: I will take that question on notice; I am personally not aware of that. With the additional beds that have been opening at Gosford and Wyong as part of the COAG health reforms, the work that the area

and the hospital management have done in terms of improving patient care, the work they have done with the Ambulance Service—we are not out of the woods yet, but the performance of Wyong and Gosford is much better than it was and I congratulate—

The Hon. MARIE FICARRA: Are you happy with 60 per cent? Is that the best we can do?

Dr SMYTH: No. I am sure we can get that up to the target. And particularly on the more urgent categories of triage 1 and 2, they meet that target every time.

The Hon. MARIE FICARRA: You realise you are actually going back in that Central Coast area? We would like to know, on behalf of constituents in the Central Coast area, an area with a growing population as you say, what you have planned to lift the performance for patients presenting with life-threatening conditions. I am not talking about colds and coughs but about life-threatening conditions.

Dr SMYTH: Patients presenting with life-threatening conditions are triage 1 and triage 2, and they are treated within the benchmark time. I have no concern in relation to life-threatening patients. Triage 3 is potentially life-threatening, and the performance of the Central Coast emergency departments is improving. It has not got to where I would like it to be, but it will. Just to give you another couple of examples, at Wyong Hospital we are also going to trial an emergency care centre. An emergency care centre is to stream patients who have not the most urgent conditions—minor injuries and other conditions that do not need the full service of an emergency department. We are going to trial that. We have been discussing that with Kate Porges, the director of the emergency department, and Matt Hanrahan and the staff there. We are also looking at creating a further treatment zone for children, with their parents, for children with more minor conditions so that they do not need to wait around and they are treated faster. I think Wyong is one of our better emergency departments.

Reverend the Hon. Dr GORDON MOYES: I appreciate all the good things that Wyong has and does, but I did ask whether you have dialysis.

Ms CARMEL TEBBUTT: I think we will need to take that on notice. You are wanting to know if there is dialysis at Wyong or Gosford. I will just check—

Reverend the Hon. Dr GORDON MOYES: No, not Gosford; Gosford has dialysis services. But they are not at Wyong, which is a big, growing area with a population expansion.

Ms CARMEL TEBBUTT: There is no doubt that the demand for access to renal dialysis services is huge right across New South Wales. While we will take that question on notice and come back to you with regard to Wyong, the reality is that we have made huge investment in renal dialysis right across the State and provided far greater access than what has been the case in the past. But I can tell that you want to move on to another question, so I will not go on.

Ms PICONE: May I add to that, and also Dr Matthews might want to make a comment on this. We have systematically been opening, as you know, additional dialysis units, both for acute and more chronic patients, and also investing in more home dialysis. The ideal form of dialysis is for people to have it in their home, but increasingly we are getting patients who are older and find it more difficult. Also, from their carers' point of view it is a very big ask to have an elderly carer also involved in home dialysis. I might ask Dr Matthews whether, in our planning with regard to bringing additional dialysis machines online, it is scheduled for Wyong at this stage.

Dr MATTHEWS: We have had a very strong rural and regional focus over the last seven or eight years, and I am personally quite pleased that of the additional roughly $60 million since 2002-03, $35 million has gone to rural and regional areas. In that time, new units have opened in Goulburn, Moruya, Manning, Griffith, Bega, Bathurst and Forbes, and Wagga Wagga, Coffs Harbour, Kempsey, Ballina, Dubbo, Broken Hill and Orange have been expanded.

Ms PICONE: And Sutherland.

Dr MATTHEWS: I am just talking about rural and regional areas. There have been additional units in the city as well. Our aim is to provide this treatment as close to home as possible, because it does—

Reverend the Hon. Dr GORDON MOYES: Dr Matthews, I appreciate that. I know you are doing some work in Forbes in three months time. We have a report of people having to travel 700 kilometres a week in order to go to dialysis now at Orange. But I was reflecting on Dr Smyth's point that Wyong is in the region of great growth and development, and yet that was not one of the areas you mentioned as part of your strategic plan.

Dr MATTHEWS: No, at this stage patient—

Reverend the Hon. Dr GORDON MOYES: But Dr Smyth says it is a great development.

Dr MATTHEWS: It is.

Reverend the Hon. Dr GORDON MOYES: And yet, you have not got it on your plans? I see a problem there.

Dr MATTHEWS: At this stage patients from Wyong flow either south to Gosford or north to John Hunter. The population growth is predominantly a young one, and we are concentrating the new units in those places with the greatest proportion of people who need it, and based on the greatest distance. Hence, that very strong rural flavour, if I can use that word, in Goulburn, Moruya, Griffith and Bega, where people were travelling the greater distance. Wyong to Gosford is definitely inconvenient when you think about it, but it is not as great a distance as the others.

Reverend the Hon. Dr GORDON MOYES: Mr Roach, I notice that the Treasurer announced that there would be a 26 per cent reduction in Government advertising over this past year. Last year the Government spent $90 million on advertising, and the latest figures I can get show that it has spent $101 million on advertising. It does not sound to me to be a 26 per cent reduction. What are your department's expenses for advertising and what has been the percentage change?

Ms CARMEL TEBBUTT: I will see if the chief financial officer has that information to hand.

Mr ROACH: No.

Ms CARMEL TEBBUTT: Can we take that on notice and come back to you?

Reverend the Hon. Dr GORDON MOYES: Certainly.

Dr JOHN KAYE: Minister, I want to start with the issue of patients with spinal cord injuries in hospitals. Would you accept that there is a substantial delay in getting patients, once they have been through the necessary hospital-based therapy, out of hospitals?

Ms CARMEL TEBBUTT: I might ask the deputy director general to respond in detail. But I would point out that one of the great benefits that have come out of the COAG agreement is extra investment in sub-acute beds, which will significantly help in terms of rehabilitation for spinal cord injury patients, along with other patients as well.

Dr MATTHEWS: As you would be aware, there are two adult and one children's acute spinal units—the adult ones at Royal North Shore and Prince of Wales hospitals, and the children's unit at the Children's Hospital at Westmead. Further rehabilitation is conducted in a number of places, including at Royal Ryde Rehabilitation Centre, where there are a number of specialist beds for that ongoing rehabilitation, as there are around the State. I would have to take on notice the exact question about delays on discharge from acute units.

Dr JOHN KAYE: You would be aware, would you not, of the community participation project that was run to look at ways in which NSW Health, the Department of Ageing, Disability and Home Care, the Department of Housing, and various other departments including the Department of Transport and the Department of Education and Training could work together in order to remove the bottlenecks that keep people recovering from spinal cord injuries in hospitals longer than they need to be there?

Dr MATTHEWS: I am aware of that work, yes.

Dr JOHN KAYE: And you are aware that the outcome of the recommendation that came out of that was that there should be better coordination of services, to reduce delays?

Dr MATTHEWS: Yes, and that is part of the plan we have for all of New South Wales produced by the Statewide Services Development Branch. We have a plan. We are expanding rehabilitation services. You would be aware that as a result of the sale of Graythwaite there are 64 additional rehabilitation beds currently being constructed at Ryde Hospital, and that will greatly enhance our capacity in that rehabilitation. Also, as a result of the Council of Australian Governments funding, as the Minister said, this year there will be an additional 107 beds for the various types of rehabilitation across the State, and in year four of the Council of Australian Governments' plan that will rise to 438.

Dr JOHN KAYE: That is lovely, but am I correct in saying that the community participation study was completed in 2007 and it is now 2010? Am I also correct in saying there has been no substantial decrease in the delays in getting people out of hospital in that period of time?

Dr MATTHEWS: As I say, I would have to check and take on notice what the actual times have been. I do not have them off the top of my head.

Dr JOHN KAYE: Could you get back to us with that?

Dr MATTHEWS: Certainly.

Dr JOHN KAYE: Because there are significant concerns about the failure to communicate between different departments holding people back in hospital, hence holding back their reintegration into the community. Can I take you to another aspect of a similar problem? I understand through EnableNSW, which is part of NSW Health, that the Government provides a variety of equipment essential for discharge, including such things as wheelchairs, commodes, pressure-care mattresses and beds. I also understand there is a database required to be completed to make this program work more successfully, and that there have been delays in completing that database. Is that correct?

Ms CARMEL TEBBUTT: I might again ask the deputy director general to respond in detail, but I can point out that the Program of Appliances for Disabled People [PADP] is a really important program. It provides assistance to people who are often very vulnerable and we have enhanced the budget in 2010-11 for the Program of Appliances for Disabled People; so the budget is $35.3 million dollars. This includes a $4 million recurrent enhancement, and that comes on top of a $5 million recurrent enhancement in July 2009. So we are investing extra funding in the Program of Appliances for Disabled People.

Dr JOHN KAYE: We are aware of that.

Ms CARMEL TEBBUTT: I think that is important.

Dr JOHN KAYE: We are aware of that and we are on record as congratulating that. This Committee conducted the inquiry, of which I am a member.

Ms CARMEL TEBBUTT: That is one of the reasons why I am pointing out to you this extra enhancement.

Dr JOHN KAYE: But the issue here is a specific problem with the database that allows easy tracking and management of the equipment for loan. We understand that database has not yet been set up, and it was supposed to have been set up some time ago?

Ms CARMEL TEBBUTT: I am not sure whether the deputy director general will have the detail to answer that, otherwise we will take it on notice and certainly come back to you.

Dr MATTHEWS: I am sorry; we will have to take that question on notice. I do not have the detail on whether the database has actually been completed.

Dr JOHN KAYE: I take you to another related issue, that being the issue of the ventilator-dependent tetraplegia program, which in the past provided nursing care as part of the care package for people who left

hospital and were ventilator dependent. We understand that the provision of registered nurses from the care package has been removed; there will no longer be registered nurses as part of that care package. Is that correct?

Ms CARMEL TEBBUTT: I will ask the director general to respond to that.

Dr MATTHEWS: No, I do not think that is correct. What happens when those folk leave hospital is that a very careful care plan is put into place that provides the type of care that they need—generally packages between $500,000 and $1 million per year to enable those people to live at home. The package provides the care for each individual that they need, which may or may not be registered nursing care depending on: (a) their needs, and (b) the resources of the family that are also caring for them.

Dr JOHN KAYE: Is it not true that originally registered nurses were always part of that care package and that now, in some cases, the work that was being done by registered nurses is being transferred to spouses, parents or next of kin?

Dr MATTHEWS: As I said, each individual patient receives the level of care they need.

Dr JOHN KAYE: I understand that but I want to take you back to what it was like previously. Is it true that every care package contained a registered nurse?

Dr MATTHEWS: I honestly cannot tell you whether every care package ever provided had registered nursing. I am very careful about the word "every". So I cannot guarantee that.

Dr JOHN KAYE: Let me try another way. Has there been a change in the way that registered nurses are provided as part of the care package?

Dr MATTHEWS: As I have said, each patient is carefully assessed and receives the level of care that they require.

Dr JOHN KAYE: So you are telling me there has been no policy change in respect of the provision of registered nurses for people on the ventilator-dependent tetraplegia program?

Ms CARMEL TEBBUTT: Look—

Dr JOHN KAYE: This question is directed to Dr Matthews if you do not mind, Minister?

Ms CARMEL TEBBUTT: No, I will actually just clarify—

Dr JOHN KAYE: You do mind?

Ms CARMEL TEBBUTT: Well, I want to just clarify it for you. The deputy director general has made it clear that he cannot provide the information about whether every package previously did involve a registered nurse.

Dr JOHN KAYE: I took that on board. I just want to know whether there has been a policy change in respect of the provision of registered nurses.

Ms CARMEL TEBBUTT: I will see if the deputy director general can answer that.

Dr MATTHEWS: I am not aware of one, but I will take it on notice and come back to you.

Dr JOHN KAYE: Minister, what action has been taken to reduce the waiting times for paediatric aids and equipment, including communication devices—given that my colleague Ian Cohen brought this issue, with supportive freedom of information data, direct to your attention some months ago?

Ms CARMEL TEBBUTT: As I have just pointed out, in the most recent budget, we have provided an extra $4 million recurrent enhancement, and that comes on top of the recurrent enhancement that was provided in the previous year.

Dr JOHN KAYE: But I am specifically talking about paediatric aids?

Ms CARMEL TEBBUTT: That enhancement will go to all of the various, different aspects of the Program of Appliances for Disabled People. If you want to know how much of it or what is the situation with particular types of aids, I am happy to take that on notice, unless the deputy director general can answer that—I will just check. No, we do not have detailed information on individual types of aids under the program but I can assure you that that additional funding will mean that the overall program is enhanced, and that will benefit all recipients including children.

Reverend the Hon. Dr GORDON MOYES: I would like to go back to Dr Matthews with a follow-up question on the Central Coast. The Government recently announced the Central Coast would be a major regional hub.

Dr MATTHEWS: For cancer treatment or—

Reverend the Hon. Dr GORDON MOYES: No, for everything. But I cannot see any strategic plan for making a regional centre for the Central Coast for Health. It is still North Sydney and Central Coast. When are you going to have a regional centre on the Central Coast for Health as other government departments do?

Ms CARMEL TEBBUTT: I will respond and then I am happy for the deputy director general or the director general to provide some additional information. You might recall a few weeks ago we released a discussion paper, which is our response to the Council of Australian Government requirement to establish local hospital networks. One of the proposals in that discussion paper is that the Central Coast would once again become a local hospital network [LHN] in its own right. So it would no longer be a part of the North Sydney Central Coast Area Health Service [NSCCAHS]. At the moment we are still finalising the response to that discussion paper. Quite significant comment was received but I think I would be right in saying that the vast majority of submissions certainly supported the Central Coast becoming its own local health network.

Ms PICONE: If I could just add? The actual area health service head office is located at Gosford.

Reverend the Hon. Dr GORDON MOYES: I know that.

Dr MATTHEWS: And it appears that the local division is in favour of a Medicare local for the Central Coast area. So it may be that the boundaries of the local health network and the boundaries of the Medicare local are the same, and this ought to enable some joint planning of primary, aged and hospital services for that population.

Reverend the Hon. Dr GORDON MOYES: Unfortunately, all three of you missed the point. The point was that the New South Wales State Government was planning, and has announced with plenty of spin, that this will be a new major regional hub. My question was: When will NSW Health actually announce it as a major regional centre? Minister, you replied by saying that it is Federal Government policy that we need to have more local area health. That is fine, but when is the State Government going to announce a regional Health hub?

Ms CARMEL TEBBUTT: Establishing the Central Coast as its own LHN [local health network] is doing precisely that. As I said, we are currently finalising our response to the discussion paper that has been released. The Deputy Director General referred to the Medicare locals. One of the things that we are keen to do is to try as much as possible to ensure that there is some alignment between the boundaries of our local health networks and the boundaries of primary health care networks or Medicare locals.

Obviously there has been a little bit of a delay in the Federal Government being able to finalise its response to the Medicare locals because of the Federal election and the intervening period of establishing the Government. I have had discussions with representatives of the Division of General Practitioners on the Central Coast and they are quite keen to have a Medicare local that is a Central Coast boundary that would line up with our LHN. That quite clearly indicates that that is making the Central Coast its own area and a clear capacity for that area to provide the health services to its local community.

Ms PICONE: If I could, I think I have got the point now. The Area Health Service Clinical Plan does deal in great detail with the development of health services on the Central Coast. The staff has certainly expressed very strongly its desire to be cut free from North Sydney. It was a very strong desire at the meetings. Having said that, and I think there is a lot of sense in that, it will never be completely set free, certainly at least for another five years because there are a number of higher end tertiary and quaternary services that will require

networking of services either between the Hunter or northern Sydney, particularly in the area of cardiology and I also think top end-type cancer services.

Reverend the Hon. Dr GORDON MOYES: So five years, Professor?

Ms PICONE: Gosford is going very well with medical recruitment. Last year we also set up some chairs for Wyong Hospital in emergency medicine, a physician and in surgery to try to build up the medical infrastructure. As you know very well, to start something like intervention or neuroradiology services or to start a top end rare cancer service takes quite some time. So they are always going to have relationships with quaternary services either to the north or south of them. There was a very strong desire to be set free from the shackles of northern Sydney, no doubt about that.

Dr MATTHEWS: A real turning point will be the completion of the new integrated cancer centre, which is jointly funded between the State Government and the Federal Government. It will greatly enhance cancer services, including two new linear accelerators in the public sector to bring the Central Coast's total to four. The completion of that work will mean that a very significant amount of the cancer work, which is a large part of our work, will be done locally with only the most complex patients flowing to Royal North Shore or John Hunter.

The Hon. SHAOQUETT MOSELMANE: Minister, could you update the Committee on the health system's overall performance in the emergency departments, elective surgery waiting lists and ambulance services over the past 12 months?

Ms CARMEL TEBBUTT: We have already had quite a bit of discussion about performance, particularly in regard to individual areas. But it is worthwhile placing on the record some of the broader achievements of the health system with regard to the most recent quarterly performance data that was released. As I said earlier, the New South Wales health system is, like many others, under constant pressure from an increasing population, a growing and ageing population. In light of these pressures, it is pleasing to note that the most recent performance report indicates that the health system is responding well to the demands that are placed on it. That is in no doubt due to the very hardworking staff in the health system right across New South Wales. I take this opportunity to pay tribute to the hardworking doctors, nurses, allied health staff, administrators and others who every day come to work and put in a huge effort to make sure that the people of New South Wales can get access to the best possible care.

With regards to our emergency departments, as I said earlier, emergency departments always give priority to the most life-threatening cases. New South Wales hospitals continue to treat 100 per cent of the most seriously ill within the national benchmark of treatment, which is a designated two-minute time frame. For those patients classified as triage category 2, or imminently life threatening, the performance in treating patients within 10 minutes in 2009-10 was 82 per cent. That is two percentage points above the Australasian College for Emergency Medicine's target level. For those patients classified as triage category 3—I think they were the patients we were discussing earlier—that is, potentially life threatening, the performance in treating patients within 30 minutes was 70 per cent. That is three percentage points above the previous year's figure of 67 per cent and 5 per cent of the benchmark target of 75 per cent.

There is no doubt that triage category 3 is the one that we are always challenged by. I said earlier that we meet four out of the five triage benchmarks. Triage category 3 is the one that we do not meet, and there is a range of reasons why that provides challenges for the health system. With regard to triage category 4, 73 per cent of patients had their treatment commence within 60 minutes, and that is three percentage points above the 70 per cent benchmark. With regard to triage category 5, 89 per cent of patients were seen within 90 minutes and that is 19 per cent above the benchmark. That is a reasonable performance: four out of five triage categories are being met with regard to the benchmark. There has been an 8 per cent improvement in patients being seen within the triage benchmark time, despite a 21 per cent increase in emergency department presentations over the period. As I said earlier, we still remain the best performing State within Australia for seeing patients within the triage category.

I turn now to elective surgery, again an important area of activity in our public hospitals. We have provided additional funding in the 2010-11 budget for elective surgery. These investments will help us deliver ongoing improvements. With regard to the June 2010 data, we have already seen that the number of patients overdue in each urgency category continues to be reduced. Across New South Wales the number of patients waiting more than 12 months for elective surgery was cut from 9,940 in January 2005 to 1,063 in June 2010.

That is an 89 per cent decrease since January 2005, but we want to see that get down even further. We do not want any patients waiting for longer than 12 months. We want them all seen within their benchmark time. I also briefly make mention of the Predictable Surgery Program. That is making sure that we are targeting elective surgery waiting lists and that more elective surgery is being performed than ever before. Also, as I said earlier, the $1.2 billion that was secured at COAG [Council of Australian Governments] will flow directly into New South Wales Health. It will mean more beds and more staff, and it will help us continue to lift our elective surgery performance.

The Hon. CHRISTINE ROBERTSON: Minister, can you please provide information about the current status of the National Health Reform?

Ms CARMEL TEBBUTT: Already we have had some discussion on this issue, particularly in response to the honourable member's question about the Central Coast and the establishment of LHNs. We have also talked a bit about the additional funding that is coming into the system as a result of the historic agreement that we reached at COAG on 19 and 20 April. Just to recap, the broad benefits that came from those negotiations was, first and foremost, a better financial outcome for our health system. The Federal Government has given a clear indication that it is prepared to invest more in our public hospitals.

There is no doubt that over the 10 or 11 years of the Coalition Federal Government we saw a significant decline in investment in our public hospitals by the Federal Government. That put huge pressures on our public health system. It has always been the case that the expectation is that the investment between the State and Federal governments in public hospitals would be about 50-50. In the final years of the Howard Government that investment went down to about 41 per cent in our public hospitals. We are very pleased that we have a Federal Government that has indicated it is willing to invest more in our public hospitals and, in fact, become the dominant funder of public hospitals.

There are other benefits that came out of the COAG agreement as well. First, the other major benefit was a greater focus on primary healthcare. we know that one of the things that puts pressure on our public hospitals is the fact that people need to be able to get access to the right care in the right place at the right time, and often if they are not able to access that care in the community, they come to our public hospitals. So we welcome the focus on primary health care and the establishment of the primary healthcare network for the Medicare locals.

Of course, there is a range of protections that we were also able to negotiate for our State: pooled funding arrangements to make sure that funding could be directed to best meet the needs of New South Wales families; block funding for small rural hospitals so that services can continue to be provided to rural communities—I know that is something that the honourable member is particularly keen to ensure; and there was quite a lot of debate in the lead up to signing the COAG agreement about how we can best protect those regional and rural hospitals in an environment where case mix funding will become the means by which hospitals are funded, because many of those hospitals simply cannot provide care at the most efficient price, they often have to fly in and fly out staff; they have transport costs; they have smaller hospitals, so they do not have the throughput. That was a really important protection that New South Wales was able to negotiate—that block funding for small rural hospitals—and also protection from future GST clawback.

To move on a little bit to where we are at now, as I said, we have announced additional beds right across the New South Wales health system as a result of the extra funding that we received through the COAG agreement. A total of 236 new beds have now been announced across New South Wales. They are examples of real improvements to our hospitals, and there are more to come. I want to make it very clear that additional beds mean more staff. A 20-bed general acute ward costs approximately $6 million in staffing costs, with typical staffing levels of around 20 nurses. So it is not just beds, it is, of course, staff that come with that.

We are also benefiting from more equipment. There is some $14 million in new emergency department equipment and $21 million in surgical equipment. As I said earlier, we have released our discussion paper with regards to our local health networks. Our discussion paper provides for 15 geographic local health networks, and also two specialty local health networks. We are currently collating the responses to the discussion paper. It has been a very good response. We made some of the governance arrangements clear in the discussion paper, including the fact that each local health network will have a chief executive and a governing council that will comprise members with a variety of health, clinical and business skills, and we will continue to discuss with the Commonwealth prior to finalising the boundaries of our local health networks to ensure that they can be up and running from 1 January 2011.

The Hon. SHAOQUETT MOSELMANE: Minister, thank you for your hard work and commitment to the people of New South Wales. Can you provide information about the current status of Caring Together reforms and what are the key priorities for 2010-11?

Ms CARMEL TEBBUTT: Thank you for the question. It is an important one because the Caring Together Health Action Plan is the Government's response to the Garling inquiry into our acute care system—I think it is the most comprehensive inquiry ever into acute care services in New South Wales. It is important to place on the record that Caring Together will remain a key focus for our health system irrespective of the fact that we are now engaged in this process of establishing local health networks and implementing the national health reform, because there has been a great deal of effort made in implementing Caring Together. I know when I move around the system—and I know the director-general did many consultations in the lead-up to the release of a discussion paper with regard to national health reform—what we heard very clearly from the health system, from the people who work in the health system, is that they wanted our focus on the Caring Together Health Action Plan to remain, and it will, because in many ways what is in Caring Together and what is part of national health reform dovetail together very, very appropriately and very properly. We will continue that focus.

We are investing some $485 million over four years to make changes. In 2010-11 that is $124 million. We have established an independent and transparent monitoring process to track the implementation of the reforms. There is an independent panel that is chaired by John Walsh. The panel reported first of all in November 2009. That report was made public. It then reported again a month later in June and, again, that report was made public. That is a really good process because it can give the community confidence that there is independent oversight of the implementation of the reform.

It has been about 18 months since Caring Together was released. I will touch on some of the key achievements. First, we have expanded the workforce and increased the skills of staff. We have expanded the number of medical positions for junior doctors in rural and regional areas. We have established 45 positions in rural areas for doctors who are in their second and third year of training. We have also added 22 specialist training positions in rural and regional areas, including Goulburn, Wagga Wagga, Tweed, Tamworth, Manning and Port Macquarie hospitals, and we have filled nearly all of those positions. We are investing extra funds in our postgraduate program—about $7.2 million in 2010-11. We have appointed 42 executive medical directors.

This was one of Garling's key recommendations and it is about trying to make sure that we can provide clinical leadership in our hospitals and enhanced clinician engagement. We have employed over 500 clinical support officers. These were the positions that, again, Peter Garling said were essential in order to be able to free up our front-line doctors and nurses so that they can focus on patient care—they can do the work that they want to do and that we want them to do. The clinical support officers can provide the administrative support that is needed in the wards in our hospitals but does not need to necessarily be done by a clinically trained person. We have expanded the number of clinical initiatives nurses and we have also expanded the number of clinical pharmacy positions.

If I can turn to patient safety and communication, because, again, that was a critical area that Commissioner Garling reported on. One of the things we released earlier this year was Between the Flags. That is a world-class program. The Clinical Excellence Commission had a critical role in bringing this program to fruition, but it was really worked through with clinicians in the health system. They used the terminology Between the Flags because it is something that all Australians can probably relate to. We are conscious of the red and yellow flags at the beach: you swim between the flags. So this is a program to ensure that clinicians recognise and respond to patients appropriately when their clinical condition starts to deteriorate. It includes the release of a standard observation chart and also the training of some 65,000 staff right across the health system, across some 250 facilities. It is a really important program and I hear good things, and I am sure the director general would say that as well. We hear good things about it whenever we move through the health system.

I can also talk briefly about the hand hygiene policy—again, a critical thing that Garling focused on. We have a statewide hand hygiene policy, and audit tools are nearing finalisation. All area health services have also developed implementation plans for safe clinical handover, which mandates the implementation of a standard set of key principles for all types of clinical handover. Strengthening local decision-making was another key area that Commissioner Garling reported on. We have established our clinical councils. Hospital clinical councils are being established from 1 July 2010. Some hospitals already had clinical councils and some areas already had clinical councils, but they were not in every hospital. Again, one of the things that I heard very clearly from meeting with doctors and nurses and other clinicians was that these clinical councils are a way of

ensuring that at the hospital level you have got the key staff involved in all of the decisions that go to how a hospital operates. I think clinical councils have been well received.

The Hon. SHAOQUETT MOSELMANE: Minister, there was a question earlier from Reverend the Hon. Dr Gordon Moyes in relation to the growing population. Can you outline the New South Wales Government's capital investments to cater to the health needs of Sydney's growing population?

Ms CARMEL TEBBUTT: It is an important issue because, as Reverend the Hon. Dr Gordon Moyes pointed out, and as others would be well aware, a growing and ageing population means that there is demand for our health services, and we have made a significant investment in capital infrastructure in this most recent budget—I think about a 50 per cent increase on the previous year with regard to our capital budget. We are spending more than $3.3 billion over the next four years building and refurbishing public health facilities. Much of this growth will occur in metropolitan areas but not all of it. The fastest-growing population is expected to be in the Sydney South-West Area Health Service. It is forecast to grow from 1.3 million people in 2006 to 1.7 million people in 2021.

We are making a range of investments in south-west Sydney. Liverpool Hospital is very important; it is a major tertiary referral hospital and it provides leadership in clinical care, teaching and research. It is also a teaching hospital for the University of New South Wales. We are expanding the hospital to meet current and projected demand. For example, it will include a new seven-storey clinical services block, a reconfiguration of the existing clinical services block, including a six-bed psychiatric emergency care unit, and an extension of cancer services. The hospital will have a capacity of nearly 800 beds when this stage is completed. That is nearly 200 extra beds compared with June 2006. I think that is on track to be opened by the end of the year and I know it will be welcomed by the people of south-west Sydney.

Western Sydney is also expecting huge population growth from 1.1 million people in 2006 to 1.4 million in 2021. Our redevelopment at Nepean Hospital is geared to meet that projected increase in demand for health services. That project will deliver six new operating theatres, 108 medical and surgical beds and six additional renal dialysis treatment spaces. Oral health services will also be consolidated on the Nepean Hospital campus, giving it a total capacity of 32 chairs. In the mental health area, a new 20-bed older persons' acute unit will be established, and adult acute mental health services will be redeveloped and expanded to provide 44 beds.

Northern Sydney is also expecting increased population growth. The Northern Sydney Central Coast Area Health Service area is expected to grow from 1.1 million people in 2006 to 1.3 million in 2021. Of course, the Royal North Shore Hospital redevelopment will provide a significant boost to health services in that area. That project represents a total investment of more than $1 billion. It is our largest ever health capital works project. I could continue, but I will conclude there. I am happy to provide more detail about the many other smaller capital investments that we are making across the Sydney metropolitan area, including at St George Hospital and a range of other hospitals.

CHAIR: Minister, I refer to your responses about surgery waiting times. Are you aware that your waiting time and elective patient management policy includes an instruction to doctors who provide a planned admission date of more than 12 months hence that that will not be accepted? Surely that would have a big effect on those waiting for 12 months?

Ms CARMEL TEBBUTT: Our goal is to treat patients—

CHAIR: If you are saying they are not accepted then they are off the list.

Ms CARMEL TEBBUTT: That is not right.

Dr SMYTH: I am happy to clarify that. The policy sets the benchmark that no-one should have to wait more than 12 months for surgery; in fact, we would prefer them to wait even less than 12 months, and certainly not more than 12 months. For a surgeon to send a request for booking for a patient more than 12 months hence—that is, they do not intend to operate on them for 15 months, two years or three years—is not acceptable because that is too long. The patient is still placed in the booking system, but the hospital will discuss with the surgeon whether the operation can be done within 12 months. If not, we look at alternatives such as increasing the operating time for that surgeon, getting another surgeon at the hospital to do the operation or offering other alternatives to the patient.

CHAIR: So you offer extra lists to surgeons?

Dr SMYTH: The patient is on the booking system.

CHAIR: Do you offer extra lists to surgeons in those instances?

Dr SMYTH: In terms of—

CHAIR: Is that the first thing you do?

Dr SMYTH: We look at the options available. It depends on the availability of the surgeon.

CHAIR: You said that you offer—

Dr SMYTH: It is one of the options that we explore.

CHAIR: It was the first thing you mentioned.

Ms CARMEL TEBBUTT: It is not the only option.

Dr SMYTH: It is one of the options that we explore to ensure that patients get their surgery.

CHAIR: I just wanted to clarify that. That is fine.

Ms PICONE: The waiting list policy has been developed with the Surgical Services Taskforce [SST], which is chaired by Dr Patrick Cregan. It has some of the most eminent and, at times, interesting surgeons in the State as members. That is regularly updated. It is not issued unless there is an agreement at the SST that that is an appropriate clinical policy.

CHAIR: The issue is those providing grassroots surgery. It is interesting that they are offered extra lists. I refer back to the access block. We were talking about Maitland Hospital. I understand that the access block refers to when patients are stuck in emergency departments for more than the eight-hour benchmark. Your new website, which you say has rich information, claims that 65 per cent of patients at Maitland Hospital were admitted within eight hours. However, the August figures from your own department indicate that that has dropped to 59 per cent. That was well and truly after the ambulance bays were repaired and updated. Is that because despite your recent claims about extra winter beds they have not been enough to unblock the emergency department?

Ms PICONE: As a general comment, the access performance data is collected almost real time with the new clinical systems. We issue a report to the system on a weekly basis.

CHAIR: That is what we want on the website.

Ms PICONE: The issue is that that remains an unaudited report—it has not been through the data quality checks. The point you have raised is very good and we should be looking at that. I am assuming that you are referring to the report that I have. On 9 August the access block was 52.8 per cent; on 16 August it was 66.9 per cent; on 23 August it had gone to 75.2 per cent; and on 30 August it was 71.9 per cent. Often depending on workload there can be variations in the access performance on a weekly and, clearly, a daily basis.

CHAIR: That is right, but the Minister announced that there were extra beds for Maitland. The issue is that they were not enough to unblock the access. In reality they were just extra winter beds.

Ms CARMEL TEBBUTT: That is not true. The Council of Australian Governments beds that we have announced are not just winter beds. We do open up extra winter beds, but the Council of Australian Governments beds are available to the system throughout the year. We obviously strive to move people out of the emergency department within the eight-hour timeframe. However, when I met with the emergency taskforce a few weeks ago they pointed out to me, and it is a point that members should be aware of, that there are occasions when it is clinically appropriate to keep a patient within the emergency department because they need the type of expert clinical support available there. Generally we aim to move people out of the emergency department within eight hours.

The Hon. MARIE FICARRA: I refer to Peter Garling's report, which you mentioned previously. You acknowledged recently in a speech in Parliament that Peter Garling recommended that much more comprehensive patient care data should be reported, including infection rates, for each unit or ward. How can you suggest that the Department of Health's website provides useful information about infection rates when it has limited data that is one year old? How can that represent fulfilling Garling's recommendations.

Ms CARMEL TEBBUTT: New South Wales is in fact the only State to report infection data. Prior to the launch of the website we were reporting infection data at an area level. I gave a commitment that we would report it at a hospital level, and that is what is available on the website. Ours is the only State to do that. With regard to the timeframe, again, this is extremely important, and we have to make sure we have the opportunity to properly collate and check the data before we report it. There is ongoing discussion and analysis within the system of how we can provide infection data at a level even greater than the hospital level. I might ask the director general to comment on this. It is important that the Committee appreciates that we are providing infection data at a hospital level. That is not done anywhere else in Australia. That is a significant achievement.

The Hon. MARIE FICARRA: I appreciate that, Minister, but the people of New South Wales want to know for each individual hospital and each department how the infection rates are being contained. That was supported by Peter Garling in his report. Simply when is it going to be done?

Ms PICONE: We had advice on this from an expert committee of infection control doctors, and I will ask Dr Smyth in a minute to go into the detail of it. We believe we are in a position now or very soon to be reporting the data quarterly. It is technically complicated and there is at a clinical level some disagreement on what should be reported. We have had to work our way through that with the senior doctors involved in it, but Dr Smyth might want to comment on some of the issues we have had getting the data up in the first instance.

Dr SMYTH: There are eight nationally agreed indicators of healthcare associated infections. New South Wales is the only State that collects those indicators for every public hospital in the State. We are the only State that does that for 100 per cent of the hospitals. We have an infection control expert advisory group with infection control specialists, doctors and nurses—nurses play an important role in infection control. Their advice to us—and I have had quite a bit of discussion with my patient safety committee about this—is what is the best way to report the data and report it in a way that is statistically valid.

The debate has really been about not only the issue of frequency of reporting but looking at trend data. For a number of indicators they are suggesting to use the statistical technique called the funnel plot, which looks at the variations on a month-to-month basis and then statistically looks to see whether there is a trend. So we have now reached the point with the infection control advisory group that we use the funnel plot for a number of the indicators. They strongly support quarterly because their view is that monthly data will vary for statistical reasons rather than a real change in infection rates. That information will allow the department to update regularly on a quarterly basis and on the My Health website.

Of the eight indicators, a number relate to intensive care, so that obviously does not apply to every hospital. The clinical advice we have received is that the staph aureus bacteremia rate is probably the best indicator of healthcare associated infections in hospitals. So that is the rate that goes on the My Health website and that is the number of hospital-acquired infections per 10,000 bed days, which is the national definition. On that rate New South Wales is well below the national comparison.

The Hon. MARIE FICARRA: Since the data is a year old, how can we believe you? Number one, we do not have any set parameters, we do not have any set standards. We are the only State that reports but we do not really know about that. When are we going to know the standards? When are we going to have up-to-date quarterly reports? When is that going to be initiated?

Dr SMYTH: I can answer that question quite easily for you. The standards are on our website and I will be happy after this morning to give you the link to the website. They have been on the website for over two years.

The Hon. MARIE FICARRA: You just said it is under discussion because there is disagreement.

Dr SMYTH: No, you have not been listening to what I have been saying, with respect. The definitions are nationally agreed. The difference is that New South Wales is the only State that collects it for every public hospital in the State. We are the only State that does that.

Ms PICONE: I will just clarify if I could. The Council of Australian Governments has proposed a national benchmark of two staphylococcus aureus bloodstream infections per 10,000 bed days, so that is what is nationally accepted. That is what we are doing.

Dr JOHN KAYE: I am sorry may have that again? That is two per—

Ms PICONE: Two per 10,000 bed days. Believe me, people do their PhDs on this area, as you would all know.

Dr JOHN KAYE: Staph aureus is golden staph?

Ms PICONE: Yes, that is correct. One thing I am quite proud of, so I thought I would get in a free plug here in that New South Wales has also led the way in dramatically reducing central line infection in intensive care units. This has been a major issue in all public hospitals. It is published quite regularly, septicaemia. The infections range from 0.5 to 2.9 per thousand bed days during January to December 2009. We also report those data regularly on our website as well, and we are the first jurisdiction to undertake that program of work led by senior clinicians. I am quite proud of that.

The Hon. MARIE FICARRA: Thank you, Professor Picone. Can we just move back to the issue of dialysis, and it is important to look at the Forbes area. In September last year Ross and Elivy Quick were told by health managers in the Greater Western Area Health Service, in the presence of the shadow health Minister the Hon. Duncan Gay and others, that they did not have to drive 700 kilometres a week for dialysis treatment in Orange as Forbes hospital would be expanded within three months. However, they are still driving 700 kilometres, and given they were told no extra nurses would be required, the chairs would be leased and the capital works required were relatively minor, why is this elderly couple having to be put through such a traumatic, long and tiring drive three times a week?

Ms CARMEL TEBBUTT: I will get the deputy director general to respond to that. We have provided additional investment in renal dialysis at Forbes. We might need to take on notice the specific details regarding the individual patient you refer to because there are sometimes reasons why individual patients may not be appropriate for the type of renal dialysis that is being provided. But I will see if the deputy director general can provide a little more detail?

Dr MATTHEWS: During 2009-10 an additional four patients have been accommodated at Forbes. I do not know the couple you are referring to but I would like to take down the names and investigate that personally and try to fix that.

The Hon. MARIE FICARRA: Ross and Elivy Quick. This was September last year, so a year has gone by and they were promised a better service and they are not getting it.

Ms PICONE: We could look into the individual patient care issue but, as I said to you earlier, many of these units are set up for what we call maintenance dialysis and if we had a number of unstable patients—and I do not know the details of this patient—sometimes that dialysis cannot be accommodated locally, but we will get on to that and get that issue resolved.

The Hon. MARIE FICARRA: Turning to the issue of staffing cuts, how many nurse redundancies were there in the year 2009-10?

Ms CARMEL TEBBUTT: I have a figure here for 2009-10—479 voluntary redundancies. That is all staff. I do not have it broken down into nurses, but we can take that on notice.

The Hon. MARIE FICARRA: The New South Wales Health Department's special task force report for the Sydney West Area Health Service identifies 291 full-time equivalent staffing position savings worth a total of $22 million-plus. My question is how much of the savings were realised in the budget result in 2009-10—and I realise you might have to get back to us on to specific answers—and how much will be realised in 2010-11? So, specifically coming back with those staffing figures—

Ms CARMEL TEBBUTT: I assume you are talking about the Browbank Sidhu report. Is that the report that you are talking about?

The Hon. MARIE FICARRA: Yes.

Ms CARMEL TEBBUTT: This was a review of various issues in the Sydney west area. It includes staffing activity and also identifying opportunities to use available resources. There is no doubt that with the growing demand for health services, despite the fact that the Government has significantly increased the health budget—in fact, increased it by about 192 per cent since we came to office, so a substantial increase in the Health budget—we do need to make sure that every dollar is used in the most effective and efficient way because, with the demand, we simply cannot afford for it to be otherwise. This report was one of a number of components or a number of ways to assist Sydney west to get an improvement in its budget performance. I will see if the deputy director general wants to add anything.

Ms CRAWSHAW: That is correct. Obviously, staffing in all the area health services, including city west, fluctuates monthly depending upon activity levels and where its priorities change. What was the snapshot for the Sidhu Browbank review might be a different situation at the current time, given we have just been through winter and we have a significant surgical program at Sydney west.

The Hon. MARIE FICARRA: But you will be able to provide us with that further information. I will just move on to the Federal health agreement. Minister, what advice were you given from your department about whether New South Wales should sign up to the agreement in the first place?

Ms CARMEL TEBBUTT: The process obviously with regards to negotiating the COAG health agreement was a long and extensive one. I received much advice throughout that process. You might recall that, of course, initially the Prime Minister had the Health and Hospitals Reform Commission, which undertook extensive consultation. The Prime Minister and then the health Minister federally also undertook extensive consultation on those recommendations. There was then the COAG process, but obviously COAG is an agreement between first Ministers, so that is the Premier and the Prime Minister.

The Hon. MARIE FICARRA: One would assume that you would have been supplied with lots of advice and briefs on the matter before signing up?

Ms CARMEL TEBBUTT: That is the case but it is the Premier who signs the COAG agreement, not the Health Minister.

The Hon. MARIE FICARRA: Nevertheless, you were well informed and received advice on the matter, were you not?

Ms CARMEL TEBBUTT: I received much advice throughout that whole process because it was such an extensive process and the agreement is one that provides huge benefit for the New South Wales health system.

The Hon. MARIE FICARRA: Did your Director General of NSW Health, Professor Picone, attend the COAG meetings where the federal health agreement was negotiated?

Ms CARMEL TEBBUTT: No.

The Hon. MARIE FICARRA: Why not? Was Dr Richard Matthews the only representative of the Department of Health present?

Ms CARMEL TEBBUTT: As I pointed out, COAG is a discussion between first Ministers, the Prime Minister and the Premier. There were a range of people who were there to provide advice to the Premier on behalf of New South Wales. Dr Richard Matthews was one of those people.

The Hon. MARIE FICARRA: In actual fact, Dr Richard Matthews was the only representative from the Department of Health who was present during these negotiations and during the signing up?

Ms CARMEL TEBBUTT: I believe that is correct. Dr Richard Matthews can answer for himself.

Dr MATTHEWS: Under the rules that were set down by the former Prime Minister, each Premier was only allowed three advisers in the room during the discussions. There were other advisers outside. I was the only person from NSW Health in the room. I would add that I was almost the only person from Health in the room.

The Hon. MARIE FICARRA: So all the rest were from Treasury and Premier's?

Dr MATTHEWS: As was continually said by the Premiers, health reform is such an important national issue that it needs to be led by the Prime Minister and the Premiers, in their view.

CHAIR: Well advised.

[*Short adjournment*]

Dr JOHN KAYE: Minister, last week you announced the finalisation of what you referred to as the decisions on the transfer of State nursing homes to the non-government sector—what the rest of us would refer to as privatisation. A number of homes were not transferred to the private sector, about nine of them in total. Would it be a fair characterisation of the list of nine to say they fell into two categories: those where the community was able to mount a substantial campaign and attract the attention of the media, and those where the finances were so problematic that the private sector would not touch them? In fact, what went to the private sector were those where there was not a strong community campaign and there were insufficient finances to make them attractive to the private sector?

Ms CARMEL TEBBUTT: No, I do not think that is a reasonable way to categorise the decision. I think it is worthwhile rewinding just a little bit. We have in fact been in the process of transferring State Government nursing homes to the non-government and private sector for some 10 years now. I said this in the House last week and people thought it was very funny. But there is a very good reason why, broadly speaking, this is the correct policy setting. That is because the Federal Government is responsible for residential aged care. The Federal Government provides support to residential aged care providers, and the reality is that the financial support that is provided to the State Government to deliver residential aged care is less than the financial support that is provided to the non-government and private sector. For a whole range of reasons, it makes sense to transfer State Government nursing homes to the non-government sector.

Having said that, there are, for a range of reasons, circumstances where it would not be appropriate to transfer a State Government nursing home to the non-government or private sector. It might be because, in a regional or rural location, the nursing home is co-located with the hospital and it is very difficult to disentangle the operations. In the case of Garrawarra, for example, a nursing home that provides a very specialised type of care and support, I need to be confident that in those circumstances that specialised care and support can continue to be provided to the community of New South Wales. So there are a range of reasons why, in some circumstances, we have not transferred certain State Government nursing homes to the non-government sector. Having said that, I think this is a very useful process we have been through, because by putting it out to market in the way we have done we are able to test exactly what issues we are delivering and whether it is being done in the best possible way.

Dr JOHN KAYE: But some of those nursing homes—and I am pleased that this has happened—were not put out to the market. The two in particular, Wallsend and Murrumburrah-Harden nursing homes, were not put out to the market because the community said they did not want them privatised. If the community in Penrith or Picton and their local members had fought as hard as the community and local members did in the case of the other two I have referred to, would those two—Governor Phillip Nursing Home and Queen Victoria Memorial Home—be taken off the list as well?

Ms CARMEL TEBBUTT: There is no doubt that the view of the local community and the council is obviously critical to this whole process. Aged care facilities are something that do need to have strong community support, so that is a factor right across the board. Having said that, however, what has driven the decision-making with regard to the nursing homes that have transferred and the nursing homes that have not transferred is a range of different factors. With regard to Wallsend and Murrumburrah-Harden, they were decisions that were announced at the end of last year; they did not make it through the next phase of the tender process.

Dr JOHN KAYE: Because the community was well enough organised to stop it happening?

Ms CARMEL TEBBUTT: No, that is not the case. My recollection is that with regard to both of those, I do not think there was strong enough interest from the non-government or private sector to take them on. You need to remember that when we went into this process the Government made it very clear that we wanted to ensure that the delivery of services remained as good as or better than what was the case under State Government operation. It may be that in some circumstances—and I think of some of the regional nursing homes, for example—the private or non-government sector might be able to take them on. But they would not necessarily be able to run them and to provide the same level of service that we were providing for the subsidy that the Federal Government provides. In those circumstances, it would not be appropriate obviously to transfer the nursing homes.

Dr JOHN KAYE: Was that the case in Wallsend and Murrumburrah-Harden?

Ms CARMEL TEBBUTT: I do not have a lot of detail on Wallsend and Murrumburrah-Harden because they occurred at the end of last year. My recollection is that there was a two-phase process and that they did not get through the first phase and that is why we were able to announce that decision at the end of last year. But I am happy to come back to you with a bit more detail about exactly what the issues were there. I cannot remember if it was that there were no non-government or private sector providers interested, or if there were some interested but they were not able to deliver the services at the standard that we deem necessary. But we can come back to you on that.

Dr JOHN KAYE: Can we go to the health care reform that we spoke about earlier? What evidence were you presented with, at the point where the decision was being made in New South Wales to sign the agreement, that case-mix funding in New South Wales—not of the regional hospitals that have blocked funding, but the other hospitals—would not attract the same degree of problems that has occurred with case-mix funding in Victoria? In particular I refer to the downward pressure on care for those patients who are not standard patients, those who present as outliers for a particular problem. They might have a specific problem that might fall within a specific category, but they are outliers because, for whatever reason, as happens given the randomness of the human body, they have an extra care need but will not be funded for that other case-mix?

Ms CARMEL TEBBUTT: I might get the Deputy Director General to respond, but I will make a few comments. This was an issue in the consultations that the Premier and I undertook as we were preparing ourselves to go to the Council of Australian Governments; this was an issue that was raised by a number of clinicians and others—that is, a concern that casemix funding can drive activity inappropriately. But you do have to also remember that there was already as a result of previous Council of Australian Governments and Health Minister agreements a move towards casemix funding right across Australia. What the Council of Australian Governments agreement did in April was to bring that forward, but that was a process that was already substantially underway. I will ask the Deputy Director General—

Dr JOHN KAYE: Just before you do, my question was specific. I asked you whether you had received any briefings about concerns about casemix funding. I am keen to hear from Dr Matthew—in fact I am enthusiastic to hear from him—but I want to hear whether you as the Minister were in any way briefed on concerns that your department or other people may have had about the impacts of casemix funding?

Ms CARMEL TEBBUTT: Since I have become the Minister I have had many briefings on casemix funding, including one memorable occasion where the Deputy Director General attempted to take me through the intricacies of casemix funding, and all of the challenges that it proposes. So I have had many briefings on casemix funding, and you can understand that it is an important issue. With regards to the Council of Australian Governments agreement, as I have previously made clear, that was an agreement that was made between first Ministers; so if you are seeking what advice the Premier had you would need to direct that question to her. But certainly we were well aware of some of the challenges with regards to implementing casemix funding because it was a process that was already under way. There were previous agreements of Health Minister around casemix funding and the Council of Australian Governments agreements I believe as well.

Dr JOHN KAYE: Your department has raised with you concerns about casemix funding and the impact it will have in driving, as you put it, Health spending in an adverse direction?

Ms CARMEL TEBBUTT: What we have discussed is how you can use casemix funding as an appropriate tool but not to have it have the impact of inappropriately driving activity. I will get the Deputy

Director General to speak to that because he is really the expert, and I hope he does not confuse you in the way that he sought to confuse me on one occasion.

Dr MATTHEWS: That is unkind, Minister.

Ms PICONE: We are still trying to get over it.

Dr MATTHEWS: The issue of outliers is an important one. Obviously outliers create budget pressure under any funding system but casemix is probably best able to deal with that. Because the more complex your case, the longer you stay, the more there is an addition to what is called your case weight. There are 59 coding fields and, on average, only four are filled out. But if you are a very complex, very long stay patient with lots of code morbidity you will get lots of fields filled out, you become a much greater case weight and, therefore, there is much more funding for you. There is a built-in process within the system to deal with complex cases.

In relation to the capacity of casemix or episode funding to drive activity, that is a risk that needs to be managed. We use episode funding in New South Wales as a tool around technical efficiency to measure the average distance from a particular price of peer hospitals to determine which hospital is the most efficient and to drive efficiency. If you use it as a prospective funding tool then, as has been the case in Victoria, you run the risk that the activity runs away, and if you look at the admission rates in Victoria they are higher than they are in New South Wales. So in setting your activity levels under casemix funding you need to be very careful that you do not create perverse incentives. But as a tool to technical efficiency, it is an excellent one.

Dr JOHN KAYE: But not as a tool for funding?

Ms PICONE: Could I just add? These are our views; I have to be frank with you. I mean casemix was originally designed as an information system, and as an information system it is excellent. Because many years ago you simply described the patients in your hospital as medical, surgical, obstetric and then, as it got more sophisticated, aged care, but when this was designed with a group through Yale University it was meant to help us understand the patients we were treating. The point you raise is a very germane point. Casemix systems, if not designed well and not as information systems, can drive activity absolutely in the wrong direction, which it has done in Victoria. For example, their chemotherapy patients are actually admitted, ours are treated as outpatients. The reason they admit them is to attract payment. So we certainly will be putting all of these things into the national—there are so many national authorities being set up—

Ms CARMEL TEBBUTT: The National Funding Authority.

Ms PICONE: Yes, the National Funding Authority. But as a prospective payment system we have a lot of concerns about casemix, particularly for older people with chronic and complex conditions, there is no question about that. For surgery it is quite good. Surgical patients, general medical, interventional patients, it is actually quite a good mechanism. As you would well know, private hospitals currently use casemix funding for the reimbursement of their patients—private funds, sorry.

Dr JOHN KAYE: May I ask a brief supplementary question? As you would know, the final mix of the casemix algorithm has not yet been finalised.

Ms CARMEL TEBBUTT: That is right. I will get the Deputy Director General to respond.

Ms PICONE: It never is finalised; it is an ongoing piece of work.

Dr JOHN KAYE: But in terms of what will be implemented once the reforms become live, there is still a debate about what that will look like.

Ms CARMEL TEBBUTT: It is in a two-phase process

Dr MATTHEWS: The National Hospital Pricing Authority will be set up under Commonwealth legislation and will commence its work notionally on 1 July next year. It will be charged with the interesting and onerous task of developing an efficient price for every activity that takes place inside public hospitals, both inpatient and outpatient.

Reverend the Hon. Dr GORDON MOYES: I just remembered a case where it was reported to me that one husband had said when his wife was going in for some serious procedure she would not have got the treatment that she really deserved if he had not also had pushed her down the stairs.

The Hon. MARIE FICARRA: That is a joke.

Reverend the Hon. Dr GORDON MOYES: That is the casemix scenario.

Ms PICONE: Please do not encourage him.

Reverend the Hon. Dr GORDON MOYES: In strategic planning I am looking at the waste of money that occurs when two departments do very similar jobs. I am wondering how you reconcile those issues. For example, you have the Keeping Them Safe program on child welfare where schools, with your department, have early intervention programs for children with disruptive behaviours. The Department of Education and Training uses almost exactly the same words to run its early intervention programs for children with disruptive behaviours in schools. Why are we doing this twice?

Dr MATTHEWS: The programs should be complementary because the clinicians we employee, and the teachers and remedial folk that they employee, have different skill sets. Our role with children who are behaving in a disruptive manner is to do the assessment, to try to determine what the cause is—for example, is there an underlying problem that needs treatment either in the child or in the parents or carers?

Reverend the Hon. Dr GORDON MOYES: Does psychological assessment come under your department or under the Department of Education and Training?

Dr MATTHEWS: Under our department. It is more than psychological. It often requires the mental health services. Often these children have parents who are our patients in drug and alcohol, and mental health services. It should be a partnership, it should be complementary.

Reverend the Hon. Dr GORDON MOYES: Does it work like that?

Dr MATTHEWS: I think post the Wood inquiry, the Keep Them Safe initiatives have meant that the government departments, not just those two, but all of the human services departments are working much better together. The Child Wellbeing Units, of which we have three, and the other departments generally have one each and are sharing information where that is appropriate abut children with continuing lower levels of risk that have tragically sometimes slipped through the net. There is a senior officer's group, a third tier just below me, as our representative that meets regularly to discuss these issues. There is always the possibility of duplication but it is really a matter of different departments bringing different skill sets to very complex social problems.

Reverend the Hon. Dr GORDON MOYES: I realise that is the aim. My concern is there still seems to be significant overlap. When I was looking at the results indicators for risk behaviour, I looked at, for example, the risk indicators for binge drinking. Your indicators were for a reduction of negative results due to risky behaviour. However, when I go to the New South Wales Police Force I find an increase. You have a decrease, they have an increase.

Dr MATTHEWS: It is what is known as mission conflict. Ours is a treatment mission. We seek to reduce the occasions of binge drinking through education and other appropriate interventions. The Police KPIs [key performance indicators] are around arrest rates, clear-up rates. On the surface—

Ms PICONE: Were you asking about risk drinking, how many glasses of alcohol?

Reverend the Hon. Dr GORDON MOYES: No, binge drinking.

Ms PICONE: There has just been a new definition for risk drinking.

Dr MATTHEWS: I do not think that Police are seeking to increase the amount of binge drinking. They are aiming—

Reverend the Hon. Dr GORDON MOYES: I was asking from a coordination point of view.

Ms PICONE: They are two different jobs.

Dr MATTHEWS: Mission conflict.

Ms CARMEL TEBBUTT: It is fair to say that we do seek to work closely with the Police. We have seen the reporting from the Police activities over the weekend. It is disappointing that there continues to be this alcohol-related violence occurring. We do seek to work with them.

Ms PICONE: At the Human Services CEO level there is very strong cooperation under the chairmanship of the head of the Public Service to try to bring together a further whole-of-government approach. Andrew Scipione and I have a very close relationship and very similar views, as you are well aware, on the whole issue of alcohol.

Reverend the Hon. Dr GORDON MOYES: Yes, thank you.

Dr JOHN KAYE: I want to ask you a question that you probably have been asked many times, as people running the State's health department. When are we going to see some progress on Wagga Wagga Base Hospital? The record is not very good. Promises and counter promises have been made for two decades. Is there any hope that we will see something sensible happen on the redevelopment of Wagga Wagga Base Hospital?

Ms CARMEL TEBBUTT: I am glad that you have asked that question. The most recent budget did see progress on Wagga Wagga Base Hospital and some sensible decisions, as you indicate, with regards to the hospital. The Government is demonstrating its commitment to improving health services for Wagga Wagga. We included in the 2010-11 budget some $5.1 million to finalise planning and to commence the $90 million stage one redevelopment of Wagga Wagga Base Hospital. It will also provide master planning for subsequent stages to enable the entire redevelopment of the hospital. I know that this has not necessarily been well received by the community of Wagga Wagga. I understand that. People always have very high expectations of what they would like. In our regional cities that is particularly the case where the hospital plays an important role.

I might just point out that this is the second largest new capital project in this year's Health budget. It will significantly enhance the facilities at Wagga Wagga. It will include new and upgraded areas for the emergency department, a paediatric inpatient wing, operating theatres, mental health beds and a number of acute inpatient areas. Importantly, the funding is going to be maximised for the construction of new buildings and the work undertaken will also enable the future expansion of the hospital. I know that Health Infrastructure has been meeting with the Greater Southern Area Health Service to discuss plans. They will be consulting with clinicians, staff and the community. We expect construction to begin in 2011.

The Hon. CHRISTINE ROBERTSON: Minister, there was a significant increase of 19 per cent in the ambulance budget in 2009-10. Can you advise what services this increase was invested in?

Ms CARMEL TEBBUTT: It is a good question. We have not had much discussion about the Ambulance Service yet, although I am sure we will.

The Hon. CHRISTINE ROBERTSON: No, just perpetual inquiries.

CHAIR: There is no need for inquiries when things are going well.

Ms CARMEL TEBBUTT: It is an issue that the Committee has taken a close interest in. We are investing $408 million in 2010-11 in the Ambulance Service. It is a significant investment. It is helping us meet demand for ambulance services. It means new vehicles, updated equipment and stations and, of course, more ambulance paramedics across the State. I take this opportunity to say thanks to the paramedics for the fantastic job that they do. It is one of the toughest jobs in the health system. They are all hard but they do a very tough and challenging job. They do a fantastic job, so I do want to thank them. We are increasing our investment in clinical staff. In 1995 there were 2,220 clinical ambulance staff. At the end of June 2010 this had increased to 3,730. That is a 68 per cent increase. That is a significant increase.

As clinical capabilities and transports improve we see a change in the way the Ambulance Service operates. They have changed a little bit from "taking the patient to care" to emergency health services "taking care to the patient". They are playing a much bigger role in doing that. We also are improving the training and professional development structures for the service to improve the skills of our ambulance officers. For

example, in 2009-10 $3.4 million was provided to expand the Extended Care Paramedic Program. This program is continuing in 2010-11.

It is operating in a number of metropolitan locations. It is a great program and there is a lot of good feedback on the Extended Care Paramedic Program. It is also operating in some regional locations: Port Macquarie, Taree, Tuncurry, Shoalhaven and Wagga Wagga. The extended care paramedics are trained in assessing and treating patients who may not need to go to hospital. It can also mean that some pressure is taken of our emergency departments. I am advised that it has resulted in over 40 per cent of patients avoiding an emergency department presentation when they are attended by an extended care paramedic.

The budget also includes quite significant funding for capital works—$28 million. That will enable construction to commence for new ambulance stations at Batemans Bay, Nelson Bay, Coonamble, Byron Bay, Cessnock, Murrurundi and Murwillumbah. We are also investing in key equipment and programs that will allow our Ambulance Service to maintain service levels and keep pace with new technologies. We are spending about $9.5 million on the current Ambulance Fleet Replacement Program to refurbish vehicles and upgrades equipment; $6.5 million to continue the implementation of the Ambulance Electronic Patient Record Program, which will hold important clinical information about patients and streamline the patient record process; and $2.5 million to purchase new medical equipment and maintain existing equipment. We are also providing $1.4 million to expand the Ambulance Aeromedical and Retrieval Service. This includes additional nurses, a nurse educator and a specialist medical retrieval consultant. The Ambulance Service budget is one that continues to grow and continues to provide important support and services to the New South Wales community.

The Hon. CHRISTINE ROBERTSON: What is the New South Wales Government doing to tackle childhood obesity in New South Wales?

Ms CARMEL TEBBUTT: Again, this is a really important area. I am sure, like me, it would disturb Committee members to focus on the figures where we see about 25 per cent of children in New South Wales are overweight or obese and 52 per cent of adults. It is quite frightening because we know that eating and exercise habits that children adopt often stay with them for the rest of their lives. It is really about making sure that we can get in early and find ways to tackle childhood obesity to encourage children to eat nutritiously, eat well and get more exercise.

We are doing a number of things. In 2010-11 we have provided just under $11.5 million for obesity prevention initiatives. We have a strong commitment to reducing obesity—it is one of the key targets in our State Plan. We aim to reduce the percentage of children who are overweight and obese to 22 per cent by 2016. It would be nice if we could get it lower than that but we know that if you look all around the world at jurisdictions that have attempted to reduce rates of childhood obesity they have not been terribly successful. It is an enormous challenge.

In 2009 we released our Government plan for preventing overweight and obesity in children, young people and their families. It identifies five priority areas for action: community information, healthy foods, active lifestyles, sport and recreation infrastructure, and prevention and early intervention services. For example, under community information we have the Healthy Kids website. We do that in conjunction with the National Heart Foundation, and it has been redesigned and enhanced to make sure that it is a credible source of information for children, young people and their families, and also teachers relating to childhood obesity. We have also got two programs, which I think the Committee has probably heard about: the Live Life Well@School and the Munch and Move program.

There is about $6.5 million over four years to support teachers in primary schools and early childhood services to improve their knowledge of childhood and healthy eating and physical activity. We work in conjunction with the Department of Education and Training because obviously it is particularly important that it is on board with these programs. For example, the Live Life Well@School program has recently been redesigned to improve the program's reach and sustainability. The revised program will better utilise online learning and videoconferencing technology to deliver a flexible and dynamic program that will suit the needs of primary school teachers.

We have also got our $2.5 million Go4Fun program. That is a more targeted intervention program that works with children and their families. It targets children between the ages of seven and 13 and it is now being run in six of the eight area health services—I can see the Chief Health Officer nodding—and we are rolling it out to the remaining two areas in early 2011. There are some really promising results from the program:

reductions in body mass index and also an increase in the number of hours spent in physical activity each week. It is a quite intensive program that works with the whole family to try to help them put in place more healthy eating patterns and get involved in activity. It tries to make it a family thing so that it is easier to sustain.

We are also working with adolescents. Earlier this year we made a submission to the Review of Food Labelling Law and Policy, which is being chaired by Neal Blewett on behalf of the Federal Government. More recently we held a food forum in August, which was very successful. We had representatives of key stakeholders, the fast food industry and academics, and we talked about a range of things. We are setting up a reference group to further advance some of those issues that were discussed at the food forum, including looking at calorie counters or menu information at the point of sale and also the initiatives that are underway to reduce the amount of salt that is in pre-packaged food.

The Hon. TONY CATANZARITI: Minister, could you please explain to the Committee the investment the New South Wales Government has made in providing better health services in rural and regional communities?

Ms CARMEL TEBBUTT: Yes, I can. We had a question earlier about what we were doing to improve the infrastructure in metropolitan New South Wales. I know the Hon. Tony Catanzariti has a huge interest in regional and rural New South Wales. I have already spoken about Wagga Wagga so I will not go over that, but that is just one of many projects that we are investing in as a result of the budget. In fact, it is a record $4.4 billion in regional and rural New South Wales in the 2010-11 budget, and that is an increase of about $280 million on the previous year.

Dr JOHN KAYE: Is that a capital works budget?

Ms CARMEL TEBBUTT: No, that is the overall budget.

Dr JOHN KAYE: That includes capital for one year?

Ms CARMEL TEBBUTT: That is the recurrent budget. The capital budget is $114.9 million in capital works funding. I can talk about some of those projects. I think the Committee will be interested in them. For example, in the North Coast we are investing $1.4 million to complete the $27 million Integrated Cancer Care Centre at Lismore; $10.5 million to complete the upgrade of the Grafton Base Hospital emergency department and operating theatres; and $500,000 to complete the Maclean Hospital emergency department upgrade. There is a range of things happening in the New England and north-west area.

There is some $843,000 to progress planning for the $10.6 million stage 2 maternity refurbishment at Tamworth—and we know that they will now benefit also from the announcement that the Federal Government made with regard to the clinical school at Tamworth; $21.7 million to continue with the redevelopment of Narrabri Hospital; and there is $3.7 million to complete planning and commence construction of the Regional Cancer Centre at Tamworth as well. That is part of the Commonwealth Regional Cancer Centre Initiative. It has a total cost of $149 million, including $35 million of New South Wales co-funding. We are very pleased with how well we did as part of that round of Federal funding, because it has seen Regional Cancer Centres on the Central Coast, in the Shoalhaven, on the North Coast and also in the Illawarra.

We are also expanding Shellharbour Hospital Renal Dialysis Unit and we are going to start the planning work for the Integrated Elective Surgical Unit at Wollongong Hospital—an $83 million project. We are making significant investment in the western and south-western part of the State as well. For example, in Dubbo we have invested some $232,000 to commence planning of the $22.7 million stage 1 redevelopment of Dubbo Hospital; there is $7.7 million to continue work at Bathurst Hospital; and at the new Orange Base Hospital there is $12.9 million to complete the building. That amazing piece of infrastructure is nearly finished and I know it will be greatly welcomed by the Orange and broader Central West community.

I will not go into detail about the multipurpose services because I know the Committee is familiar with them, but we will see, this year I believe, multipurpose services start at Werris Creek, Gundagai and Lockhart, and I think we have Eugowra coming online. They are great facilities for rural and regional New South Wales because they mean that you can co-locate a range of services. We are working with the Federal Government with respect to getting those multipurpose services underway.

The Hon. TONY CATANZARITI: Minister, could you outline progress on the issue of overdue payments of invoices from creditors?

Ms CARMEL TEBBUTT: I am a little bit surprised that it has taken us this long to get into the estimates process without anyone asking about creditors, but I am happy to share the good news with the Committee because it is a very good outcome this year. In 2009-10 our health system paid around $3.7 billion to suppliers for goods and services and other operating expenses—that is about $10 million a day. As I have said on many occasions, the Government expects that businesses that provide goods and services to the health system will be paid on time. I can advise the Committee that as at the end of June 2010 there were no overdue trade creditors that were ready for payment—that is, no overdue trade creditors of more than 45 days. That is a very significant achievement.

Last year's overdue creditors totalled $69.2 million as at 30 June 2009. The Government made it very clear that that was not a good enough performance and the system has worked very hard to manage the creditor issue. We have done a number of things. We have worked with suppliers providing goods and services where there is an approved purchase order in place and we have asked them to send their invoices directly to health support services, which is our shared service provider. We have strengthened internal controls with things such as a dedicated telephone number for creditor inquiries and timely feedback to creditors in relation to their inquiries. Health service purchase orders are to contain appropriate telephone contact numbers for supplier inquiries, a log of telephone inquiries is to be maintained and payment to suppliers is to occur within the stipulated payment terms.

The Department of Health worked with health services whose financial performance was of concern in 2008-09 and 2009-10 to ensure that strategies were in place to continue to improve their financial position and that creditor payments were made according to the benchmark. We will continue to monitor the situation. I want to ensure that the improvements in financial performance that we have seen to date are maintained. It is important to recognise that people also owe money to our health services. While we managed not to have any outstanding or overdue creditors at 30 June 2010, we were owed $58 million by overdue debtors. We will continue to work hard in this area to ensure that our performance is maintained.

The Hon. SHAOQUETT MOSELMANE: Minister, can you update the Committee on the role and work activity of the Bureau of Health Information since its inception?

Ms CARMEL TEBBUTT: We have had a discussion about this, so I will not spend too long answering this question. The Bureau of Health Information is an independent board-governed statutory health corporation established under the Health Services Act. The chief executive officer is Dr Diane Watson, who was appointed in October 2009. Its functions include the preparation and publication of regular reports on the New South Wales public health system, including an annual report to Parliament on the performance of the health system, which will be tabled later this year. The role of the bureau is to provide the community with information about the performance of the New South Wales health system in ways that enhance the system's accountability.

The bureau's first report, entitled "Insights into Care—Patients' Perspectives on NSW Public Hospitals", was published in May 2010. It looked closely at the care experiences of patients who spent a day or one or more nights in New South Wales public hospitals in 2009. The department undertook the survey and the bureau analysed it in careful detail and provided a range of useful information. The report looks at health care professionals and the community and it compares performance across large New South Wales public hospitals.

As I said, we have also transferred to the Bureau of Health Information responsibility for the preparation of the quarterly performance reports, and it published the first of those reports last Friday. That report covered the period April to June 2010. The performance report contains information about admitted patients, elective surgery patients and patient care in emergency departments. It includes an expanded array of new information about care in emergency departments for 66 public hospitals in New South Wales and new information for those same public hospitals on how patients rate care in emergency departments and how emergency departments compare on issues that mattered most to patients in 2009. That information has not been provided in previous quarterly performance reports. Those reports were much more focused on how we were meeting our emergency department and elective surgery benchmarks.

The bureau has also provided extra information about patient experiences in emergency departments. The report is good and it provides a broader and more contextual picture of what is happening in our emergency departments. As I said, the bureau hopes to focus on elective surgery performance in its next quarterly

performance report, which will cover the July to September quarter and which will be released within about eight weeks after 30 September. It will again try to provide more contextual information to the community.

The Hon. MARIE FICARRA: I refer again to the Council of Australian Governments Federal health agreement. As Dr Matthews was the only representative of the New South Wales Department of Health at the discussion on the new Federal agreement, was any briefing or written advice supplied by him, Professor Picone or any other manager in the department? This is fairly important. Minister, you said you received a lot of advice. Was there any written brief?

Ms CARMEL TEBBUTT: Do you mean at the Council of Australian Governments meeting itself?

The Hon. MARIE FICARRA: In preparation for the meeting or brought to the meeting.

Ms CARMEL TEBBUTT: As you would be aware, in the lead-up to the Council of Australian Governments meeting the Prime Minister released a series of books setting out the Federal Government's offer with regard to health reform. We in New South Wales then convened a seminar of key health stakeholders and had extensive discussions with them. I think we provided the opportunity to submit input through the website on what was in the Prime Minister's green book. As I have previously said, a representative from New South Wales Department of Health was in the group of people advising the Premier. A Cabinet minute was submitted prior to the Council of Australian Governments 2010 meeting.

The Hon. MARIE FICARRA: That is not my question. I appreciate the Minister's providing a bit of background, but my question was whether Dr Matthews, Professor Picone or any other senior executive manager provided her with a briefing paper or advice on this most important health issue.

Ms CARMEL TEBBUTT: As I said, a Cabinet minute was submitted. I was not at the Council of Australian Governments meeting and they are not usually dealt with through written briefings. Obviously the deputy director general was on hand to answer any questions from the Premier. However, I think on a number of occasions the meeting took place without officials in the room. Those Council of Australian Governments processes are very intense. The answer to the question is that no written brief was provided to me while the Council of Australian Governments meeting was underway. A minute went to Cabinet prior to the meeting and the Premier reported back to Cabinet before the agreement was signed.

The Hon. MARIE FICARRA: Did you ask the senior officers of your department to supply you with written advice and briefings on the most important issue that has ever confronted your department? Did you not ask them to give you a written briefing on how this Federal health agreement would affect the running of the Department of Health, hospitals, patients and the community?

Ms CARMEL TEBBUTT: As I said, we were briefed by the Health Care Advisory Council and the clinicians. We went through an extensive process and we had a website through which people could make submissions.

The Hon. MARIE FICARRA: I am not talking about the public or clinicians; I am talking about your managers, who are paid by New South Wales taxpayers. I am talking about your experts sitting around this table. Did any of them provide you with a brief in writing?

Ms CARMEL TEBBUTT: I was not at the Council of Australian Governments meeting. You seem to be confusing the process leading up to the meeting—

The Hon. MARIE FICARRA: Did you get any advice prior to or during the meeting?

Ms CARMEL TEBBUTT: Yes, but it was obviously a Cabinet minute. Cabinet minutes were submitted by the previous Minister for Health and by me. This health reform process was very lengthy. From recollection, at least two Cabinet minutes were submitted and then there was a Cabinet meeting the day after the Council of Australian Governments meeting at which the Premier provided a briefing on what had been determined at the meeting.

The Hon. MARIE FICARRA: None of that advice could be made public in response to a freedom of information request made by the Opposition. We were told there was "nothing available from the Department of Health on this issue".

Ms CARMEL TEBBUTT: As you know, I do not get involved in freedom of information requests. However, it is not usual—

The Hon. MARIE FICARRA: Can any of your senior managers answer that question? Why is there absolutely nothing that the public can access in terms of expert advice about how the New South Wales Department of Health, the community and hospitals would be affected by this agreement?

Ms CARMEL TEBBUTT: An enormous amount of information was available in the public domain, if that is the question. It is not usual to release Cabinet documents.

The Hon. MARIE FICARRA: In other words you are not prepared to release it.

Ms CARMEL TEBBUTT: There is a timeframe within which they are released. I do not know whether the director general or the deputy director general want to comment any further. However, extensive consultation was undertaken and the department prepared a discussion paper.

The Hon. MARIE FICARRA: I sense a cover-up.

Ms CARMEL TEBBUTT: From memory, that discussion paper on national health reform was on the website. That was all publicly available.

The Hon. MARIE FICARRA: It is obvious we are not going to get anywhere. It is an extensive, good cover-up. The public will never get to learn whether New South Wales is going to be advantaged or not.

Ms CARMEL TEBBUTT: It was a very transparent process from the Commonwealth's point of view also. You might recall the Commonwealth pulled out a number of detailed documents. We then responded with a discussion paper or a briefing paper. We had a seminar at Royal Prince Hospital. We had a website where people could put in submissions.

The Hon. MARIE FICARRA: That is not the line of my questioning. Let us move on, because I know you are not going to answer the question.

Ms CARMEL TEBBUTT: You seem to be implying that there was a lack of transparency.

The Hon. MARIE FICARRA: There was a lack of expert advice that has been made public on this most significant point of health reform that this State has had for years and you, Minister, are not willing to table any of the expert advice that you would have received. It probably was not received in writing because you knew that we would be asking for it under freedom of information. Anyway, I move on to my next question because we are getting nowhere. Since, in this Federal health agreement, it costs $4 million per day to run the New South Wales health system, that is the 2009-10 budget, are you aware that the additional money you have negotiated through the reform process will fund only 23 days over four years—that is, six days per year? Would you consider this to be the single largest reform of the health and hospital system as was quoted? Do you believe that New South Wales got any great advantage out of this—six days per year additional funding? That is what we are talking about.

Ms CARMEL TEBBUTT: As I have said on a number of occasions, I know the Coalition does not support the extra funding that came through the Council of Australian Governments agreement. The shadow Minister made that very clear. But it was $1.2 billion for the New South Wales health system over four years. That does not include the extra funding that comes to New South Wales, not specifically to the New South Wales health system. So, that is a substantial benefit for our health system. In fact, we get nearly $300 million in 2010-11; about $200 million in 2011-12; about $235 million in 2012-13; and I think about $288 million in 2013-14, and that does not include the money that comes for long stay older patients and it does not include the money that comes for multipurpose services.

I think the premise of your question also does not recognise that extra funding is very welcome and very important as part of the national health reform agenda but we always went into this process recognising that there also had to be structural reform. It was not just about more money going into doing things the same way that we always have done. If that is the case, we are not going to have a sustainable health system into the future. I have used this figure on many occasions, but we provide nearly a third of the State budget to health

funding at the moment. Some of the work that has been done would indicate that if we continue to grow the health budget by the same rate, by the middle of the century the health budget will consume the entire State budget. That means there would be no funding for any of the other things State governments need to do. Clearly that is not a possible situation. So, we need to find different ways of doing things, and that is why what came out of the Council of Australian Governments agreement is so important.

It was about more funding but it was also about a focus on primary care and about making sure that people can get the right care in the right place at the right time. It was also the Federal Government taking on responsibility for aged care. If you can get those three pieces right, if you can get the primary care setting right, what happens in our public hospitals right and what happens in aged care, and you can get that working more effectively, then you are going to get a more sustainable health system. The Council of Australian Governments agreement did not deliver everything we wanted, no agreement ever does, but it is a substantial improvement and provides real opportunities to make changes for the future, and I welcome that.

The Hon. MARIE FICARRA: On 1 July we were told by Premier Keneally that through this new health agreement we would start seeing great benefits from 1 July; we would start seeing them right away in emergency departments, in mental health, in acute care and in subacute care from 1 July. Can you outline what we have seen?

Ms CARMEL TEBBUTT: We have announced quite a number of new beds right across New South Wales as a result of the Council of Australian Governments agreement. I am happy to share those with the Committee because I think the Committee would be interested in that. There are at least 12 beds for the Prince of Wales Hospital; 20 beds for Campbelltown Hospital; 21 beds for Wollongong Hospital; 26 beds for Nepean Hospital; 27 beds for the Sydney Children's Hospital network; 17 beds for Sutherland hospital—we spoke about those earlier; 22 beds for the Royal North Shore Hospital; 12 beds for Maitland—I think I have already spoken about that; 16 beds for the John Hunter Hospital; 19 beds for St George; 10 beds for Mt Druitt; 16 beds for—

The Hon. MARIE FICARRA: Can we have that tabled, Minister, rather than take up time just reading out the list.

CHAIR: We are happy to have that tabled.

Ms CARMEL TEBBUTT: I am happy to provide that information.

CHAIR: I want to ask you about Shellharbour Hospital. We were talking earlier about some of the potential life-threatened patients and treatment times. At Shellharbour it is taking much longer for those patients to be seen. Is that because of a critical shortage of doctors? We see that on occasions there is only a junior medical officer with limited experience being left there. Given that Shellharbour Hospital is a very busy hospital, it has more than 150 beds, do you think that is a safe and appropriate situation?

Ms PICONE: With the triage 3 performance data and then the staffing levels, it has been travelling okay—76.3, August 9; 75.2, August 16; 82.5, August 23; and 75.7 August 30. I would have to take on notice the actual staffing arrangements on each shift, particularly the medical staffing arrangements. Having worked in that area I know what it is but I want to make certain I give you the correct figures.

CHAIR: That is fine. I am also informed that that hospital is having a review by the Institute of Medical Education and Training, which might see further downgrading of accreditation for junior medical staff. Given there is a loss of accreditation of physician training in 2007 and a loss in the past 12 months, I wonder why you are not taking some action to alleviate that chronic problem there.

Ms PICONE: I will have to take that on notice. I am not aware. Perhaps Dr Chant might be able to help?

Dr CHANT: There are certainly workforce challenges there and obviously in a place like Shellharbour we need the appropriate supervision in order to have the accreditation for specialist training and for intern accreditation.

CHAIR: If you are taking that on notice can you also tell us why the results of the external review have not been acted upon and what you can say about that please?

Ms PICONE: If I could also just say in relation to Shellharbour, the clinical academic appointments there have gone quite well since the establishment of the medical school, but we will have to get you the proper information rather than just guess.

CHAIR: That is fine. I know the chief executive of Hunter New England Health made some comments about identification of the new hospital in the Hunter region sometime ago. Can you tell us, given that that is a growing area, what progress has been made? Have you identified a site? What are your plans for the new hospital in the Hunter region?

Ms CARMEL TEBBUTT: I am not aware of what comments you are referring to. Do you have the comments?

CHAIR: Nigel Lyons commented on the identification of a possible new site for a regional hospital in the Hunter region. Perhaps you could take that on notice?

Ms CARMEL TEBBUTT: Yes, we will take that on notice.

CHAIR: There were comments about South West Sydney, Campbelltown Hospital, for example, where 71 per cent of patients were found a bed within eight hours, but only 62 per cent were moved on. What is your comment about that? Information has been provided from staff there who are very unhappy because you are not providing the resources to treat your patients. What are you doing about that?

Ms CARMEL TEBBUTT: I might see if the deputy director general has any specific details with regards to that?

Ms PICONE: Is this Campbelltown Hospital?

CHAIR: Yes?

Dr SMYTH: With Campbelltown Hospital, again I think it is important to remember that the growth in emergency department attendance is not just at major teaching hospitals, and Campbelltown again is a very busy and growing hospital. The staff at Campbelltown emergency department ought to be congratulated on the work that they do. They are seeing somewhere between 900 and 1,000 people a week. In terms of their overall performance, on triage 3, which is one of the things that people have been asking about, they actually exceed the national target, the College of Medicine target of 75 per cent, with treatment commencing within 30 minutes.

In terms of looking at what we can do to assist them, we are going to trial five urgent care centres in New South Wales—two of those at children's hospitals. The other three will be at Campbelltown, Westmead and Wyong. They have been deliberately chosen because they are areas with growing populations, particularly growth in demand of emergency departments.

CHAIR: When will that begin?

Dr SMYTH: In this financial year. We are already well on the way with discussions with the hospital, particularly the clinical staff in the emergency department there about how they would like to get that urgent care centre up and running. Campbelltown has a similar issue to Wyong in terms of availability of general practitioners, particularly availability of general practitioners after hours, so that is another issue at Campbelltown. Campbelltown does great work particularly in ambulatory care, reducing the length of time people have to spend in hospitals, and community support services. In fact, one of the sites that we draw attention to with our international visitors is to go and see what Campbelltown does. They have a fantastic team down there.

Through winter we have provided funding for additional staffing in all of our 45 major emergency departments for every day of July, August and September, with an additional nurse on every shift to assist in meeting winter demand, and I think the urgent care centre will be a significant addition to the Campbelltown triage services.

Ms PICONE: Can I just say something?

CHAIR: We only have about one minute to ask a question.

Ms PICONE: It is just the most telling statistic of all, and I will absolutely have the *Hansard* checked that it is correct, that in the last seven years the New South Wales population has increased by 9 per cent but the attendances at emergency departments have increased by 49 per cent, so when we talk about places like Wyong and Campbelltown where there are often copayments associated with general practice and no out of hours, you can see the role that our emergency departments are taking in terms of primary healthcare, and that is why we are quite convinced that this new model around urgent care centres over time will take the pressure off the emergency departments and allow those sorts of patients to attend to those types of units.

The Hon. MARIE FICARRA: I have one final question going back to the Federal Health Agreement, and it is a multiple-choice answer. What proportion of GST is New South Wales actually giving up as part of its COAG health reforms? Is it (a) 30 per cent as per the Commonwealth Government's recent budget papers, (b) one-third, (c) 35 per cent as per the New South Wales Government's website, or (d) unknown, an unknown agreed amount to be determined as per the National Health and Hospitals Network Agreement? What is the right answer?

Ms CARMEL TEBBUTT: You ask the questions, we answer them. I will get the deputy director general to respond.

Dr MATTHEWS: The answer is (d).

The Hon. MARIE FICARRA: I knew that—unknown.

Dr MATTHEWS: There is a good reason for that. There is a good reason for everything. The amount of GST will not be locked in until 2013-14. There are a range of services funded by the State that are to be part of further consideration of COAG—drug and alcohol, child-maternal, community, mental health, et cetera. It is not until all those decisions are made and also until all the services are costed—which has not yet happened, much to the chagrin of Treasuries at both levels of government—that the actual dollars at 2013-14, as a percentage of GST at that time, will be determined.

Ms PICONE: Could I come back to your excellent question about Dr Nigel Lyons making an unadulterated grab for a new hospital? There has been a whole-of-government planning process, particularly for the lower Hunter, where the population growth will be, and we contributed with a vision planning statement for where a new hospital might be located in the next 15 to 20 years.

CHAIR: Are you going to provide that vision statement?

Ms PICONE: Yes, we will. You gave me such a fright that I had to follow it up.

CHAIR: It certainly was an interesting thing, but it is true that the growth is going to be 70 per cent within the next 20 years.

Reverend the Hon. Dr GORDON MOYES: I have two questions, first of all to Dr Kerry Chant. It is very important in your area of work to see the increasing percentage of persons in the community being immunised, both at adult and child levels, to reduce the incidence of death from preventable diseases and yet an extremely strong anti-immunisation lobby is developing. I think you are losing out on the public awareness campaign on the importance of immunisation. What strategies do you have in place to reverse that?

Dr CHANT: It is always important to understand that there is globally very good support across the community for immunisation. We do achieve quite good immunisation coverage, reaching around 95 per cent for our childhood populations. There is an element of anti-immunisation and that is often geographically based—

The Hon. CHRISTINE ROBERTSON: The North Coast.

Dr CHANT: —which then exacerbates the problem, because you have a geographical region where the immunisation coverage is lower. We are currently working with the Commonwealth in relation to an immunisation campaign and the launch of the new national immunisation strategy. In addition, we are doing some specific work around pertussis. As you might be aware, there was the death of a young child from pertussis and we did see a significant increase in pertussis and that led us to do a number of things, including

making immunisation available to anyone in contact with young children under 12 months, particularly parents and grandparents. That has been well taken up. We are now in the process of developing a pertussis strategy, to take up your point about increasing awareness in the community, and that should be with us soon.

Reverend the Hon. Dr GORDON MOYES: Within the next 12 months or so?

Dr CHANT: I think very shortly actually.

Reverend the Hon. Dr GORDON MOYES: Thank you. You have answered my question.

Dr CHANT: In addition to that, the children's hospital network has also launched a website and an excellent video, which we have then distributed through child health services and pre-schools called Web of Protection, which has been done by the National Centre for Immunisation, Robert Booy. We are very keen on continuing the message around immunisation and I would support everyone here getting their annual influenza immunisation because it also helps us with our acute hospitalisations as well.

Reverend the Hon. Dr GORDON MOYES: Professor Picone, with the COAG funding arrangements with the Commonwealth now taking up 60 per cent of the capital ongoing recurrent costings in hospitals and so on, this would surely mean you would require less bureaucrats in the back office. What staff changes are there?

Ms PICONE: I am just checking with the Minister to seek if she is happy for me to answer.

Ms CARMEL TEBBUTT: I will just say that at the time that we signed up to COAG, remember that the Prime Minister made it very clear that there is to be no increase in bureaucrats over the period of time.

Reverend the Hon. Dr GORDON MOYES: The thrust of my question was, what decrease can we expect?

Ms CARMEL TEBBUTT: I will let the deputy director general respond because I know she will, but I want to make the point, because it is often not well understood, that in fact less than 5 per cent of our total health workforce comprises corporate service staff, the staff traditionally who are understood to be health bureaucrats, so it is actually a quite small proportion. The reality is that, as we set up our local health networks with the 15 geographic-based health networks, or whatever it ends up being as a result of the consultation we are currently undertaking, it will be a challenge to do that and to meet the Prime Minister's requirement that there be no net increase in bureaucrats. But we will need it; that is what we will do. The director general can probably give you a bit more detail about that.

Dr JOHN KAYE: Before you do, does that 5 per cent include people such as the pay clerks and the people who determine pay?

Ms CARMEL TEBBUTT: It is staff involved in corporate services. It does not include cleaners, clinical support officers or ward clerks. I am not quite sure where the pay people fit in.

Ms CRAWSHAW: It is corporate services, human resources, and payroll.

Ms PICONE: Reverend, if I could answer your question. It is sitting at around 4 per cent. It is the lowest in the public sector in this State and it is the lowest percentage of bureaucrats, for want of a better word, of any health jurisdiction in the nation. It should not increase. We do have a difficulty in going from eight administrative operational units, which are the area health services, up to whatever number the Government eventually determines. So it will be a case of the "loaves and fishes", but there cannot be a single increase in the number.

Reverend the Hon. Dr GORDON MOYES: I understand that. My concern was with the number of sectors going like this—

Ms PICONE: With the people in Canberra?

Reverend the Hon. Dr GORDON MOYES: Yes.

Ms PICONE: You could start me on that!

Reverend the Hon. Dr GORDON MOYES: What would be the State decrease in that percentage?

Ms PICONE: I know that we are not increasing, but I have observed in Canberra that there are a number of agencies being established. I do not know what their increases will be as a result of these COAG reforms. But I shall watch their annual reports with great interest.

Dr JOHN KAYE: I refer to the closure by the Greater Western Area Health Service of Gulgong Hospital. Minister, when were you first aware of a plan to close Gulgong Hospital?

Ms CARMEL TEBBUTT: I would have to check my records as to exactly what date. My recollection is that there had been an ongoing issue with WorkCover and that there had probably been some briefings at some point with either me or my office about that. I should say there had been issues about the WorkCover briefing and there had also been the ongoing desire for a multipurpose service and the department's work to establish the funding for a Health One facility. So all of those things had gone on. My knowledge of the closure itself was only days before the announcement was made. But with regard to these preceding issues, yes, my office or I would have been briefed on them. But I do not have the exact dates.

Dr JOHN KAYE: WorkCover's report into the needed upgrades at Gulgong Hospital was delivered on 20 May. Were you aware before that that there was a desire to close Gulgong Hospital?

Ms CARMEL TEBBUTT: No. As I said, there was certainly a process that the department needed to go through in order to qualify for the funding for the Health One facility, and going back in time there had been quite a campaign for a multipurpose service. But these things are dealt with at an area or departmental level; they do not usually involve the Minister.

Dr JOHN KAYE: Professor Picone, when were you first aware of a plan to close Gulgong Hospital?

Ms PICONE: I am just reading directly from my notes here. A WorkCover inspection was prompted by the New South Wales Nurses Association, and that occurred at the hospital on 31 March 2010.

Dr JOHN KAYE: That was a meeting that triggered the need for a WorkCover investigation?

Ms PICONE: That was a WorkCover inspection that was prompted by ongoing issues that the Nurses Association had been raising at the local level. On 18 May 2010 WorkCover issued its seven provisional improvement notices. I would have to give you dates as to when I was then formally advised as director general—I would normally deal with these as operational issues—and I can provide those to the Committee.

Dr JOHN KAYE: Minister, you would be aware that with regard to Gulgong Hospital the intention is to place an accident and emergency service on Mayne Street, the main street of Gulgong. You would also no doubt be aware that the main street of Gulgong is a very crowded, mostly one-way but partially two-way street where, at the best of times, one can never get parking. Are you aware of the concerns raised by the local community about an accident and emergency department on Mayne Street with regard to access to it?

Ms CARMEL TEBBUTT: First and foremost, I have to say that it is an emergency response service that would be provided. Currently that emergency response service is being provided from the existing hospital, which has been vacated, but there is a proposal that that will move to the main street, as you have put it. That really came out of discussions that occurred with the local council and others who wanted to make sure that there is an appropriate means to provide initial support and stabilisation to patients, who would then be treated largely at Mudgee Hospital—which is pretty much what happened when Gulgong was fully operational. The aim of the area health service is to lease two buildings in Gulgong to provide community health and emergency care services. There will be three beds located within the emergency care service. They will be used for short-stay acute presentations of patients who require observation or treatment such as with intravenously administered fluids or treatment while awaiting transfer to Mudgee.

Ms PICONE: It is a very good point about the parking. The health service sees around about six patients a day through that emergency department, and three to four of those are usually during business hours. There is the commencement in the town of a second general practitioner, so some of those patients would get picked up through those general practitioner appointments. They are the numbers we are talking about.

Dr JOHN KAYE: Nonetheless, Mayne Street remains a problematic place for that sort of service?

Ms CARMEL TEBBUTT: That was not raised with me at the meeting I had with the mayors and the local community representatives. It certainly would be my understanding that the area health service chief executive officer would be looking very carefully at that access issue. But I think the point the director general makes is a good one: we are not expecting a flood of people. But what this emergency response capability can do is to make sure that there is a place where people can be stabilised if necessary, short-term treatment can be provided, and if they need treatment prior to being transferred to Mudgee, that can be provided.

Dr JOHN KAYE: Part of the reason for closing Gulgong Hospital is the extraordinary cost associated with not only dealing with asbestos but making the windows shatterproof, and various other things that were identified in the WorkCover report dated 20 May. The costings that are being used by the department had been challenged by a number of people in the local community as being inflated. Have you already considered—and if not, would you now consider—having an independent audit of those costs and having an alternative model for those costs? It may well be that the costs are not as high as have been quoted.

Ms CARMEL TEBBUTT: I think perhaps you are missing the point of what has happened at Gulgong. I know that there is enormous community concern with regard to having to vacate the premises at the time we did—and that was very much driven by the WorkCover report and the cost of implementing the recommendations that would need to be done to make the place safe and secure. But there has been, for some time now, an acceptance that Gulgong Hospital is not a long-term, appropriate facility from which to deliver contemporary health services. That is why the community, for a long time now, have been wanting a multipurpose service on the site. So the timing, in a sense, is driven by the WorkCover report, but there had already been a process to try to get Commonwealth support for a multipurpose service.

The State Government had agreed that we would put the funding in for a Health One facility. I think that if you talk to the vast majority of the Gulgong community, you would find that they all accept that Gulgong Hospital is not adequate to deliver contemporary health services; it is more of an issue around timing than anything else. That is why we have made it very clear that with the funding that we are going to invest to build the HealthOne facility we will do it in such a way that if the Commonwealth does approve a multipurpose service, we will be able to bolt that on. The reason why we need the Commonwealth to approve a multipurpose service is because they fund that aged care component, and the recurrent funding for aged care beds gets back to our previous discussion about State Government nursing homes. Hopefully we will be able to get approval from the Commonwealth for a multipurpose service in a time frame that means it can all move together in a parallel way.

Dr JOHN KAYE: I am sure you are aware of Professor Carapetis's work for the Cooperative Research Centre for Aboriginal Health at the Menzies School of Health Research with respect to skin infections in Aboriginal children. He identified that 75 per cent of Aboriginal children in the Northern Territory have scabies. His team also identified the long-term health consequences of scabies—via scabies to a streptococcus infection to what is called post-streptococcal disease with specific implications for long-term renal disease and long-term heart disease via rheumatic fever. I am sure you know more about that than I do. In New South Wales do we have an understanding of the number of Aboriginal children who are similarly affected? Is it as high as 75 per cent of Aboriginal children in New South Wales who have scabies? What are we doing to reduce this appalling episode?

Dr CHANT: I would have to take on notice the question on the percentage of scabies because generally that figure has been derived from a survey methodology that they have looked at. I would not want to mislead the group. I will certainly look at what surveys have been done. Certainly there have been reported outbreaks both in indigenous and non-indigenous communities of impetigo, which is again staph and strep, which can also then lead to glomerulonephritis, the renal disease that you were talking about. One of the initiatives we have put in place which is very important is a program called Housing for Health. This is a program where we ensure basically that housing has running water, a kitchen that functions, electricity that functions. We have released an evaluation—

Dr JOHN KAYE: And a laundry that functions?

Dr CHANT: Yes. It has all those elements. It is approved methodology. I would be pleased to show you an evaluation that has been done, which shows that it is an incredibly effective intervention. We are extending the trial of that program to some urban environments. Traditionally that has been rolled out more in

regional communities. We are doing a smaller study with new money that we have received under the Aboriginal partnership agreement. That is one of the things we do. We also have a series of public health units that will work with local communities and general practitioners. They will be alerted if there are scabies outbreaks or impetigo in a school. We provide information on how to control and contain that. Obviously impetigo and scabies are often seen in general practice. Having good access to primary health care is important for managing those conditions, as well as linkages with the public health units to notify and respond, which requires a much more integrated response in the context of an outbreak. I am happy to give you some advice if I can find some literature on scabies.

Dr JOHN KAYE: I would appreciate that, Dr Chant. Does the department undertake regular monitoring of the incidence of scabies amongst Aboriginal and non-Aboriginal children?

Dr CHANT: Scabies is not notifiable and neither is impetigo, but we are certainly notified—public health units are there and have linkages to general practice for assistance in responding to outbreaks when general practitioners see it. They might see a stream of children from a school and the schools themselves will notify us as well. Scabies is not generally a notifiable condition.

Reverend the Hon. Dr GORDON MOYES: Among homeless people it is still rife.

Dr CHANT: That is right. Scabies is an important condition and from time to time we have outbreaks in some closed facilities. We take that seriously and we work with the facilities to ensure that appropriate treatment is put in place.

Dr JOHN KAYE: Given the evidence presented by Professor Carapetis, the implications of scabies and its high rate of incidence amongst Aboriginal people in the Northern Territory, in your opinion is that a case for scabies to become a notifiable disease and for the Department of Health to pay more attention to where it is and how it is being dealt with?

Dr CHANT: We pay attention to diseases that are not notifiable and notifiable. There are some particular elements. There is a nationally agreed set of notifiable conditions. We are certainly interested in reducing the range of conditions, even if they are not notifiable, an example being chickenpox. I would have to first see feedback from the area health services and public health units. It has not come to my attention. But I am happy now that you have raised it to go back and explore whether scabies is a significant issue amongst our indigenous population in New South Wales.

Dr JOHN KAYE: I would appreciate that, thank you.

The Hon. CHRISTINE ROBERTSON: Minister, what is the New South Wales Government doing to close the gap in life expectancy for Aboriginal people?

Ms CARMEL TEBBUTT: That is a good question following on from issues raised by Dr John Kaye. We are committed to closing the gap in terms of life expectancy between Aboriginal and non-Aboriginal people, of which this Committee is no doubt well aware. Aboriginal men in New South Wales live on average nine years less than non-Aboriginal men and Aboriginal women in New South Wales live on average 7.5 years less than non-Aboriginal women. This year the Government is investing $93 million towards improving the health of Aboriginal people in the State. That is an increase of $30 million compared to the last financial year. In 2008 we signed the National Partnership Agreement for Closing the Gap in Indigenous Health Outcomes. Under this agreement the Government has made a commitment of $180 million over the next four years to tackle Aboriginal health issues.

The implementation plan includes a range of programs in relation to closing the gap. These are now underway—for example, strategies to address chronic disease management for Aboriginal people. Across New South Wales, health services are introducing 48-hour follow up after discharge from a hospital for all Aboriginal patients with a chronic disease to make sure that the patient has an appointment to see their general practitioner and access the right medication. Through this initiative there is better communication between the hospitals, community health and the primary health care services. We also are implementing the Severe Chronic Disease Management Program, which will enrol Aboriginal people who have had three unplanned admissions to hospital for a chronic disease in the last 12 months. This program will help support Aboriginal patients to access support services and to self-manage their disease.

We have committed $6.5 million over four years to a new initiative to make sure that Aboriginal people have access to oral health services across New South Wales. This program will see Aboriginal community-controlled health services which have dental chairs but have been unable to employ dentists to offer the services. They will be able to access dentists on a rotating basis. There will be four dentists and a team of dental assistants who will have the potential to see over 4,000 Aboriginal patients per year in rural and remote communities in New South Wales. With regards to tobacco smoking, which is a leading cause of premature death and the greatest contributor to disease amongst Aboriginal populations in Australia, we are doing a range of things. We are spending $1 million on phase two of a scheme to help tackle the high rate of smoking within the State's Aboriginal community.

The SmokeCheck Program, funded by New South Wales Health and the Cancer Institute, provides training workshops for health professionals who work with Aboriginal communities to encourage and assist clients in giving up smoking. Since its launch in 2007, 44 per cent of Aboriginal health workers in New South Wales have taken part in workshops, with participants increasingly confident about tackling the issue of smoking with clients. We recently signed the statement of intent to work in partnership with Aboriginal communities to achieve equality in health status and life expectancy between Aboriginal and non-Aboriginal Australians. That was signed on the floor of the House by the Premier and by the Leader of the Opposition. We will continue to roll out a range of programs that addresses the health needs of Aboriginal people in New South Wales in efforts to close that gap.

The Hon. TONY CATANZARITI: Minister, could you update the Committee about plans for the Clinical Education and Training Institute?

Ms CARMEL TEBBUTT: This is one of the four pillars that were established as a result of the Caring Together Health Action Plan and the inquiry by Commissioner Garling that we spoke about earlier. There is the Clinical Excellence Commission, which already existed prior to the Garling report; there is the Agency for Clinical Innovation; there is the Clinical Education and Training Institute; and the Bureau of Health Information, which we have spoken about already. Professor Steven Boyages has been appointed as the inaugural chief executive of the Clinical Education and Training Institute. The overall purpose of the Clinical Education and Training Institute is to oversee, coordinate and assist to deliver education and training to medical, nursing and allied health staff and clinical support staff. It has a multidisciplinary focus, which is very important. It will support aspects of professional development for clinicians and will continue the functions of the Institute of Medical Education and Training, including setting standards and accrediting institutions for pre-vocational training, as well as coordinating postgraduate clinical training networks.

There are two New South Wales health organisations with a strong history in clinical education and training that have been absorbed by the Clinical Education and Training Institute—one is the Institute of Medical Education and Training and the other is the Institute of Rural Clinical Services and Teaching, and that will become the Clinical Education and Training Institute medical and rural division. A number of Clinical Education and Training Institute programs are supported by the Caring Together funding. As I said, there is a primary focus on multidisciplinary training, including the multidisciplinary New Starters Training Program, and that is to commence in 2011. The Clinical Education and Training Institute will work closely with health services and consumer representatives to ensure that clinical education and training programs support and enhance health service delivery. There is obviously a big capital component as well in terms of clinical education and training, so the Clinical Education and Training Institute will obviously need to work with the various Federal bodies that are involved in this space as well.

The Hon. SHAOQUETT MOSELMANE: Minister, in relation to the ambulance inquiry and reform, what improvements has the Government made to address the issue raised by the parliamentary inquiry into ambulance services?

Ms CARMEL TEBBUTT: We had a question earlier with regard to budget enhancements and funding for the Ambulance Service, but this is much more about the inquiry—

CHAIR: Caring for the staff.

Ms CARMEL TEBBUTT: Absolutely—a clear focus on how best we can support Ambulance Service staff. The Government released its response to the inquiry's findings. We supported 35 of the 45 recommendations, and I know since the initial inquiry there has been the review by the committee chaired by the current chair of this Committee. We cooperated with that review and we prepared a detailed submission on

progress and implementation of the 35 recommendations, which the Government supported for the Committee's consideration. We have either implemented or we are in the process of implementing those 35 recommendations. The focus is very much, as the chair indicated, on a range of strategies that will improve service for the people of New South Wales but also provide a supportive work environment for the staff of the Ambulance Service.

We are currently finalising our response to the Committee's review report, which was released in April 2010. One of the major themes covered during the inquiry was workplace culture and, in particular, bullying and harassment. The Ambulance Service commenced its Healthy Workplace Strategies Program in 2007 to address concerns raised by both staff and managers about resolving workplace grievances, which predates the Committee's inquiry. The strategy is designed to improve the workplace environment, help staff members resolve workplace issues, simplify policies and procedures for managing workplace concerns, and improve communication and the ability to handle workplace change. There has been an extensive range of activities as part of the Healthy Workplace Strategies Program, including the provision of respectful workplace training for all staff in the use of the Straight Talk tool—new simplified standard operating procedures for raising workplace concerns, and preventing and managing workplace bullying.

There has been the establishment of a permanent respectful workplace management adviser role to develop and implement strategies to eliminate bullying in the workplace. There have been continuing workshops, forums and surveys to discuss and promote our values. There has been the review and strengthening of support services for staff, including increased numbers of peer support officers and chaplains. There has been the appointment of grievance contact officers in September 2009. There has been the establishment of an Employee Resilience and Wellbeing Advisory Panel as well as access to trained mediators if issues cannot readily be resolved at the local level; the inclusion of staff relationships as a standing item on staff and management committees to ensure that staff issues are being dealt with appropriately; additional skills and training of front-line managers through the Ambulance Management qualification; and also the inclusion of healthy workplace strategies management accountabilities in all managers' annual appraisals. I am sure the Committee appreciates that cultural change is a long-term process; it is not something that happens overnight. But the Ambulance Service has in place a whole range of initiatives to help build a more supportive and respectful workplace for all who work in it.

Reverend the Hon. Dr GORDON MOYES: Leadership can make a difference very quickly.

Ms CARMEL TEBBUTT: Absolutely.

The Hon. TONY CATANZARITI: Minister, could you update the Committee on the progress with developing cancer services in regional areas?

Ms CARMEL TEBBUTT: This is obviously an issue close to the member's heart, but it is a really important issue because we know that access to cancer services in regional and rural New South Wales is obviously not as available as access in metropolitan parts of the State. For people who need cancer services it can be a very debilitating and difficult time, and it is obviously far better for those people if they can be closer to their friends, their family and their support network. We have made a big investment in trying to improve and expand cancer services in regional and rural New South Wales. We are currently investing in a new radiotherapy service at Orange and that will provide services closer to home for the residents of the central west—Orange, Dubbo, Parkes, Forbes, Mudgee.

I mentioned in answer to an earlier question the completion of the Lismore Integrated Cancer Centre. This is the third site of the North Coast Cancer Institute, which also has facilities at Coffs Harbour and Port Macquarie. We are working to deliver the new and expanded cancer centres as a result of the Commonwealth program that I spoke about earlier—$35 million is coming from the State. There will be cancer centres on the Central Coast, in the Illawarra and the Shoalhaven, in New England and on the North Coast. The new Central Coast cancer centre, funded by $38.6 million from the Regional Cancer Centre's Initiative, will include a new facility at Gosford Hospital with two linear accelerators and expanded medical oncology, and an enhanced multidisciplinary clinic and day oncology unit at Wyong Hospital.

The Government recognises that travelling from the Central Coast to Sydney or Newcastle for radiotherapy can be onerous for patients, and this state-of-the-art centre will mean that patients will have public services in their local area. There are $14 million worth of enhancements to the Illawarra Cancer Care Centre at Wollongong Hospital, and that includes an additional linear accelerator and six medical oncology treatment

spaces. The cancer centre at Nowra will be a $34 million centre and will include one linear accelerator and capacity for a further accelerator; eight additional chemotherapy chairs or beds; radiotherapy treatment planning equipment, including a CT scanner; and a 10-room patient and carer accommodation facility.

In New England, I think I have already spoken about this, but there will be $41.6 million for a New England and North West Regional Cancer Centre at Tamworth. Under the Cancer Centres Initiative the Commonwealth and New South Wales governments are funding expanded treatment capacity at the North Coast Cancer Institute, with second linear accelerators to be installed at Lismore and Port Macquarie radiation oncology treatment centres. Lismore will also receive a PET-CT scanner and Coffs Harbour will receive an MRI unit.

The Hon. CHRISTINE ROBERTSON: What investment has the Government made to secure our nursing workforce for the future?

Ms CARMEL TEBBUTT: I take this opportunity to record my appreciation to the 43,200 nurses and midwives working in the public health system in New South Wales. That number represents an increase of about 10 per cent since 2005. However, investing in our nursing workforce is about more than numbers. The Government must also invest in strategies that will strengthen our existing workforce by supporting them to develop their skills, to provide them with career paths and to assist them in caring for patients. In 2010-11 the Government is investing $24.1 million in recruitment and retention strategies for nurses and midwives. This includes initiatives to support new general and midwifery graduates to transition into practice and ongoing clinical skill development programs for registered and enrolled nurses. The aim of these initiatives is to encourage nurses to remain working in the public health system in New South Wales. The Government has also allocated $6.9 million for an additional 100 clinical nurse educator positions. These positions are vital for new nurses transitioning into the workforce from study.

The Government further supports nurses' and midwives' education and development through the provision of scholarships and education grants. More than $4 million has been awarded in 2010 in education scholarships and grants to more than 770 potential and 950 existing nurses and midwives across New South Wales. Some of those scholarships and grants were awarded at a wonderful ceremony in Parliament House earlier this year. This investment equates to 42 undergraduate scholarships to students from rural areas undertaking a bachelor of nursing or midwifery degree, 473 undergraduate scholarships to enrolled nurses undertaking a bachelor of nursing or midwifery degree, 132 scholarships for nurses undertaking a postgraduate diploma in midwifery—50 of which were for registered nurses working in rural New South Wales—346 postgraduate scholarships for nurses and midwives for postgraduate study and 733 grants to students in bachelor of nursing or midwifery degrees to undertake clinical placements mainly in rural areas.

In addition to the investments in recruitment and retention strategies, the Government is investing in programs that build the skills and career paths for nurses and that recognise the central role that nurses play in the delivery of our health services. One example of that is the Take the Lead Program. This program is strengthening the role of the nursing and midwifery unit managers by providing training in leadership and management skills. Nurses obviously need clinical skills, but they also need management skills because they play a leadership role. This program enhances those skills. We have also continued to recognise the advanced clinical skills that nurses can offer and have continued to build on the clinical career paths for nurses.

New South Wales leads the nation with the highest number of nurse practitioners, with 157 in total. The 2010-11 budget includes $2.1 million to employ 18 nurse practitioners in rural and regional areas. That is important because they potentially have a positive effect on nursing rates and they also improve patient access to high-quality care. They are just some of the things that the Government is doing to support our nursing workforce.

The Hon. SHAOQUETT MOSELMANE: What is the Government doing to strengthen and grow the Aboriginal health workforce in New South Wales?

Ms CARMEL TEBBUTT: That is an important question. We have talked a little about what the Government is doing to close the gap and some of the key issues confronting Aboriginal communities across New South Wales. However, we know that if we do not have the right workforce we will not be able to make the gains that we want to make. Many Aboriginal communities are in regional and rural New South Wales and they face workforce challenges. A key focus for the Government is encouraging Aboriginal people to be involved in the delivery of health services. For example, we are making steady progress in meeting the 2.6 per

cent target for public sector employment of Aboriginals. New South Wales Health has employed 1,364 New South Wales Aboriginal and/or Torres Strait Islander personnel, including more than 30 Aboriginal doctors and more than 320 Aboriginal nurses. We also have programs in place to support the Aboriginal health workforce. For example, the Government has invested $1.64 million per year in an initiative that provides local employment career paths and mental health services.

The Aboriginal Mental Health Workforce Training Program employs Aboriginal people as full-time, permanent employees of a mental health service. Prospective employees are recruited as non-graduate Aboriginal health education officers and are supported in acquiring a mental health-related bachelor degree as a condition of employment. The program has now grown to 50 trainee positions across New South Wales. The Government is also investing to increase the number of Aboriginal nurses and midwives across New South Wales and improving opportunities for career development for Aboriginal people working in the New South Wales public health system. The Aboriginal Nursing and Midwifery Cadetship program also provides financial support and clinical experience to Aboriginal students. New South Wales Health now employs 48 Aboriginal student nursing and midwifery cadets. Since the program was established in 2004, 24 cadets have graduated. New South Wales Health has committed to offer a further 64 cadetship positions each year over the next four years. It is important to mention the Aboriginal Environmental Health Officer Training Program, which aims to develop an Aboriginal workforce with the leadership and skills to progress environmental health issues into the future. That is very significant.

Dr JOHN KAYE: That is a very good program.

Ms CARMEL TEBBUTT: It is.

CHAIR: We all watched with interest the negotiations with the Independents after the Federal election. As part of that, Prime Minister Gillard announced an extra $1.8 billion for health. What is the Government doing about getting a fair share of the funding, or do you know how much this State will get?

Ms CARMEL TEBBUTT: That relates to the Health and Hospitals Fund, to which States can make application. The Federal Government indicated that it would be looking to fund the fourth pod at Port Macquarie Base Hospital and Tamworth Base Hospital out of that fund. I understand that formal applications will be invited later this month.

CHAIR: Are they the priorities the New South Wales Government will be pursuing?

Ms CARMEL TEBBUTT: The Government has done some planning work on the forth pod at Port Macquarie Base Hospital. We have worked with the local member, Peter Besseling, who has been a strong advocate for the forth pod. Port Macquarie hospital is very busy and it is experiencing a surge in population growth, particularly elderly people. We need to go through our strategic processes to establish what we should put forward to the Federal Government to secure funding from the Health and Hospitals Fund.

The Hon. MARIE FICARRA: We believe that this morning part of the roof of the Royal North Shore Hospital intensive care unit has fallen in. Have you been notified of that incident? How is patient safety being handled?

Reverend the Hon. Dr GORDON MOYES: It was an after-shock.

The Hon. MARIE FICARRA: And perhaps an auditing of all low intensive care units so we can prevent further structural decline? There must be a number of hospitals where there are problems with infrastructure. Can anyone answer?

Reverend the Hon. Dr GORDON MOYES: It was on the Hornsby fault line.

Ms PICONE: I am normally notified of any of those matters 24 hours a day. I have not had an advice, but I could get that advice for the Committee and let you know.

The Hon. MARIE FICARRA: We hope no-one is injured in it.

Ms CARMEL TEBBUTT: Absolutely. We have a substantial building program underway. I do not know if it is relevant. We will come back to it.

The Hon. MARIE FICARRA: Just let us know how that is going to be handled.

Ms PICONE: Reverend the Hon. Dr Gordon Moyes has pointed out—and I did not realise until today—that there is a fault line along there somewhere. We will also be checking that.

Reverend the Hon. Dr GORDON MOYES: It starts at Hornsby hospital and runs south.

The Hon. MARIE FICARRA: To meet the predicted 9 per cent growth that we talked about previously, how many additional acute overnight beds does New South Wales Health plan to open in the next four years to meet the growth that is predicted? Does that amount include the new beds that were negotiated under the Federal health agreement?

Ms CARMEL TEBBUTT: It is a very good question because we know there is a growing demand for health services. I think it is important to state that these are an enormously important part of how we respond to growing demand for health services, but they are only one part of the story about responding to the needs, because obviously we need to make sure about services in the community, we need to make sure there is access to general practitioner services, and we need to make sure that our acute care system can work well with the general practitioner and primary care system. So, we announced in the budget some 488 beds this year—that is both acute and subacute beds. I think it was 107 subacute and therefore the balance, 381, would be the new acute beds. We do our budget on a year-by-year basis. That is part of the record $16 billion budget, which is an 8.6 per cent increase on last year's budget.

The Hon. MARIE FICARRA: Would you be able to provide more detail of what is projected over the next four years? You projected population growth. If you do not know this now, it can be supplied to us.

Ms CARMEL TEBBUTT: We can certainly provide you with some information on notice. The Commonwealth agreement provided for 438 subacute beds over the four years of the agreement. We are delivering 488 subacute and acute beds this year, but we will come back to you with some more detail. We are not going to be able to give you a bed-by-bed breakdown, year by year, that is obviously dependent on budgets.

Ms PICONE: And it is not just beds though.

Ms CARMEL TEBBUTT: That is right, as the director general points out.

Dr JOHN KAYE: Just to go back to a previous question I asked, where the response was an expression of reservation about case-mix funding under the Federal health agreement and, previous to that, concerns about the way it might be implemented, presumably, Dr Matthews, you or someone in the department was doing fairly intensive analysis of the whole Federal health agreement as it was evolving.

Ms CARMEL TEBBUTT: Can I just—

Dr JOHN KAYE: If I may complete my sentence first, Minister, and you are welcome to have an opinion on it. Presumably you or your department was engaged in ongoing analysis of the Federal healthcare agreement. I presume it is correct to say that you put some of that analysis in writing?

Ms CARMEL TEBBUTT: Sorry just to go back, because you made a statement at the beginning of your question which I do not think is entirely correct, where you indicated there were reservations about the Council of Australian Governments agreement with regard to case-mix funding. The discussion we were having earlier was about case-mix funding generally but, as the deputy director general and director general pointed out—

Dr JOHN KAYE: Yes, I have that, Minister, I am on board with that.

Ms CARMEL TEBBUTT: Well, I am here to answer the questions; you are here to ask them.

Dr JOHN KAYE: I questioned Dr Matthews and that—

Ms CARMEL TEBBUTT: The questions come to me as the Minister and I want to finish what I am saying because I think you have misconstrued information we have provided. I think it is important to put the

record straight. As I said, the way the Council of Australian Governments agreement works is that there is a process over a number of years to transition to case-mix funding and there are ways to manage some of the potential adverse impacts of just a pure case-mix model, including the fact that there will be block funding for rural and regional hospitals, including the fact that it will be transitioned over a number of years, and including the fact that we will be closely involved in that process. With regard to—

Dr JOHN KAYE: So as to not waste time, I will withdraw the word "reservations" and I will say that you have explained that there were potential adverse or inappropriate outcomes from case-mix funding if it was not designed correctly.

Ms CARMEL TEBBUTT: That is right.

Dr JOHN KAYE: My question was in respect of analysis of that aspect of the Federal health agreement. I understand that case-mix funding has a longer genesis but it was a key component. Accelerated application was a key component of the Federal health agreement. My question is more a process question than a content question. Your department was doing an analysis of the various aspects, including the GST component, I presume, including the case-mix funding component, including which hospitals would be exposed to case-mix funding and which would be block funded. So, my question is: Were you doing that analysis, when were you doing it and did you put any of it in writing?

Dr MATTHEWS: You remember the commission produced a report and the Prime Minister said some things and put some things on the table. We provide advice by way of Cabinet minute to the Government. Some of those things you mention—for instance, blocked funding to smaller hospitals—really only emerged during the course of meetings in Canberra over two days. So, there was clearly no time to put anything in writing about some of those issues.

Dr JOHN KAYE: So, what you are telling us is all of your analysis of the Federal healthcare agreement has culminated in a Cabinet minute?

Dr MATTHEWS: Absolutely.

Dr JOHN KAYE: There is nothing that did not culminate in a Cabinet minute?

Ms CARMEL TEBBUTT: And the discussion paper that we put out to the community, but that was spoken about previously.

Ms PICONE: And also there are detailed notes of the issues you are raising that came out of the meeting that the Premier and Deputy Premier convened with the clinical and general communities. Let me assure you there is quite detailed analysis there of some of our concerns.

Dr JOHN KAYE: But what I am trying to get to is that all the analysis that was conducted internally by the department remains Cabinet in confidence?

Dr MATTHEWS: Except for the things the director general just enumerated. We prepared a presentation to a group at Royal Prince Alfred Hospital. That was virtually a public meeting about what was being put forward and about the risks and opportunities.

Dr JOHN KAYE: But that was more a consultation exercise than an analysis exercise?

Ms CARMEL TEBBUTT: No. From memory it was a pretty comprehensive discussion paper.

Dr JOHN KAYE: Is that discussion paper in the public domain?

Ms CARMEL TEBBUTT: It is on the website.

Dr JOHN KAYE: I guess I am going to the issues that led to the Cabinet minute and to the Premier's response to the Prime Minister. All of that is now Cabinet in confidence?

Ms CARMEL TEBBUTT: You would have to check with the Premier. I do not know what information—

Dr JOHN KAYE: No, your department's analysis, all the stuff your department analysed is now behind Cabinet in confidence?

Dr MATTHEWS: No, not all of it. Some of it was in the discussion paper, which was on the website. Some of it was discussed at the meeting. I did quite a comprehensive presentation at the meeting of what was on offer, but the work we did in the department did culminate in a Cabinet minute.

Ms PICONE: Something that might help you with the case-mix is that we did get from the University of Wollongong's Professor Egar, who is now the pre-eminent authority on case-mix probably in Australia since Don Hindle retired, quite a detailed analysis on the case-mix issues, particularly our concerns about small rural hospitals, and I think that is on our website.

Dr MATTHEWS: Certainly on hers.

Ms PICONE: But I have some very good news for the Committee, if I could. There has been a burst water pipe in a corridor outside the intensive care unit at the Royal North Shore Hospital but no beds have been affected and no patients have been affected. Apparently there are also six tiles being replaced in the same corridor as well. Whether that led—which goes against the thesis of the fault line—to the burst water pipe, I do not know.

The Hon. CHRISTINE ROBERTSON: Minister, will you update the Committee on the work and achievements of the Clinical Excellence Commission over the past year?

Ms CARMEL TEBBUTT: Yes. As I said earlier, the Clinical Excellence Commission is one of the four pillars that Peter Garling referred to in his report. The Clinical Excellence Commission is the first of the four pillars because it was established in 2004. It has been an important part—

CHAIR: This Committee has been part of that.

Ms CARMEL TEBBUTT: Yes, of course. So, it is an important component of New South Wales Health's comprehensive patient safety and clinical quality program. It is an ambitious program. It sets an agenda for one of Australia's most comprehensive clinical safety and quality programs. A key role of the Clinical Excellence Commission is building capacity for quality and safety improvement in health services.

CHAIR: This is driven through training and education initiatives, such as clinical practice improvement, patient safety programs and also the clinical leadership programs. A snapshot of some of the current projects illustrates a very important role that the Clinical Excellence Commission plays. It was instrumental, as I referred to earlier, in developing Between the Flags, which is a safety net for patients in New South Wales hospitals through improved and standardised observation charts that better enable health professionals to track changes in patient vital signs and also standardised triggers and actions in response to changes in vital signs that identify a patient as clinically deteriorating, ensuring a rapid assessment and appropriate treatment.

Some 45,000 frontline clinical staff have now completed a specially developed training program and more staff are to be trained. I understand that the Australia Commission on Safety and Quality in Healthcare has noted the pioneering work that is undertaken in New South Wales and it is exploring how the program might be adopted across Australia. That is a great outcome for the Clinical Excellence Commission. The Clinical Excellence Commission also plays a major role in reducing healthcare-associated infections. We had quite a big discussion about that previously. We know that hand hygiene amongst healthcare workers is the single most effective intervention to reduce the risk of healthcare associated infections.

Reverend the Hon. Dr GORDON MOYES: Exactly.

Ms CARMEL TEBBUTT: The commission pioneered a successful hand hygiene awareness campaign, Clean Hands Save Lives, across many hospitals. They are building on this in the implementation of a comprehensive hand hygiene program under the national hand hygiene initiative, which has been developed by the Australia Commission on Safety and Quality in Healthcare. The Clinical Excellence Commission has now trained more than 300 gold standard assessors and more than 700 ward auditors across every area health service in New South Wales.

They are also working in partnership with our intensive care units to improve the quality of antibiotics use in intensive care units. The benefits of more appropriate choice and more effective use of these drugs are threefold, so there is a reduction in the multi-resistant organisms but there is also a decrease in side-effects for patients and there is more cost-effective expenditure on antibiotics, which frees up funds for more patient services. The commission also has six monthly public reports on all reported clinical incidents. The patient safety team produces these. The report identifies issues and lessons learnt to assist our clinical teams and health services managers to make our health system even safer.

The commission also plays a key role in the review and analysis of the outcome of root cause analysis reviews of serious adverse events. We have a very rigorous process of reporting and analysing incidents in our hospital system to see what we can learn from those incidents, and the Clinical Excellence Commission plays a key role in that.

The Hon. SHAOQUETT MOSELMANE: I think you might have one minute left—

The Hon. CHRISTINE ROBERTSON: Twenty-seven seconds.

The Hon. SHAOQUETT MOSELMANE: I will ask my last question in my first budget estimates in relation to the Health Care Complaints Commission. Could you update the Committee on the work and achievements of the Health Care Complaints Commission?

The Hon. CHRISTINE ROBERTSON: You might like to take it on notice as you have 14 seconds?

Ms CARMEL TEBBUTT: I might take it on notice, but I just point out that with the move to national registration, we do have a co-regulatory approach in New South Wales and we have made our Health Care Complaints Commission, which I know has been very important for the sector.

CHAIR: Thank you all very much. That concludes the hearing. Please note that you have 21 days to reply to questions on notice and anything that you have undertaken to provide to the Committee. I thank everyone for the professional way the estimates hearing has been conducted. It has been very useful.

Ms CARMEL TEBBUTT: I thank you, Madam Chair, and I thank the Committee.

The Committee proceeded to deliberate.