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GENERAL PURPOSE STANDING COMMITTEE NO. 2

Monday 8 October 2012

Examination of proposed expenditure for the portfolio area

HEALTH, MEDICAL RESEARCH

The Committee met at 2.00 p.m.

MEMBERS

The Hon. M. A. Ficarra (Chair)

The Hon. D. Clarke
The Hon. G. J. Donnelly
The Hon. L. Foley
The Hon. J. A. Gardiner
The Hon. P. Green (Deputy Chair)
Dr J. Kaye
The Hon. W. Secord
The Hon. H. Westwood

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PRESENT

The Hon Jillian Skinner, *Minister for Health, and Minister for Medical Research*

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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 open to the public this hearing for the inquiry into budget estimates 2012-13. I welcome Minister Jillian Skinner and accompanying officials to this hearing. This afternoon the Committee will examine proposed expenditures for the portfolios of Health and Medical Research. The portfolio of Health will be examined between 2.00 p.m. and 5.00 p.m. The portfolio of Medical Research will be examined from 5.00 p.m. until 6.00 p.m. Before we commence, I will make some comments about procedural matters. In accordance with the Legislative Council's guidelines for the broadcast of proceedings, only Committee members and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, you must take responsibility for what you publish or what interpretation you place on anything that is said before the Committee. The guidelines for broadcast of the proceedings are available at the table by the door.

Any messages from advisers or members' staff who are seated in the public gallery should be delivered through Chamber or support staff, or the Committee clerks. I remind Minister Skinner and the officers accompanying her that they are free to pass notes, and the Minister is free to refer directly to her advisers who are seated at the table behind her. Transcripts of this hearing will be available on the web from tomorrow morning. The House has resolved that answers to questions on notice must be provided within 21 days. I remind everyone to turn their mobile phones on to silent mode. All witnesses from departments, statutory bodies or corporations will be sworn prior to giving evidence. I remind Minister Skinner that she does not need to be sworn; she already has sworn an oath to her office as a member of Parliament. For all other witnesses, I ask that each of you in turn state your full name, job title and agency, and either swear an oath or make an affirmation.

ROHAN JOHN HUNGERFORD HAMMETT, Deputy Director General, Strategy and Resources, Ministry of Health, and

KAREN JANE CRAWSHAW, Deputy Director General, Governance, Workforce and Corporate, Ministry of Health, and

KERRY CHANT, Chief Health Officer, Ministry of Health, and

MARY CHRISTINE FOLEY, Director General, Ministry of Health, and

JOHN SIDNEY ROACH, Chief Financial Officer, Ministry of Health, sworn and examined:

CHAIR: I declare open for examination the proposed expenditure for the portfolios of Health and Medical Research. As there is no provision for a Minister to make an opening statement before the Committee commences questioning, we will begin with questions from the Opposition. There will be a 25-minute session for the Opposition, crossbenchers and Government members in the initial stages before we have a short break.

The Hon. LUKE FOLEY: Minister, good afternoon. You have widened the definition of "bed" so as to claim 2,009 more beds in the New South Wales hospital system, have you not?

Mrs JILLIAN SKINNER: I am sorry, to claim 2,009?

The Hon. LUKE FOLEY: Two thousand and nine additional beds in the New South Wales hospital system.

Mrs JILLIAN SKINNER: No.

The Hon. LUKE FOLEY: The 2010-11 annual report of New South Wales Health delivers 2,009 more beds because, in your words in answer to a question on notice, the report contains more comprehensive reporting of beds than in previous years.

Mrs JILLIAN SKINNER: Yes.

The Hon. LUKE FOLEY: Why have you done that?

Mrs JILLIAN SKINNER: Because we have now broken down how we report those beds to be more accurate. Previously there was a sort of generic terminology when you used "beds". As I indicated last year, we have broken it down to different categories of beds. For example, we have hospital beds available for admission from emergency departments. That was a major criticism of the former Government. It kept on talking about bed occupancy rate across the whole system, regardless of the reality being that the beds that were needed were mostly needed for admission of emergency department patients.

So we have broken it down to be hospital beds available for admission from emergency departments; other hospital beds, which would include hospital in the home, transitional aged care, residential aged care, mental health community residential; and then other beds, which would include day only, mental health including drug and alcohol, sub- and non-acute beds, statewide specialist services, maternity, neonatal and palliative care. As you can understand, these beds are not beds that will be available for emergency department patients to be admitted. That is where the big difference lay. Then we have treatment spaces—again, because there was much criticism of the former Government, which counted cots, bassinets and recliner chairs as hospital beds in the total package. So what we have done is broken down the total number into these categories.

The Hon. LUKE FOLEY: Is a chair a bed?

Mrs JILLIAN SKINNER: A chair is a treatment space.

The Hon. LUKE FOLEY: Is a chair a bed?

Mrs JILLIAN SKINNER: A chair is not a bed. It is a treatment space. That is why we have defined it as such in the annual report. It was included starting for the first time last year and it will be continued this year so that you will be able to compare one with the other.

The Hon. LUKE FOLEY: Is a chair a treatment space?

Mrs JILLIAN SKINNER: A chair is a treatment space.

The Hon. LUKE FOLEY: In your answer to a question on notice—

Mrs JILLIAN SKINNER: If it is a recliner chair in things like oncology, in things like renal dialysis and so on, it is a treatment space.

The Hon. LUKE FOLEY: I am confused, Minister, because in your answer to a question on notice from the shadow Minister, in which you tell us about more comprehensive reporting of "beds", you tell us that the increased number is because you are now including bassinets, transit lounges and other things. You just told me a transit lounge is not a bed, but in your answer to the question on notice you tell us that a transit lounge is a bed.

Mrs JILLIAN SKINNER: That was the definition when you were in government.

The Hon. LUKE FOLEY: No, this is your answer—

Mrs JILLIAN SKINNER: I am saying that it is broken down.

The Hon. LUKE FOLEY: —as opposed to today, Minister.

Mrs JILLIAN SKINNER: As I just said—would you like me to answer, or not? I will answer you this way.

CHAIR: Order! I remind all members that if they ask the Minister a question, they must allow the Minister time to answer it properly, without interjection.

Mrs JILLIAN SKINNER: I believe I have answered it, but I will go through it again. There is a total number, and then it is broken down into those categories. The total number includes treatment spaces, other beds, other hospital beds, and beds available for emergency department patients. What we have done is broken it down to be far more comprehensive in terms of what patients can occupy what space.

The Hon. LUKE FOLEY: Two minutes ago you told us a transit lounge is not a bed. In this answer, in your own words, you tell us a transit lounge is a bed. Is a transit lounge a bed, or is it a chair?

Mrs JILLIAN SKINNER: A transit lounge can be a treatment space where a patient is treated. It is equivalent to a bed.

The Hon. LUKE FOLEY: "Equivalent to a bed"?

Mrs JILLIAN SKINNER: Yes.

The Hon. LUKE FOLEY: Are you sitting on the equivalent of a bed now, are you?

Mrs JILLIAN SKINNER: I am not being treated, I do not think, sir—am I?

The Hon. LUKE FOLEY: You tell us.

Mrs JILLIAN SKINNER: No. A treatment space is where you—

The Hon. LUKE FOLEY: Are you telling us that a chair is a bed?

Mrs JILLIAN SKINNER: Look, you might be a cancer patient getting an oncology treatment, or you might be a dialysis patient having dialysis. It is a bed where you are being treated. That is why it is called a treatment space in this definition.

The Hon. LUKE FOLEY: So a transit lounge is a bed. A delivery suite is a bed—yes?

Mrs JILLIAN SKINNER: It is not counted in the beds that are available for an emergency patient. That was the whole point of breaking down these categories.

The Hon. LUKE FOLEY: But, Minister, in your fact sheet of March 2012 titled "Hospital Beds", you tell us delivery suites are beds.

Mrs JILLIAN SKINNER: They are in the total package, but they are broken down—

The Hon. LUKE FOLEY: Oh, so they are.

Mrs JILLIAN SKINNER: They are broken down in the categories that, as I have just described, give a much clearer indication of what kind of patients they can be filled by. Previously when you were in government, you counted all beds when you were looking at bed occupancy rates, which was clearly inappropriate when you are looking at what beds were available for emergency patients.

The Hon. LUKE FOLEY: Minister, we know you have widened the definition of "beds" so as to tell us in your last annual report there are 2,009 more beds in the system.

Mrs JILLIAN SKINNER: Yes.

The Hon. LUKE FOLEY: You tell us in your fact sheet of March 2012, do you not, that delivery suites are beds?

Mrs JILLIAN SKINNER: They are called "other hospital beds" in this category. They are not available though for the emergency department patient, which was the reason we went into this extra categorisation. As I said, under the former Government there was a lot of disinformation out there about bed occupancy rate particularly in relation to when an emergency department specialist was looking for a bed into which a patient could be admitted.

The Hon. LUKE FOLEY: Indeed in opposition I note in your election policy that you were very critical of the former Labor Government for including bassinets in the definition of beds?

Mrs JILLIAN SKINNER: Bassinets, cots, yes, in the total picture without breaking it down into these categories, which is why we went to the great effort to break it down and to categorise them as such in the annual report. We will continue to do that.

The Hon. LUKE FOLEY: Why in your answer to Dr McDonald do you tell us that one of the reasons for the increased figure of 2,009 beds is that you are including bassinets?

Mrs JILLIAN SKINNER: We are including them in the total picture. It is called "other beds". I am sorry, is that in "other beds" or is it in—

The Hon. LUKE FOLEY: Is a bassinet a bed or not under your definition?

Mrs JILLIAN SKINNER: No, it is "other hospital beds". Have you read the annual report? I do not think you have read it.

The Hon. LUKE FOLEY: Something you bagged up hill and down dale in opposition; Minister, you are now counting bassinets.

Mrs JILLIAN SKINNER: You have always counted bassinets. I am now categorising them in a way that indicates clearly they are not beds that should be counted in the overnight bed occupancy rate for emergency department patients. It is as clear as that.

The Hon. LUKE FOLEY: So we have transit lounges as beds, delivery suites as beds, bassinets as beds. Recovery rooms are beds, are they?

Mrs JILLIAN SKINNER: You had all those things as beds. Your Government counted all those things as beds. I have broken them down into different categories to give a much clearer picture about what sort of beds are available for emergency department patients.

The Hon. LUKE FOLEY: But you have added transit lounges; you told us that five minutes ago, Minister.

Mrs JILLIAN SKINNER: I call that a treatment space.

The Hon. LUKE FOLEY: Yes, so you can count a chair as a bed.

Mrs JILLIAN SKINNER: No, you counted it as a bed; I am counting it as a treatment space.

The Hon. LUKE FOLEY: And a treatment space is defined as a bed in your answer?

Mrs JILLIAN SKINNER: A treatment space is where a patient who needs treatment can be treated.

The Hon. LUKE FOLEY: So sitting upright and you count it as a bed?

Mrs JILLIAN SKINNER: Well, they are usually recliners. Have you ever been in a hospital and seen a cancer patient having oncology treatment—

The Hon. LUKE FOLEY: Indeed I have.

Mrs JILLIAN SKINNER: They are not sitting up in a chair like this.

The Hon. LUKE FOLEY: Indeed I have, Minister.

Mrs JILLIAN SKINNER: Well then you are misrepresenting the facts.

The Hon. LUKE FOLEY: Minister, if my wife goes into hospital if we have another baby, if she is in a lounge waiting for her contractions to quicken, you will count that as a bed.

Mrs JILLIAN SKINNER: Well, it depends.

The Hon. LUKE FOLEY: If she goes into the delivery suite you will count that as a bed, yes?

Mrs JILLIAN SKINNER: Well you count it as a bed; I am counting it as an "other hospital bed" because it is not available—

The Hon. LUKE FOLEY: As an "other hospital bed" as opposed to a bed? That makes it clearer, Minister.

Mrs JILLIAN SKINNER: It is under the categorisation of "other hospital beds" because I do not think the emergency department is going to put an emergency patient into that bed which your wife will be occupying. That is the whole point. I do not think you want to get it.

The Hon. LUKE FOLEY: The delivery suite is a bed, yes?

Mrs JILLIAN SKINNER: If it has a bed in it, it is an "other hospital bed". How many times do I have to answer your question? Do you not get it?

CHAIR: No.

Mrs JILLIAN SKINNER: Clearly not.

The Hon. LUKE FOLEY: A recovery room is a bed, is it?

Mrs JILLIAN SKINNER: If it has a bed in it, it is a bed but it is probably an "other hospital bed". The whole point of this exercise—

The Hon. LUKE FOLEY: Is an "other hospital bed" not a bed? Please enlighten us.

Mrs JILLIAN SKINNER: It is a bed but not available for emergency department patients and it is certainly not counted in the emergency department bed occupancy rate which you always did very dishonestly when you were in government. It was not just me criticising this; it was doctors, specialists, colleges—everyone. You counted the lot when you looked at bed occupancy rates, which is why I go to hospitals—

The Hon. LUKE FOLEY: You told us in your answer to a question on notice that the reason you have knocked up 2,009 more alleged beds in your last annual report is that you are providing more comprehensive reporting of what constitutes a bed—your words, not mine. You have widened the definition, Minister, have you not?

Mrs JILLIAN SKINNER: I have certainly been more specific about the definition rather than having a generic bed which totally distorted how many beds were available for patients to be admitted to, which was the practice when you were in government.

The Hon. LUKE FOLEY: Let us get this straight. My wife goes in for another baby. She is made to sit while her contractions quicken and that is a bed. She is put in a delivery suite and that is a bed. She is put in a recovery room and that is a bed. She is then found a ward and that is a bed. And the bassinet for the baby is a bed. One woman, one baby, five beds, is that right?

Mrs JILLIAN SKINNER: No, that is how you did it.

The Hon. LUKE FOLEY: That is what you have come up with here.

Mrs JILLIAN SKINNER: No, hang on a minute. You counted all those as the total bed number. I am categorising them so that we can break it down to make sure everyone understands that the bed occupancy rate for overnight acute emergency department type patients is a more realistic reflection of what is available because you used to say, "Oh, we have an 85 per cent bed occupancy rate." Dr Kaye knows this. It happened all the time.

The Hon. LUKE FOLEY: He is just reclining on a bed over there.

Mrs JILLIAN SKINNER: He is not being treated. I would go to hospitals and they would say that they had a 100 per cent bed occupancy rate of the beds available for emergency department patients. You were dishonest.

The Hon. LUKE FOLEY: I asked you why you could come up with 2,009 more beds when you have said you have added transit lounges.

Mrs JILLIAN SKINNER: No, you had transit lounges. I did not say that I added 2,009.

The Hon. LUKE FOLEY: You did 10 minutes ago, Minister.

Mrs JILLIAN SKINNER: No, I did not. I said what we have done is broken down—

The Hon. LUKE FOLEY: You have widened the definition?

Mrs JILLIAN SKINNER: No, I have widened—

The Hon. LUKE FOLEY: In your own words, more comprehensive reporting than in previous years is the answer as to why you have come up with 2,009 more beds.

Mrs JILLIAN SKINNER: You included all these beds in your total number. What I have done is broken them down into categories that enable people to see exactly how many are available particularly for the emergency department patient.

The Hon. LUKE FOLEY: Four categories?

Mrs JILLIAN SKINNER: Yes. I have already said what they are.

The Hon. LUKE FOLEY: Then you add up those four categories to give us a total bed number; that is how it works?

Mrs JILLIAN SKINNER: That is how you had it but you did not have the categories; that is the whole point.

The Hon. LUKE FOLEY: Yes, and when you add up your four categories, including transit lounges, recovery rooms and the like—

Mrs JILLIAN SKINNER: No, it is not transit lounges.

The Hon. LUKE FOLEY: You have come up with a figure of 2,009 more beds than were in the system previously, have you not?

Mrs JILLIAN SKINNER: No, I do not know whether that is the case. I do not have the figures in front of me.

The Hon. LUKE FOLEY: You do not have the figures. Let me enlighten you.

Mrs JILLIAN SKINNER: I said in front of me. Do not misrepresent me.

The Hon. LUKE FOLEY: In the 2009-10 annual report the total number of beds in that report, we were told, was 22,421. In the 2010-11 report, your first annual report as Minister, that figure has gone up by 2,009 to 24,513, has it not?

Mrs JILLIAN SKINNER: I have not got it in front of me because I thought this was budget estimates.

The Hon. LUKE FOLEY: You have not got it in front of you.

Mrs JILLIAN SKINNER: No, I thought it was budget estimates.

The Hon. LUKE FOLEY: You have been asked by the shadow Minister: How did you get 2,009 more? You have said that you added categories.

Mrs JILLIAN SKINNER: Yes. That is exactly what I have been saying for the past five minutes.

The Hon. LUKE FOLEY: To count chairs as beds.

Mrs JILLIAN SKINNER: Which is what you did. No, you counted chairs as beds. I can bring you the press releases if you want to see them.

The Hon. LUKE FOLEY: I have all your past press releases—

Mrs JILLIAN SKINNER: No, I have yours too. There was one, I think, with St George Hospital opening new beds and they were all recliners.

The Hon. LUKE FOLEY: —bagging up hill and down dale what Labor did, but you have widened the definition to knock up an extra 2,009 beds, have you not?

Mrs JILLIAN SKINNER: No. All I have done is added additional information about the categories.

The Hon. LUKE FOLEY: You are a miracle worker, Minister.

Mrs JILLIAN SKINNER: I know I am a miracle worker.

The Hon. LUKE FOLEY: One woman delivers one baby and you deliver five beds. This is some immaculate process.

Mrs JILLIAN SKINNER: That is not true, Mr Foley. One bed is a maternity bed and it is categorised as "other hospital beds". Your wife sitting in a chair waiting to go into labour—

The Hon. LUKE FOLEY: And the bassinet for the baby is a bed, is it not?

Mrs JILLIAN SKINNER: Well I did not think your wife was occupying the baby's bed. You just said your wife occupied five beds. Get real. She occupied the maternity bed where she had been after—

The Hon. LUKE FOLEY: The recovery room you count as a bed, the transit lounge you count as a bed and the place where she waits while her contractions quicken you count as a bed?

Mrs JILLIAN SKINNER: God, your wife requires a hell of a lot of treatment in this hospital. She is a maternity patient in a maternity bed.

The Hon. LUKE FOLEY: Be very careful, Minister.

Mrs JILLIAN SKINNER: And it is categorised as that.

The Hon. LUKE FOLEY: Be very careful.

Mrs JILLIAN SKINNER: So should you. Take your own advice.

The Hon. GREG DONNELLY: Minister, I take you to the next issue and ask you some questions about the budget cuts which have been announced in recent times. Specifically on the question of those budget cuts—and I am looking at the article in the *Daily Telegraph* although these have been reported broadly—it has been announced there will be $775 million in labour expense cuts and $2.2 billion with respect to other cuts, or $3 billion in round figures for the purpose of this discussion. On the issue of nurses, would you clarify an issue for me because I am a little unclear about the definition of "nurses"? I refer to the 2009-10 Department of Health annual report where at page 201 there is a definition:

> Nursing includes registered nurses, enrolled nurses, midwives and assistants in nursing.

Mrs JILLIAN SKINNER: Correct.

The Hon. GREG DONNELLY: In the 2010-11 report there has been a change. It now reads:

> Nursing includes registered nurses, enrolled nurses and midwives.

So "assistants in nursing" has been dropped from the definition. Can you explain why that took place?

Mrs JILLIAN SKINNER: It is an omission.

The Hon. GREG DONNELLY: Sorry, this is an omission in the annual report?

Mrs JILLIAN SKINNER: Yes, there is an omission in the accounting, but they are certainly—

The Hon. GREG DONNELLY: No, the definition here—

Mrs JILLIAN SKINNER: It should be in. We have assistants in nursing. They are still there; they are a very valued part of our nursing workforce.

The Hon. GREG DONNELLY: So there was no intention to change the definition?

Mrs JILLIAN SKINNER: None whatsoever.

The Hon. GREG DONNELLY: It was just that some words had been left out?

Mrs JILLIAN SKINNER: Yes.

The Hon. GREG DONNELLY: On the issue of numbers of nurses, you answered a question in the House on 15 August 2012 that the Government employs more than 46,000 registered nurses and midwives?

Mrs JILLIAN SKINNER: Yes.

The Hon. GREG DONNELLY: If you go back to the previous year's annual report, which is June 2011, the figure was 40,303?

Mrs JILLIAN SKINNER: Yes.

The Hon. GREG DONNELLY: If you go back to the equivalent 12 month period before that, I understand it was 39,352?

Mrs JILLIAN SKINNER: Yes.

The Hon. GREG DONNELLY: So we move from the last financial report of 40,303?

Mrs JILLIAN SKINNER: Yes.

The Hon. GREG DONNELLY: And it has jumped to 46,000? Is that 46,000 full-time equivalents or heads?

Mrs JILLIAN SKINNER: It is headcount.

The Hon. GREG DONNELLY: With respect to the report itself, that is full-time equivalents?

Mrs JILLIAN SKINNER: That is full-time equivalents, yes.

The Hon. GREG DONNELLY: Thank you for clarifying that.

Mrs JILLIAN SKINNER: The annual report is always full-time equivalents.

The Hon. GREG DONNELLY: I thought that was the case. The 46,000 looked like a high figure and I thought there would be a reason for it.

Mrs JILLIAN SKINNER: The number this year is expected to go up to around 41,000-something, full-time equivalents.

The Hon. GREG DONNELLY: In dealing with what has been the reaction to the announcement about the cuts, you said clearly—and I am quoting from an article in the *Sydney Morning Herald*—"but nurses are exempt."

Mrs JILLIAN SKINNER: Yes, front-line nurses are exempt. That has always been the case.

The Hon. GREG DONNELLY: I want to be clear about this. The article quotes you as saying, "but nurses are exempt" as a general statement. Are you clarifying that now by saying front-line nurses are exempt?

Mrs JILLIAN SKINNER: Yes, it has always been front-line nurses.

The Hon. GREG DONNELLY: Can you distinguish the difference between a front-line nurse—who I assume deals one-on-one with a patient on an ongoing basis?

Mrs JILLIAN SKINNER: One on whatever the nursing-patient ratio is.

The Hon. GREG DONNELLY: For the purpose of our understanding, can you name other examples of non front-line nurses in their terminology?

Mrs JILLIAN SKINNER: I know there have been instances in the Hunter-New England area where some nurse managers who are not delivering direct patient care, and therefore I would classify as front-line, have been asked would they like to take voluntary redundancy.

The Hon. GREG DONNELLY: Sorry, did you just say nurse managers who are front-line?

Mrs JILLIAN SKINNER: They are not delivering clinical care.

The Hon. GREG DONNELLY: But are they front-line?

Mrs JILLIAN SKINNER: They are not delivering direct clinical care, that is what I meant.

The Hon. GREG DONNELLY: So they are not front-line?

Mrs JILLIAN SKINNER: They are front-line but they are not direct—

The Hon. GREG DONNELLY: Let us be clear about this. The article was very clear about nurses being exempt. You are now trying to distinguish—and I do not argue with you—between front-line and non front-line. Can you please describe to me examples of non front-line nurses?

Mrs JILLIAN SKINNER: I am saying the nurses that are exempt are those who are delivering direct patient care.

The Hon. GREG DONNELLY: And I have asked you to give me examples of non front-line nurses?

Mrs JILLIAN SKINNER: The only example I know where a nurse has been offered a voluntary redundancy is in the Hunter-New England area, and I believe it was a senior nurse manager.

The Hon. GREG DONNELLY: With respect, I am not talking about redundancies. I want to know the classification names of non front-line nurses?

Mrs JILLIAN SKINNER: A nurse manager that is not directly involved in direct patient care.

The Hon. GREG DONNELLY: Are there other non front-line nurses who have a title or a name or a classification?

Mrs JILLIAN SKINNER: It would be nurse manager—in managing positions they are not delivering direct personal patient care.

The Hon. GREG DONNELLY: Are there any others? Perhaps one of the other witnesses might be able to help. I understand it is a technical point.

Ms CRAWSHAW: A CNC, clinical nurse consultant, who is engaged in research activity as opposed to delivering care. But obviously there are quite a number of clinical nurse consultants also delivering patient care.

The Hon. GREG DONNELLY: So there could be some clinical nurse consultants who are non front-line. Are there any other classifications of nurses who are not front-line?

Ms CRAWSHAW: They would be the main ones.

The Hon. GREG DONNELLY: So in New South Wales hospitals there are only two types of broadly understood classifications of non front-line nurses and they are called, generically speaking, nurse managers and clinical nurse consultants, is that right?

Ms CRAWSHAW: Clinical nurse educators [CNE] who are not delivering care at the beds are not counted as part of the nursing hours for patient day arrangements, but the Government has a policy of increasing the number of clinical nurse educators. There is another classification of the more senior level—less than 300 in the State—of nurse educators as well, who are not at the ward.

The Hon. GREG DONNELLY: When looking at the $775 million, which is the expense cap, will doctors be exempted in the consideration of cuts?

Mrs JILLIAN SKINNER: I think you misunderstood this whole question about the so-called $3 billion budget cuts. There is no $3 billion budget cut.

The Hon. GREG DONNELLY: I did not say $3 billion.

Mrs JILLIAN SKINNER: No, but you referred to it at the beginning of your question, so I will refer to it at the beginning of my answer. There is $2.2 billion of efficiency savings which will be rolled over and delivered into more front-line services. Some of those things are delivered by new models of care, just as some of the labour expenses savings are new models of care. The perfect example is happening—local health districts are the ones coming up with these ideas.

The Hon. GREG DONNELLY: I understand, yes.

Mrs JILLIAN SKINNER: There is an example in the Murrumbidgee Local Health District with the appointment of a director of medical services—an individual who has gone around the area and is recruiting full-time permanent staff to be employed in those hospitals, which is saving millions of dollars.

The Hon. GREG DONNELLY: I asked a specific question which you have not answered, so I will move to my next question.

Mrs JILLIAN SKINNER: No, I will finish answering this question, if you do not mind.

The Hon. GREG DONNELLY: I asked a question about doctors—

Mrs JILLIAN SKINNER: I am answering the question about a doctor.

CHAIR: The witness is answering about a doctor. She is answering the question.

Mrs JILLIAN SKINNER: We have full-time doctors being appointed instead of locums. Locum doctors are not being used in that instance, so, yes, those doctors are affected. Those local doctors are not being recruited and employed. We are replacing them with full-time staff doctors. It is much better for patient outcomes.

The Hon. GREG DONNELLY: You have not answered my question.

Mrs JILLIAN SKINNER: Yes, I have.

The Hon. PAUL GREEN: I commend the Government for allocating $64 million for around 500 more nurses at hospitals throughout the State. However, there is a considerable pool of experienced registered nurses in the community who, through life circumstances—for instance, choosing to opt out of clinical practice to have a family—have allowed their registration to expire in light of recency of practice laws. Given that they have effectively been locked out of re-registration unless they pay for a prohibitive $10,000 re-entry course, what steps will you take to increase accessibility for re-registration, as many of these practitioners are in rural and regional Australia?

Mrs JILLIAN SKINNER: It is a very good question and one that has exercised my mind. This is part of the new requirement for national registration. People who have been out of the nursing workforce for five to 10 years have to demonstrate recency of practice. That meant doing an eight-week course, four weeks of which were theoretical and the other four of which were in a hospital placement. It is true that the College of Nursing, which was the only accredited provider, was charging $10,000 for that course. I was concerned about that and that is the reason why we provided full $10,000 scholarships for those nurses to do that training—60 positions over two years with a return to service obligation of two years in a hospital where they would do the second four weeks. Some of those scholarships are still available, so if anyone out there is still experiencing difficulty please let me know.

To accommodate particular problems in relation to country people having to come to the city, we have been able to negotiate with the Australian Health Practitioner Regulation Agency [AHPRA], the national body,

and hospitals an opportunity for some nurses in places where there is a big enough hospital to do on-the-job training. I am very pleased with where we have been able to land in that regard. We have invested in those nurses coming back to the workforce.

The Hon. PAUL GREEN: I am happy to hear that and I am sure that will alleviate stress to some people. Maybe the word needs to go out about the availability of the scholarship.

Mrs JILLIAN SKINNER: I would be very happy if everybody in this room advertises it because we do have some available. We have put it on our website and we have let the nurse union know, but it has not published that. It published a petition asking people to protest but when we provided the scholarship it did not publish that, which is a pity.

The Hon. PAUL GREEN: I understand that the College of Nursing is the only accreditation point. Does the Minister have any thoughts about some of the regional universities being able to take up this process, given that they are already training registered nurses?

Mrs JILLIAN SKINNER: No, we have asked them all and none were interested in taking it up. You understand that this is a national scheme; I do not have control of any of this.

The Hon. PAUL GREEN: But you have influence.

Mrs JILLIAN SKINNER: Unfortunately, we asked all the universities and none of them were interested in taking it up. That is why we were able to negotiate an on-the-job component for some of those country nurses.

The Hon. PAUL GREEN: It is my understanding that at one point the previous Government allocated revenue from speed cameras to spinal cord injury research. Is that still the case and, if so, how much speeding camera revenue goes towards this area of research?

Mrs JILLIAN SKINNER: The money going from those additional speed cameras was announced by former Premier Bob Carr when Christopher Reeve was in town—I happened to be there when he announced it—but sadly it ended before the term of the last Government. What we have done is substantially increase funding for medical research, including support for those institutes and others that are doing spinal cord injury research. I would be very happy to answer more now, or later in the research part of the questions and answers, if you like.

The Hon. PAUL GREEN: We note that the Federal Government and the State Government have virtually come to agreement about the future of e-health and national broadband being the way to assist regional and rural Australians, particularly those in isolated areas of New South Wales. I refer to the suggestion that 495,000 people will be treated by 2015 and that that figure will increase in 2020 by about 90 per cent for those needing assistance to address chronic diseases and other issues. I note that recently there has been grave concern about Mullumbimby hospital in relation to reducing locums to put on full-time staff. Obviously there is great concern about taking the locum out of play. For people who have a cardiac arrest or who need cardiac care, being 30, 40 or 45 minutes away from hospital is too far if they need expert medical help, which they certainly do not think can be achieved in a teleconference situation. What does the Minister feel about the outcomes at Mullumbimby and how will we transition the rest of New South Wales if we cannot transition one hospital?

Mrs JILLIAN SKINNER: There are two parts to that question really.

The Hon. WALT SECORD: We probably would have got better answers if Chris Crawford was here.

CHAIR: Order! I ask members not to interrupt in crossbench time, or at all.

Mrs JILLIAN SKINNER: I am very happy to answer any questions about Mullumbimby. New South Wales is further advanced on investment in e-health than any other State. We have substantially increased funding for e-health. The Commonwealth rollout of the electronic patient record is slower than anticipated. Nevertheless, we are investing the money that is needed into the various components, particularly bringing hospitals up to date in their investment in technology—PACS-RIS, which is X-rays, and so forth. In relation to Mullumbimby, I think I mentioned a minute ago that I had the great good fortune to be in Canberra recently with the Chief Minister to announce—she could not be there unfortunately—the Federal Minister's commitment

to fund electronic telehealth—Connecting Critical Care is the program—from Canberra hospital with four southern New South Wales emergency departments. That gave those smaller emergency departments much greater access to the higher level of clinician diagnostics and care, and if they found a patient who needed transportation, that is exactly what would happen. That is in Canberra. It is endorsed not only by this Government but also by the Australian Capital Territory Government and by the Federal Government. In fact, Prime Minister Julia Gillard is very much on the record as saying that this is a good model.

This is happening also in other parts of New South Wales. I visited Macksville Hospital where I spoke with staff at the emergency department, nurses and a very senior nurse practitioner in the emergency department overnight who had difficulty recruiting a doctor to be there singing the praises of the telehealth connection they have to a major emergency department so that they could get the second opinion of a more experienced doctor. This is a model of care that is now happening internationally. A number of years ago I was at a conference in San Diego where they talked about doctors in Ireland working with doctors in America and in Europe to provide a second opinion, and diagnostic assistance not only for patients in emergency departments but also for patients in an operating theatre, which is the new way of delivering health care.

The Hon. PAUL GREEN: Minister, what are you doing to alleviate the concerns of the people of Mullumbimby that this is the new way forward? How are you transitioning that community?

Mrs JILLIAN SKINNER: Mr Crawford has been holding community consultations. We have said we would like to pilot this at Mullumbimby, but we are not proceeding until we can get community buy-in. I have suggested that it is like years ago when people had concerns about multipurpose services. At that time I suggested to communities, "Why don't you go and see it in operation?" That is what happened. As people saw how it was operating, they bought into it and it has now become widespread—in fact it is sought after—and I believe that is how this will go.

The Hon. PAUL GREEN: Obviously one of the frustrations in the hospital system is that not everyone is on board at every hospital about what is happening in the emergency department. Beds are being blocked there and that flows on through the rest of the hospital.

Mrs JILLIAN SKINNER: Yes.

The Hon. PAUL GREEN: What initiatives are you putting forward that doctors must buy in to some sort of consultation on a daily basis with the rest of the staff so as to be aware of what is happening in that facility, given that quite often their beds are blocking the system?

Mrs JILLIAN SKINNER: It is a very good question. I will ask the director general to give you some examples of the patient flow portal and so on, but I want to tell you a story first. It is about Westmead Hospital's emergency department. It was always a hospital that had most difficulty in meeting triage benchmarks. Patients were lining the corridors in ambulance trolleys and ambulances were locked up stopped outside. I will not say that does not happen on occasion, especially this winter; there has been a huge increase in very sick flu patients and patients with cardiac problems.

The director of that emergency department has introduced a new model of care. It is the whole-of-hospital system where he, being the most senior person on staff, triages patients when they arrive at the emergency department so that he has the confidence and experience to say, "You don't need to be admitted. You do need this treatment and then you may be on your way" or "We think we need to do more diagnostic tests. You need to be in for observation. Go over here" or "You are a cardiac patient. Go to the cardiac ward." All the different wards and people within the hospital system have been brought into this system. The figures speak for themselves. The improvements have been dramatic. Would you like to get some more information?

The Hon. PAUL GREEN: I will, but I want to put something else. Is it not perhaps wise to have a general practitioner clinic within the hospital to deal with terrible bed block situations?

Mrs JILLIAN SKINNER: I wish we could. On occasion there are general practitioner clinics within hospitals—Belmont in the Central Coast-Hunter area is one. I know it works extremely well because I took my daughter there one Easter when we were staying up in that part of the world. But it is not widespread and, unfortunately, there are some restrictions on doing that, according to the Medicare agreement and the Commonwealth. I would love to see more general practitioner clinics co-located with hospitals where patients can be transferred or referred if they are not considered to be an emergency department patient.

Dr JOHN KAYE: Is it correct that there now is work being done on creating new uniforms for registered nurses [RNs], enrolled nurses [ENs] and assistants in nursing [AINs]?

Mrs JILLIAN SKINNER: I will ask Karen Crawshaw to answer.

Ms CRAWSHAW: Yes, that is correct.

Dr JOHN KAYE: Am I correct in saying that those new uniforms are not differentiated—that is, the uniforms for registered nurse, enrolled nurse and assistant in nursing will be identical?

Ms CRAWSHAW: No, that is not correct. They are differentiated.

Dr JOHN KAYE: How will they be differentiated?

Ms CRAWSHAW: They are differentiated by the colour of the uniform. There are different colours depending upon the classification.

Dr JOHN KAYE: So they will be by different colours?

Ms CRAWSHAW: Yes.

Dr JOHN KAYE: That will be the same across the entire health network?

Ms CRAWSHAW: Across NSW Health?

Dr JOHN KAYE: Yes.

Ms CRAWSHAW: Yes.

Dr JOHN KAYE: Will charts be available in hospital so people will know whom they are dealing with?

Ms CRAWSHAW: We are happy to make charts available but, yes. Do not forget also that they are all required to wear a prominent identification, which includes their actual title as well.

Dr JOHN KAYE: But that would require somebody to read fairly small print identification.

Ms CRAWSHAW: Yes, but the colour of the uniform will also differentiate.

Mrs JILLIAN SKINNER: We will put up charts.

Dr JOHN KAYE: My next question relates to the matter agitated by Mr Donnelly: front-line services. From your answers to Mr Donnelly I understand that it is front line if it delivers direct-to-patient care although you then—

Mrs JILLIAN SKINNER: Roughly speaking.

Dr JOHN KAYE: Roughly speaking? I will try to get to the bottom of that in a minute.

Mrs JILLIAN SKINNER: Okay.

Dr JOHN KAYE: In the same article from which Mr Donnelly quoted you basically said, "Except for nurses", which was covered in your answers to Mr Donnelly, "it was up to them", that is—

Mrs JILLIAN SKINNER: Local health districts.

Dr JOHN KAYE: It is up to the local health districts as to who is and is not front line. For example, would an aged care assessment team worker be front line?

Mrs JILLIAN SKINNER: As I said, it is up to the local health districts, but they have obligations under their service agreements to treat their patients. They are not likely to put off people who are fundamental to getting their patients treated. An aged care assessment team [ACAT] is an extremely important team in trying to find other accommodation besides acute beds, which are more appropriate for the care of older patients.

Dr JOHN KAYE: What about a biomedical electronics technician, for example?

Mrs JILLIAN SKINNER: If I am the local health district and I decide I have too many biomedical technicians, then I might consider that. I am not second-guessing and micromanaging what the local health districts decide.

Dr JOHN KAYE: Are you suggesting that there are too many biomedical electronics technicians in the system?

Mrs JILLIAN SKINNER: No, I am not.

Dr JOHN KAYE: Okay.

Mrs JILLIAN SKINNER: You have given me a hypothetical; I am giving you a hypothetical. I will leave it to the local health district. If they believe they can better serve their patients and get better outcomes for their patients by doing it differently, that is up to them.

Dr JOHN KAYE: What about patient support officers, occupational therapists, sterilisation technicians, cardiac technicians?

Mrs JILLIAN SKINNER: Same answer.

Dr JOHN KAYE: Same answer?

Mrs JILLIAN SKINNER: Same answer: It is up to the local health district.

Dr JOHN KAYE: You have identified, I understand, $2.3 billion over the next four years that will be transferred from back-office services to front-line services, is that correct?

Mrs JILLIAN SKINNER: None of this money gets lost to Health. It is all still within Health.

Dr JOHN KAYE: No, I did not say that.

Mrs JILLIAN SKINNER: It is $2.2 billion over four years in efficiency savings

Dr JOHN KAYE: So it is $2.2 billion over four years, which is transferred from so-called back-office to front-line services?

Mrs JILLIAN SKINNER: Well, less efficient to more efficient. So it might be Hospital in the Home. In fact, I think the chief executive of the South Eastern Sydney Local Health District gave this as an example in the media where he said he believed he could cut—he knows he could cut—an average length of stay from 22 days to 12 for rehabilitation patients by providing them with support and clinical care for treatment in their home. That is a huge benefit for the patient, but it is also a saving.

Dr JOHN KAYE: I have a whole list of categories of people who work in hospitals, each and every one of whom—from the laundry assistant through to the patient support office and the occupational therapist— I would argue would be critical to the recovery of a patient.

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: You have identified $2.2 billion, but you cannot really tell what services are being oversupplied at the moment or what categories are oversupplied. From where did that figure of $2.2 billion come?

Mrs JILLIAN SKINNER: It had its genesis in 2009 in a document published by the former Government. It was about efficiency savings.

Dr JOHN KAYE: Minister, I should point out to you that I am an equal opportunist here: I do not mind either Government.

Mrs JILLIAN SKINNER: I know. It is a new models of care document. I am sure you know that there are new models of care. Hospital in the Home is a very good example. We have already heard that dialysis patients are no longer put in a hospital bed but treated as day patients only; day surgery is increasingly the norm. These are new models of care that not only save money but are much better for individual patients.

Dr JOHN KAYE: Do you think that just with new models of care alone there is $2.2 billion—

Mrs JILLIAN SKINNER: Over four years.

Dr JOHN KAYE: Over four years?

Mrs JILLIAN SKINNER: Yes, I do.

Dr JOHN KAYE: And you rely on—

Mrs JILLIAN SKINNER: Out of a budget over that period—keep it in context—of $70 billion.

Dr JOHN KAYE: Sure.

Mrs JILLIAN SKINNER: With a budget of $70 billion and $2.2 billion in new models of care, is it highly likely? Yes.

Dr JOHN KAYE: So it is a 3 per cent efficiency gain?

Mrs JILLIAN SKINNER: Yes. I could keep giving you examples.

Dr JOHN KAYE: No, I do not want you to, if you do not mind, Minister.

Mrs JILLIAN SKINNER: No, I did not think you would.

Dr JOHN KAYE: I am interested in examples but I have limited time. If we had unlimited time, I would enjoy those examples enormously.

Mrs JILLIAN SKINNER: I am sure you would.

Dr JOHN KAYE: You are relying on a Labor Party document to—

Mrs JILLIAN SKINNER: No, we have extended it. We thought it was good policy, so we have kept it and extended it.

Dr JOHN KAYE: So you have accepted their document and extended it?

Mrs JILLIAN SKINNER: Yes. It was very flimsy in what it meant, but I have clearly given more examples.

Dr JOHN KAYE: Are you prepared to make public your study on this that shows the $2.2 billion?

Mrs JILLIAN SKINNER: It is in the service agreements this year, is it not? I mean, it is over each year.

Dr FOLEY: The labour expense cap is explicitly in the service agreements. The efficiency savings targets are ones where each district identifies each year how they are going to find their share. As well, from the whole of NSW Health, we look at areas where we can do things on a statewide basis that will assist. The largest focus of the efficiency savings year-on-year is about new models of care which allow greater patient throughput

for a lesser price. For example, we have explicitly purchased the new funding model this year: 38,000 additional weighted admissions of patients fully priced at the average cost. What districts achieve when looking for these efficiencies is new models of care where they can treat more patients for that investment. That is primarily where it comes from. I can give you examples of how that works.

Dr JOHN KAYE: I understand that.

Dr FOLEY: It is not about looking for positions that are no longer required. On the labour front, particularly in country areas, it is much more about the very large areas of costs in terms of locums, general agency costs with nursing and other categories of employment and issues of unplanned overtime. They are the sorts of areas where labour efficiencies can be made. Otherwise it is very much about productivity savings in the context of explicitly funded growth.

Dr JOHN KAYE: There is the issue of the labour expenses cap. We are talking about the issue of efficiency savings but there is also the labour expenses cap. You are supposedly protecting front-line services but not the back-office services.

Mrs JILLIAN SKINNER: That was the latter part of the Director General's answer. It is about ending such a great reliance on locums and agency nurses and overtime. It was spelt out by the Premier and Treasurer in the budget that was brought down. They made it plain it was not about cutting staff positions but about using your staff resources more efficiently.

Dr JOHN KAYE: How many full-time staff positions will go under the labour expenses cap?

Dr FOLEY: We will have more staff year on year because we are explicitly purchasing growth: growth in admissions and growth in emergency department attendances. Overall it is growing but we will get the growth more efficiently, which should enable the districts to absorb the savings within the context of significantly increased budgets. All districts have budget increases greater than indexation, ranging from 2.9 to 6.8 per cent increase in funding which is tied to service volumes and the opening of new services related to their demand patterns.

Dr JOHN KAYE: You would appreciate the difficulty that somebody like me has grasping what you say. On the one hand you say you are going to cut back on the amount of money you are going to spend on people in the system and on the other hand you say you will have more people in the system. I understand locums and agency nurses—you employ more full-time staff rather than rely on contractors. That makes sense. You are saying $760 million over four years.

Mrs JILLIAN SKINNER: Yes, $89 million out of a budget of $17.3 million recurrent this year.

Dr JOHN KAYE: Would you put the figures behind that in the public domain?

Mrs JILLIAN SKINNER: It is in the service agreements, which are all going up on the website now. You can have a look at it right now.

Dr JOHN KAYE: I shall do that. Can we have a look at Frenchs Forest hospital?

Mrs JILLIAN SKINNER: Northern beaches hospital.

Dr JOHN KAYE: It is supposed to be at Frenchs Forest.

Mrs JILLIAN SKINNER: It is in Frenchs Forest.

Dr JOHN KAYE: It is in Frenchs Forest. It is scheduled to be in Frenchs Forest.

Mrs JILLIAN SKINNER: Work has started on the site.

Dr JOHN KAYE: I think we can take it as read that we are talking about the same animal here. You told the *Manly Daily* in the first half of this year that you were effectively putting it out for expressions of interest with private health providers. Effectively it will be a public-private partnership at the Frenchs Forest

site. Can you say how many public beds and how many private beds you envisage at the point of opening the hospital?

Mrs JILLIAN SKINNER: The hospital is on track exactly as we said. We did put out an initial request for expressions of interest. We did a market sounding and we got a very positive response. We are looking at around 500 beds across the Mona Vale and the new northern beaches sites. It has now been more narrowly defined in terms of the specific numbers. It will be a public-private partnership of one kind. The form will depend on the next round of discussions with the private sector.

Dr JOHN KAYE: Does that mean that Mona Vale will become part of the public-private partnership?

Mrs JILLIAN SKINNER: It could do. Mona Vale will be the complementary hospital at the subacute end. as has always been intended.

Dr JOHN KAYE: How many of those 500 beds will be public?

Mrs JILLIAN SKINNER: That is to be determined.

Dr JOHN KAYE: It could be zero?

Mrs JILLIAN SKINNER: No, there will be public patients traded in this facility—absolutely.

The Hon. WALT SECORD: I want to commend the Hon. Paul Green on his sudden interest in Mullumbimby hospital.

CHAIR: It is now Government time. Calm down, I know you are very anxious.

The Hon. WALT SECORD: I thought you were waiving your questions.

CHAIR: No.

The Hon. WALT SECORD: I thought he was doing your Dorothy Dixers.

CHAIR: You have had your session and it will come again. There has been a lot of misunderstanding and enlightenment about the budget savings and how they are going to be implemented in the health portfolio. I was interested in hearing some of the examples that you were outlining before. It clarifies in our mind where we are going to get the efficiency savings and how we are going to get these budget savings over four years.

Mrs JILLIAN SKINNER: Thank you, Madam Chair. As I said previously the $3 billion so-called cut is not true. There is a $2.2 billion efficiency saving expected over the four-year period. I described a couple of those models of care. It is worth noting because they are very exciting and most of them have been driven by the clinicians. If you allow the clinicians on the front line to have a real say in a devolved model, that is where you get new models of care coming to the fore. It is why I am happy to point out what happened at Westmead Hospital with the director of the emergency department—because he told me he could do this about four years ago and he was not allowed to do it. He is doing it now and he has made a huge improvement.

I have a few examples from different local health districts. In south-western Sydney they are improving the operation of medical assessment units to reduce the average length of stay in hospital, which also improves patient outcomes. They are using Hospital in the Home to deliver better patient outcomes. Hospital in the Home has been around for years. It started when the Hon. Ron Phillips was the Minister for Health. It gathered pace and it is now right up there as a preferred option. I will give you an example: I have a friend who has a deep vein thrombosis [DVT]. It is the second time she has had a DVT after travelling. On the first occasion she was put in hospital for daily injections and monitoring. On this occasion she was allowed to stay at home in her own comfortable bed and a nurse came and visited her every day to provide the medications and supervision.

The Hon. WALT SECORD: Did you count that as a bed?

Mrs JILLIAN SKINNER: No, but you did when you were in Government. I used to joke about it. I used to say the bed you bought at Harvey Norman was a hospital bed. He has caught himself out. In the Shoalhaven area they have introduced a day rehabilitation program to facilitate the discharge of patients from

acute and subacute settings. This is a coordinated rehabilitation service which provides ambulatory care and outpatient care so patients can safely return home. They are reviewing high volume diagnostic related groups. These are groups of conditions to identify inefficiencies and develop strategies to promote efficient best clinical practice. Through some of the pillars that have been enhanced in our new models—the Clinical Excellence Commission and the Agency for Clinical Innovation—networks of doctors of a particular specialisation are coming up with much improved ways to treat patients that get them out of hospital quicker or prevent unnecessary hospitalisation in the first place. It has a better patient outcome and is a better use of resources.

In other places there is greater investment in severe and chronic disease management. The Commonwealth Government has picked up on some of this as well. Diabetes patients are being provided with more comprehensive health care, particularly primary health care, by general practitioners and some of the allied health professionals, podiatrists and dieticians so that the diabetic person is kept as well as possible in order to avoid the very sad possible consequences of the disease, and later hospitalisation. There are many examples of this right across the system. For example, in northern Sydney they are investing in nursing and medical staff within the intensive care unit to reduce the average length of stay there. Amazing things are happening right through the system; and I am very pleased to say it nearly always involves the clinicians themselves taking the initiative and coming up with new models of care—because all of a sudden they are being told that their opinions are respected and their wishes are coming to the fore.

CHAIR: Hear! Hear! I am biased: I am married to a public health physician, who has been saying these things for years.

The Hon. JENNIFER GARDINER: Minister, earlier there was reference to locums and to locums being replaced by permanent doctors. Could you expand on that, and on how the health workforce in regional New South Wales is better managed by the use of that new model of care?

Mrs JILLIAN SKINNER: I started talking a bit about what happened at Griffith, because I think that is a good example of what has happened. It is a good example of a rural hospital where a fresh approach is being used to provide better patient care and to reduce significant locum costs. Previously the emergency department was heavily reliant on medical locums. The position of director of the department had been vacant for three years, and only three of the nine career medical officer positions in the department had been filled. Training and supervision issues had been identified as well.

A specialist director from the United Kingdom has been appointed to the emergency department. She is expected to commence in early 2013. Two career medical officers have also been appointed. In addition, a resident medical officer has been promoted to the career medical officer position. The hospital is also in the process of advertising for another 1½ resident medical officer positions. I understand that suitable candidates have been identified: they are interested in coming. If a few come they act as a magnet, and suddenly you get a much healthier permanent workforce.

It is expected that the Griffith Base Hospital emergency department will have nine career medical officer positions in place by next February. This scenario facilitates improved patient care because with permanently employed staff there is a consistency of practice. They know their patients, especially in a country town, and they know the practices of the hospital and the staff. That is much better for the patient than relying on locums, who are also very costly. The hospital has indicated a potential saving of approximately $670,500 in medical locum costs in the emergency department for this financial year. With an additional specialist appointed in surgery, an active recruitment program in anaesthetics, obstetrics and gynaecology, the hospital estimates overall savings on using locums of approximately $905,000 just this financial year; that is, one hospital, nearly $1 million. That is a fabulous example of what one can do by making more efficient use of resources. It is also much, much better for patient outcomes.

The Hon. DAVID CLARKE: Minister, what is the New South Wales Government doing to improve organ donation rates?

Mrs JILLIAN SKINNER: This is a subject dear to my heart. As the member would know, both the Premier and I, even when we were in opposition, have been very supportive of the need to increase organ donation rates in New South Wales. Sadly, even though we had a very long register of people who had indicated through the register of the former Roads and Traffic Authority, now Roads and Maritime Services, that they wished to become donors, that was not actually translating into organ donation. Last year only 77 of 210 potential donors actually became donors. It was found that was largely because even though people had ticked

the box when applying for a drivers licence they had done so incidentally; they had not had a discussion about that with their families, so the families did not know what their wishes were and said no to organ donation. Doctors have told me that they will never be willing to take organs from a patient if the family object to that.

So last year we put out a discussion paper with a whole lot of scenarios and asking for feedback. We received that feedback, and out of that came this document "Increasing organ donation in NSW", which we released in August. In it we outline a move to a national register managed as part of the Medicare system. New South Wales is the last State to come on board with that. We have done a number of other things, including creating new positions in hospitals called designated requestors. These are specialists who are being trained in the art of having that very difficult conversation with family members in the event of the death of a loved one who may potentially become an organ donor. There will be advertising campaigns and other initiatives.

The Commonwealth Government has come on board with us in this initiative. We are hoping that this will make a major difference. Just two weekends ago, on the long weekend, I had the privilege of launching the Transplant Games in Newcastle. More than a thousand people participated. Some 700 people ran in the fun run on the Sunday morning of the long weekend. After the run, when the organisers asked anyone who had been an organ recipient to stand, about 500 people stood up. That demonstrated the huge value in putting effort into this program and the importance of having that family conversation, because everyone tells me that is what makes the difference.

CHAIR: Minister, I have a particular interest in Telehealth; and tomorrow I will be at the oncology unit at the Women's Hospital, where the colposcopist, Dr Michael Campion, sings your praises. He is actually involved in Telehealth analysis of colposcopy scans from rural female patients, therefore not having to subject them to long periods of travel into the city. Can you tell me what NSW Health is doing with Telehealth and give some similar examples?

Mrs JILLIAN SKINNER: There are a lot of things meant by Telehealth, but I will refer to just a couple of them. We have already had questions from the Hon. Paul Green about Mullumbimby and the Connecting Critical Care Program. That is, I believe, a model of practice that will become more and more prevalent. People should look at some of the equipment that is now used. I was talking to a John Hunter specialist doctor who tells me that he was called to the intensive care unit to assist with determining the best treatment for a patient who was in a distant hospital. He said the camera the hospital uses could focus on a freckle on the man's face that he would not have been able to see with such clarity using the naked eye. So it really is quite dramatic. As I said, that is helping to diagnose a patient's condition, but it is also helpful in supervising and treating the patient as well as with consulting the patients themselves.

One of the other investments we have made is in the Telehealth program. Professor Mohamed Khadra of Nepean Hospital, using what is really similar to a Skype camera in a patient's home or in the general practitioner's rooms anywhere, but say in Broken Hill, can give patients the results of diagnostic tests they might have had during a hospital visit, and then talk about ongoing treatment—or advise that there is no need for any treatment if that is the case. That means that patients do not have to lock up a shop, close a business, get time off work or arrange child care. They get a much better outcome. There are other examples of the benefits of telehealth.

In April this year a young pregnant woman presented at the hospital at Dorrigo and the medical officer on duty had never delivered a baby. The doctor was connected to Coffs Harbour and District Hospital and the baby was successfully delivered. Clearly the mum could not get to another hospital in time for the delivery. The Connecting Critical Care project will enable expansion through all emergency departments on the mid North Coast and northern New South Wales by June next year. Several services also have been established in the Hunter-New England area and in greater western New South Wales. As I said earlier, the Prime Minister has endorsed telemedicine. She said in a press release on 29 June last year:

> Telehealth will transform the way healthcare is delivered in Australia by removing distance, time and cost as a barrier to accessing care—delivering better health outcomes for patients.

Former State Minister for Health, the Hon. John Hatzistergos, said on 22 September 2006:

> This is a big boost to patients, particularly those in rural and remote areas.

It is generally accepted that telehealth improves patient outcomes and makes access to care much better and easier for patients, and particularly those in country areas.

The Hon. JENNIFER GARDINER: On a similar theme, in terms of improving patient care, can you update the Committee on how the Government is improving pain management services?

Mrs JILLIAN SKINNER: This is another issue that I highlighted when the Coalition was in opposition. I promised that an O'Farrell government would develop a pain management plan for New South Wales. The New South Wales Pain Management Plan, which provides a blueprint for developing pain management services across the State, was released earlier this year and the Government has committed an additional $26 million over the next four years to support the program. It involves the development of new pain management services, particularly in regional areas. We are also enhancing services in tertiary hospitals, which need greater support, and so on. This will enhance existing research into chronic pain and services.

I was motivated in this regard by a meeting I had many years ago with Professor Michael Cousins from the Royal North Shore Hospital Pain Management Service. He is considered to be one of the most prominent experts in this area in the world and his book on pain management is seen as the bible in this field. I have visited his centre a number of times and met patients that he and his team have helped to live with chronic pain to the point where they are now leading productive lives, working, playing with their children and so on, rather than being bedridden. It is a truly well worthwhile investment.

The New South Wales Pain Management Plan also includes money for new dedicated medical, nursing and allied health positions—that is part of the increased staffing—to meet service and training requirements in tertiary areas. Additional money will be provided each year to establish new tier 2 pain management services at Tamworth, Orange, Port Macquarie and Port Kembla. Those locations were chosen because they already had a semblance of a pain management service. It was indicated to me through the Agency for Clinical Innovation network that we had to get people on the ground who were interested in expanding the service, and that is why that is happening.

Further money has been allocated to tertiary hospitals to provide them with the capacity to support the development of country services. Other money has been provided for a regional paediatric service at John Hunter Hospital, for primary health care information systems, for an early intervention trial at Concord Repatriation General Hospital for injured workers and for specialist training positions in various hospitals.

The Hon. DAVID CLARKE: Can you update the Committee about the New South Wales Government's commitment to renovate the State hospitals in western Sydney?

Mrs JILLIAN SKINNER: I had the good fortune to be in western Sydney on Friday for the beginning of work at the Blacktown-Mount Druitt Hospital and also on the new car park at Nepean Hospital. At $324 million, the Blacktown-Mount Druitt Hospital development is the Government's largest single investment. That investment will provide an additional 180 hospital beds, extended emergency departments, cancer services, mental health services, new wards and so on.

As I said while I was at the hospital, not long after I was appointed as the Minister I met with the medical staff council at Blacktown Hospital and I have never met a more demoralised or, frankly, angry group of doctors. I think the director general met with them at the same time. They had been promised things that had not been delivered, demand in the area was enormous and they were having difficulty coping. When I was there on Friday I remarked on the smiles on their faces because they could see that work was being commenced. Health Infrastructure NSW has done a fantastic to job working with the clinicians in designing the building. They have used new technology to produce a computer simulation of the new building. It is a truly spectacular project that provides an aesthetically pleasing connection to the old hospital. It also includes a new clinical school courtesy of the Federal Government's Health and Hospital Fund. That project is well and truly up and running.

The Government has also provided additional funding to enhance Mount Druitt Hospital's capacity as an elective surgery centre, to provide a new urgent care centre at which people of lower acuity can get much better emergency care and an additional 10 rehabilitation subacute beds. The mental health and dental health buildings at Nepean Hospital will also be completed next year and work has commenced on the car park. Interestingly, every patient survey undertaken indicates that car parking is the most important issue. It is about being able to access the hospital. This 650-space car park on seven floors is a huge facility that will serve not only patients but also staff. I was very pleased that the NSW Nurses' Association representative at the hospital helped to turn the first sod. He most vociferously highlighted this issue during the by-election campaign when

Stuart Ayres, the member for Penrith, was elected. The union representative, Stuart Ayres and I turned the first sod and he said that the nursing staff would be thrilled because they had real problems accessing the hospital, particularly after hours and at night.

The Hon. DAVID CLARKE: You referred to the demoralisation you found when you became the Minister for Health. Was that widespread at the time?

Mrs JILLIAN SKINNER: It was and it had been noted in a number of reports and reviews. Justice Peter Garling's review of acute care referred to the toxic health system.

The Hon. DAVID CLARKE: Who referred to it as the "toxic health system"?

Mrs JILLIAN SKINNER: Justice Peter Garling.

The Hon. DAVID CLARKE: When did he do that?

Mrs JILLIAN SKINNER: His report was handed down in 2009. The former Government repeatedly implemented initiatives in an attempt to address bullying and harassment in the health workforce. Of course, this Parliament held an inquiry into bullying in the Ambulance Service of New South Wales. I am thrilled with some of the initiatives that have been implemented to address this issue and the vast improvement in morale in the hospital system.

Full credit to the nursing staff in particular who have come up with essentials of care. This program was started under the former Government and has gathered apace so that now I think more than 600 wards are actively involved in this program where nurses get together, share their understanding of how they fit in and develop the sense of common values. They might come from very different backgrounds, especially in some of those hospitals like Auburn that has so many different cultural experiences. They arrive at a shared view of what their work involves. They then plan how they will work together for the benefit of the patients. They hold showcases of the work they are doing. The excitement around what is happening in these wards is palpable.

The Hon. DAVID CLARKE: Have you found an upbeat mood in western Sydney?

Mrs JILLIAN SKINNER: I have; I can tell you from being out there last week. It is quite amazing.

CHAIR: Ever since the change of Government.

Mrs JILLIAN SKINNER: Since the change of Government.

(Short adjournment)

CHAIR: We will complete the Health portfolio at 5.00 p.m., which will mean a round of about 28 minutes each, 14 minutes for cross benches.

The Hon. WALT SECORD: Minister Skinner, you seem to be locking in eHealth video links replacing doctors. Are you aware of a case in early July involving a 44 year-old-man who visited Mullumbimby Hospital in the middle of the night of 1 July but was told there was no overnight doctor. He returned home and decided to wait until 7.00 a.m. However, in that time his condition sharply deteriorated and the next day his family found him at his home confused and delirious. They called the ambulance. By that point his care was beyond Mullumbimby Hospital and he had to be transferred to Brisbane Hospital. He was found to have a viral infection which was life threatening. There was no overnight doctor in the emergency department at Mullumbimby Hospital. Do you still stand by your decision to replace the overnight emergency doctor in Mullumbimby emergency department with a video camera?

Mrs JILLIAN SKINNER: I do stand by my support for connecting critical care, absolutely, without doubt especially where there is such difficulty in recruiting doctors to these country hospitals. I do not know the individual case that you are talking about, but I am happy to take it on notice.

The Hon. WALT SECORD: Minister, you do not need to recruit an emergency overnight doctor; one is being replaced by a video camera. There is already a doctor there.

Mrs JILLIAN SKINNER: One doctor cannot work 24 hours a day, seven days a week, as you would know.

The Hon. WALT SECORD: On that point, is the Minister aware that on 26 December, Boxing Day, 63 patients were in the emergency department being attended to by a doctor and a nurse and it was the busiest day of the year in Mullumbimby Hospital?

Mrs JILLIAN SKINNER: During the day?

The Hon. WALT SECORD: Yes.

Mrs JILLIAN SKINNER: No, I am not aware of that number during the day but I can tell you that overnight the average patient attendance at Mullumbimby Hospital I think is 1.5 attendances.

The Hon. WALT SECORD: Those figures were supplied and put into the public arena by Mr Chris Crawford. Why is Mr Chris Crawford not here today? We put in a formal request for his attendance.

Mrs JILLIAN SKINNER: I can answer questions, as can the officers at this table in relation to Mullumbimby Hospital.

The Hon. WALT SECORD: But he is the architect of the plan that you want to roll out across the State, he is the person who explains it on the North Coast at public meetings attended by up to 400 people and he is the person who has all the answers. Are you aware that the doctors and nurses up there said that in that figure that you quoted of 1.5 that he has put in the public arena, he counts people who arrive at 11.01 p.m. but does not count people sitting in the emergency department before 11.00 p.m.

Mrs JILLIAN SKINNER: I believe the figures relate between 11.00 p.m. and 7.00 a.m.

The Hon. WALT SECORD: He does not count people who are in the emergency department at 11 o'clock?

CHAIR: Allegedly.

The Hon. WALT SECORD: You are calling doctors and nurses up there liars?

CHAIR: No, according to you, allegedly.

The Hon. WALT SECORD: Doctors and nurses, I cannot break their confidence. They are whistleblowers but they provided that information.

CHAIR: Allegedly.

Mrs JILLIAN SKINNER: I will get you further answers on notice should you wish. I am told that 1.5 is the average attendance overnight, with most of those attendees being lower acuity. Mullumbimby Hospital emergency department support from Tweed Hospital I believe is the way to go, as it has been proven to be the case in other hospitals as I have pointed out, supported not only by me but by the Chief Minister in the Australian Capital Territory and by the Federal Minister, Tanya Plibersek, who is funding some of these programs.

The Hon. WALT SECORD: I put it to you that they are cooking the figures.

Mrs JILLIAN SKINNER: Are you accusing the Australian Capital Territory Minister of cooking the figures?

The Hon. WALT SECORD: No, I am listening to doctors and nurses who say there are 10 to 12 people in that emergency department at 10.59 p.m. Chris Crawford and your department—

Mrs JILLIAN SKINNER: Are you accusing Mr Crawford of being a liar?

The Hon. WALT SECORD: Cooking the figures.

Mrs JILLIAN SKINNER: What does that mean?

The Hon. WALT SECORD: Do you believe Chris Crawford?

Mrs JILLIAN SKINNER: I do believe Mr Crawford, yes.

The Hon. WALT SECORD: On the subject of nurses and doctors, on 26 July I was invited to the hospital by doctors and nurses. I repeatedly sought permission to attend to see the equipment and I was refused. Have you launched an investigation or are you taking any disciplinary action against those doctors and nurses who invited me and the Federal member to see the equipment?

Mrs JILLIAN SKINNER: No.

The Hon. WALT SECORD: Dr Foley, how many other New South Wales hospitals are currently under consideration for similar video links replacing doctors in emergency departments?

Dr FOLEY: I cannot give you an answer about that off the top of my head. I would have to ask different districts as to what is in their thinking at the moment about opportunities. It is a very common part of service delivery models, particularly for rural areas. We can give you examples of where it is already in place. It is a core part of mental health networks, for example. When I was in my first week in the role visiting Gilgandra's Multi Purpose Health Service, for example, Telehealth is available within that facility, connecting it back to Dubbo base for being able to review mental health patients.

It is not the sort of brave new world; it is a very important tool. The thing about it is that it enables the connectivity of a health system—we have a very good health system and we operate as a system—to be able to connect patients up to the sort of sub-speciality care, advice, diagnosis and so on that otherwise cannot be available in those smaller centres. How you best deploy it and get the best from it is very much a matter for local health services when looking at how to design and to implement it. I am happy to seek information and bring it back to you as a question on notice in terms of where districts might be considering further implementation.

The Hon. WALT SECORD: I have three quick questions that you will probably want to take on notice. What is the total budget for the North Coast Area Health Service? What is the total budget for Mullumbimby hospital? In real terms is that an increase or decrease in the 2010-11 budget?

Dr FOLEY: If you will bear with me I will check the numbers because I cannot give it off the top of my head, but I can give you the district budget. I will have to take the Mullumbimby one on notice because it is a matter for the district to determine that and I will confirm that detail. In terms of the overall budget for northern New South Wales, which is the relevant district, for 2012-13 it is $611,722,000—that is a 4.7 per cent increase in funding.

The Hon. LUKE FOLEY: Minister, can we go back to beds? Your election policy was to deliver an extra 1,390 beds, was it not?

Mrs JILLIAN SKINNER: It was to make an extra 1,090 beds available, yes.

The Hon. LUKE FOLEY: Some 1,390?

Mrs JILLIAN SKINNER: I have got the policy here—1,390.

The Hon. LUKE FOLEY: As do I; I never leave home without it. The commitment was. "A New South Wales Liberals and Nationals government will deliver the New South Wales health and hospital system: (1) an additional 1,390 beds available in our health system to unblock our emergency departments and deliver better patient care."

Mrs JILLIAN SKINNER: Here it is. To make them available, yes. It goes on to say that we would make 550 adult acute overnight public beds available in addition to the 840 new beds funded by the Commonwealth Government—page 15.

The Hon. LUKE FOLEY: Indeed. The last I have seen from you is a fact sheet from March 2012 telling us that "565 beds of the 1,390 beds are now open (as of 31 January 2012)." Is that the case?

Mrs JILLIAN SKINNER: Whereabouts is that?

The Hon. LUKE FOLEY: That is in your March 2012 hospital beds facts sheet that we were traversing earlier.

Mrs JILLIAN SKINNER: It is in that fact sheet, yes. I do not have the figure in front of me.

The Hon. LUKE FOLEY: Do you stand by that statement?

Mrs JILLIAN SKINNER: I do.

The Hon. LUKE FOLEY: Is it not the case that 405 of those 565 beds were actually opened when the former Labor Government was in office?

Mrs JILLIAN SKINNER: Yes, and these are part of the COAG-funded subacute beds that were only funded for the one year and we have had to find additional State funding to keep those beds open.

The Hon. LUKE FOLEY: Of the 565 beds that you claim have opened, only 165 of those beds have been open since 26 March 2011, have they not?

Mrs JILLIAN SKINNER: Making those beds available—read my lips "available"—means providing the money to keep them open. The former Government—your Government—with the Commonwealth and Council of Australian Governments funding opened them temporarily—

The Hon. LUKE FOLEY: Opened them, indeed.

Mrs JILLIAN SKINNER: —if the money had not been found by the O'Farrell Government to keep them open they would have been closed.

The Hon. LUKE FOLEY: So you want to do a lap of honour for not closing 405 beds, do you?

Mrs JILLIAN SKINNER: We have found the money to make those beds available on an ongoing basis; that is exactly what we said in our policy document.

The Hon. LUKE FOLEY: So not closing 405 beds you redefine as opening an additional 405 beds, do you?

Mrs JILLIAN SKINNER: Your Government closed beds—

CHAIR: Order! The member asked the question, allow the Minister to answer it.

Mrs JILLIAN SKINNER: —we have kept beds originally funded under the Council of Australian Governments and we have found the money within our budget to make them available on an ongoing basis. I am very proud to make that public statement.

The Hon. LUKE FOLEY: There were not an extra 1,390 beds; there were 405 beds already in the system and you are taking credit for them, are you not?

Mrs JILLIAN SKINNER: You really are absolutely disgraceful. I said "make those beds available". That means provide the funding to keep patients in them.

The Hon. LUKE FOLEY: Who opened them, Minister?

Mrs JILLIAN SKINNER: You closed beds—

The Hon. LUKE FOLEY: The Keneally Labor Government opened them, did they not?

Mrs JILLIAN SKINNER: Actually, no. They were COAG-funded beds.

The Hon. LUKE FOLEY: That is what your facts sheet tells us.

Mrs JILLIAN SKINNER: No, they were COAG-funded beds; it was not the Keneally Labor Government.

The Hon. LUKE FOLEY: They were opened when the Keneally Labor Government was in office.

Mrs JILLIAN SKINNER: You do not allow me to claim—

CHAIR: Order! The member asked the question; let the Minister answer.

Mrs JILLIAN SKINNER: What we said was that we would make beds available. We have made them available by keeping the funding going to keep patients in them. They were only momentarily funded when you were in government. The money ran out.

The Hon. LUKE FOLEY: You have not closed 405 beds—

Mrs JILLIAN SKINNER: We have made available.

The Hon. LUKE FOLEY: —and you will claim them as 405 new beds opened on your watch, will you? You are joking.

Mrs JILLIAN SKINNER: Make those beds available—that is exactly what I am claiming and it is exactly what we have done. You can protest as much as you like with that little hidden grin on your face. The reality is we said we would make those beds available and we are making them available.

The Hon. LUKE FOLEY: Of the 1,390 beds you promised, in fact there will only be 1,390 minus 405. That is the promise now, is it?

Mrs JILLIAN SKINNER: We said we would make 550 adult acute overnight hospital beds available in addition to the 840 beds funded by the Commonwealth Government.

The Hon. LUKE FOLEY: You promised an additional—

Mrs JILLIAN SKINNER: That is a promise.

The Hon. LUKE FOLEY: I quote your policy here, "an additional 1,390 beds available in our health system".

Mrs JILLIAN SKINNER: Correct.

The Hon. LUKE FOLEY: That was a policy taken to the election in March 2011?

Mrs JILLIAN SKINNER: Correct.

The Hon. LUKE FOLEY: But the additional 1,390 included an existing 405, did it not?

Mrs JILLIAN SKINNER: It included 840 actually—you are wrong. This is the document here. This document was put out in March 2011. Yes, we said we would make 1,390 beds available. Some of them would have closed if we had not provided the additional funding.

The Hon. LUKE FOLEY: An additional 1,390 beds—

Mrs JILLIAN SKINNER: Available.

The Hon. LUKE FOLEY: —and 405 of them were already open, were they not? How can that be additional?

Mrs JILLIAN SKINNER: Because they would have closed if we had not provided the money. That is what you did all the time.

The Hon. LUKE FOLEY: So you did not close them and you are telling us they are additional beds because you did not close them.

Mrs JILLIAN SKINNER: The beds were only funded momentarily by your Government. I suspect you reckoned you might lose the election so you only provided money for a very short time and left us to find the money to keep them open, which is exactly what we have done.

The Hon. HELEN WESTWOOD: Does the category of "available beds" include beds in emergency departments?

Mrs JILLIAN SKINNER: As I have said, we have classified beds according to categories. There are beds available for admission from the emergency department. Clearly they are not emergency department beds, they are "other hospital beds". These are ones where there is a whole range of beds included. Wait till I find my place and I will give you the definition. These "other hospital beds" are day-only mental health—emergency department beds are included in "other hospital beds".

The Hon. HELEN WESTWOOD: Does that include the beds in emergency department cubicles?

Mrs JILLIAN SKINNER: In places where patients lie down in the emergency department. The chairs or the recliners in the emergency departments are called treatment spaces.

The Hon. HELEN WESTWOOD: So the ones in the triage and consulting areas, where would they be?

Mrs JILLIAN SKINNER: If you are talking about lying down in a bed—would Dr Hammett like to have a go at answering this?

The Hon. GREG DONNELLY: So he's the health Minister?

Mrs JILLIAN SKINNER: Well, I have answered it but you do not want to hear the answer. I will get some definition and maybe you will be more polite to the officers.

CHAIR: I remind members to be a little more respectful.

The Hon. LUKE FOLEY: Fair enough, but we do not need editorialising from the Chair either, Madam Chair.

CHAIR: Dr Hammett would like to give you further information on this question?

The Hon. LUKE FOLEY: Just pretend to be a straight Chair.

CHAIR: Come on, be nice.

The Hon. LUKE FOLEY: You do not need to be editorialising either.

CHAIR: Are you interested in the answer?

The Hon. LUKE FOLEY: Indeed.

Dr HAMMETT: Just to clarify, emergency department beds are classified in the treatment spaces classification. The intent, as the Minister has outlined, has been to try to divide transparently the types of beds that are available in the health system so that there cannot be any attempt to gain bed count numbers but also to enable us to move beyond a relatively simple exercise of slinging bed numbers at each other to understand what activities might be provided in the health system and how we might best provide that so that instead of thinking just in terms of a bed, which might in fact treat multiple patients in one 24-hour period, we actually start to think in terms of the number of patients that we can treat in the system.

I am a gastroenterologist by training. When I started my training we used to put people in hospital for weeks at a time to treat them for a stomach ulcer. They would go into hospital for weeks. They would need lots of treatment. These days we treat stomach ulcers on an outpatient basis. If we had continued to simply count the number of beds available to treat stomach ulcers it would not have been an accurate measure of how we actually treat patients in the system. We now know that we treat thousands of patients for stomach ulcers, but we do not do it just in beds. We treat them in a whole lot of different spaces, so the classification system has been designed so that people can understand what the available treatment opportunities might be, and can do that and see that transparently.

The Hon. LUKE FOLEY: That may well be the case, Dr Hammett, and that is a very legitimate point that you make, but in the annual report there is a list—figures, numbers of beds—and we are entitled to make the point that the definition of what is a hospital bed has been widened significantly by this Minister or by the Government, has it not?

Dr HAMMETT: I am not in a position to answer for the Government, but I think in fact there is a mistake in the characterisation of those annual report figures. I think in fact you are comparing apples with oranges so that there was a way of classifying beds in 2009 that is different to the way they are classified in 2010-11.

The Hon. LUKE FOLEY: Indeed.

Dr HAMMETT: And so a different calculation needs to be done to compare apples with apples, so I do not think it is correct to characterise a change in 2,000 beds. Although you look at those two figures there I actually do not think that you are comparing apples with apples. This is where it becomes confusing and the attempt to provide classification was to provide a greater level of understanding. Indeed, in the longer term it would be helpful if we moved beyond counting actual beds and started to talk about how many patients we are treating in the system; how many new patients this year are being treated across the New South Wales health system because that is really what public health outcomes are about.

The Hon. LUKE FOLEY: Thank you, Dr Hammett. It is the case, is it not, that the bed numbers in the 2010-11 annual report when compared to the bed numbers in the 2009-10 report—we are comparing apples and oranges—the component parts of the total bed number have changed, have they not?

Mrs JILLIAN SKINNER: This table out of the annual report shows equivalents in 2007-08, 2008-09, 2009-10 and so on, so you have a capacity to compare one with the other out of the annual report because they have used classifications.

The Hon. LUKE FOLEY: I was agreeing with you, Minister. I think we have found common ground.

Mrs JILLIAN SKINNER: I think you have, but it is far more transparent than it ever was previously.

The Hon. GREG DONNELLY: Just returning to the issue of nurses and front line versus non-front line. It was classified in the last series of questions. What you meant was that front-line nurses would be exempt from the cap, is that the position?

Mrs JILLIAN SKINNER: Yes, and as has been pointed out, we have employed more than 2,900 additional nurses since we have been in office. That is more than ever before.

The Hon. GREG DONNELLY: In regard to the non-front-line nurses, we heard from a witness earlier who went through two or three examples of a non-front-line nurse. Have any voluntary redundancies been offered to any non-front-line nurses to this point?

Mrs JILLIAN SKINNER: I actually did indicate that. I understand there had been some in the Hunter-New England, but I do not know whether any have actually been taken up.

Ms CRAWSHAW: Which period of time are you referring to?

The Hon. GREG DONNELLY: I am talking as of today's date have there been across all the districts and locations any voluntary redundancies of non-front-line nurses?

Ms CRAWSHAW: Non-front line?

The Hon. GREG DONNELLY: Correct, yes.

Ms CRAWSHAW: Hunter-New England, we believe, has offered some voluntary redundancies.

The Hon. GREG DONNELLY: To non-front-line nurses?

Ms CRAWSHAW: There is a discussion going on with the non-front-line nurses.

Dr JOHN KAYE: Did you say offered voluntary redundancies?

Ms CRAWSHAW: Yes.

The Hon. GREG DONNELLY: How many?

Ms CRAWSHAW: I cannot give you the exact figure at the moment.

The Hon. GREG DONNELLY: So there is one local health district where there has been an offer of redundancies to non-front-line nurses?

Ms CRAWSHAW: There has been a discussion. I am just looking at the overall number for 2012-13. The first two months, 40 staff, 36 in the health service. I cannot give you a breakdown of what classifications they were.

The Hon. GREG DONNELLY: Could you take that on notice, please?

Ms CRAWSHAW: I can indeed.

The Hon. GREG DONNELLY: I am looking for by local health district the number of voluntary redundancies of non-front-line nurses as of today's date. I pass a copy of this document to the Minister. This is a document that has become available.

Mrs JILLIAN SKINNER: Well, it is on the internet, so it is not very hard to find it.

The Hon. GREG DONNELLY: It is available.

Mrs JILLIAN SKINNER: Yes, on the internet.

The Hon. GREG DONNELLY: You will see there in red, first of all, for the Prince of Wales Hospital the figure of 206 and over the page with respect to Sydney, the Sydney Eye Hospital, 405. Are you in a position to provide a copy of this for each hospital within each local health district in New South Wales?

Mrs JILLIAN SKINNER: You will see that this is the Prince of Wales but it is also Sydney, Sydney Eye Hospital.

The Hon. GREG DONNELLY: Correct.

Mrs JILLIAN SKINNER: This is from the South Eastern Sydney Local Health District website. It has posted all of its hospitals on their website.

The Hon. GREG DONNELLY: Correct.

Mrs JILLIAN SKINNER: It has been published in the Herald because the chief executive provided that information to the Herald for its report. It is all part of the service agreement. They are all being published on the websites. It is up to the local health districts whether they publish it at this level or not.

The Hon. GREG DONNELLY: When you say "this level", what do you mean by that?

Mrs JILLIAN SKINNER: Whether it is by individual hospital or not, that is up to the local health district.

The Hon. GREG DONNELLY: So they do not have to?

Mrs JILLIAN SKINNER: I do not know whether they are all doing it or not. They are being encouraged to make as much information available as possible as part of our commitment to transparency.

The Hon. GREG DONNELLY: But they are not told that they are required to have this posted on the website?

Mrs JILLIAN SKINNER: No, this was their initiative, which I am encouraging, but I want to point out, since you have raised it, that it identifies $2.2 million in savings. The net result of their budget is $292,561,000, so it is a very small amount in the total scheme of things and it shows you the breakdown. They have acute, non-acute and sub-acute funding. It is the first time ever—

The Hon. GREG DONNELLY: I can read it, Minister.

Mrs JILLIAN SKINNER: It is interesting, is it not, because that has never been published before? That is transparency.

The Hon. GREG DONNELLY: Can you provide a copy for each local health district and for each hospital in New South Wales?

Mrs JILLIAN SKINNER: No, but I would suggest you might want to go to the website and find them because that is where they are available.

The Hon. GREG DONNELLY: So you will not make a copy available to this Committee?

Mrs JILLIAN SKINNER: No, they may well be there; I have not had a chance to look at it all.

The Hon. GREG DONNELLY: I am not asking you to do it yourself, but could you make available to the Committee a copy for each—

Mrs JILLIAN SKINNER: It is on the website. I am not going to get each of those for you. You may look at it on the website.

The Hon. GREG DONNELLY: It is for the Committee. Are you not going to agree to provide to this Committee the details—?

Mrs JILLIAN SKINNER: No, the Committee can do exactly what you have done and look at it on the website.

The Hon. GREG DONNELLY: So you are not prepared to provide it?

Mrs JILLIAN SKINNER: No. It is available.

The Hon. GREG DONNELLY: You talk about transparency and you say you will not provide the Committee with information that is available. Is that what you are saying?

Mrs JILLIAN SKINNER: I am saying that not only this Committee but every member of the public here or anywhere in the world can go and find this document.

The Hon. GREG DONNELLY: You are not prepared to provide the Committee with information in response to a reasonable request at a budget estimates hearing. Is that what you are saying?

Mrs JILLIAN SKINNER: I am saying that every person in the world can look at this information. That is true accountability and transparency.

The Hon. GREG DONNELLY: Going to the $2.2 billion which we traversed—

Dr JOHN KAYE: Is it possible to table the document so that the rest of us can see it?

Mrs JILLIAN SKINNER: I am very happy to.

Document tabled.

The Hon. GREG DONNELLY: With respect to the $2.2 billion, you explained the nature of that amount earlier, but is it possible that at a local level—and I understand how matters are devolving through your new framework and how you are encouraging local decision-making—a decision could be taken at a hospital to reduce staffing and that could fall within the $2.2 billion overall saving that is being sought?

Mrs JILLIAN SKINNER: Certainly I have given examples of how there have been decisions to reduce locum and agency staffing, but if you go to the website you will find that they all have service agreements about the additional patient care they have to provide. It is highly unlikely they are going to provide that additional patient care without additional nurses, additional doctors, additional allied health professionals.

The Hon. GREG DONNELLY: I am talking about cleaners, counsellors, social workers and people like that. At the end of the day you are not going to try to micromanage decisions made at a hospital level about whether or not they have X versus Y number of social workers, are you?

Mrs JILLIAN SKINNER: What we have done is provided a total framework, which is the service agreement signed by the director general, with each of those board chairs about the level of care that they will provide within their district and furthermore broken down according to the different services they will provide. You do not have to be a rocket scientist to work out that you need staff to provide those services, so I am not anticipating that there will be any cuts in major service groups. I am leaving the detail of how they come up with those labour expense caps, particularly in relation to overtime, locums, et cetera, to the districts.

The Hon. GREG DONNELLY: So the decision is made at the local level? [*Time expired.*]

The Hon. PAUL GREEN: Returning to the subject of Mullumbimby hospital, how many patients on average for the year would the doctor or doctors have seen?

Mrs JILLIAN SKINNER: I would have to ask Dr Hammett.

The Hon. PAUL GREEN: I will also put these questions on record. What is the costing or budget to run that doctor or those doctors per year?

Mrs JILLIAN SKINNER: I would have to take that on notice as well.

The Hon. PAUL GREEN: How many locums over a period of a year are used at Mullumbimby hospital to cover that one position?

Mrs JILLIAN SKINNER: I would have to take that on notice as well.

The Hon. PAUL GREEN: Further to that, I believe it is a bit of a team with the registered nurse?

Mrs JILLIAN SKINNER: Yes.

The Hon. PAUL GREEN: I would be interested in the statistics of the registered nurse position complementary to the doctor manning the accident and emergency department. What is the costing of using telehealth; what are the potential savings? You quoted earlier that the average is serving 1.5 patients overnight.

Mrs JILLIAN SKINNER: Yes.

The Hon. PAUL GREEN: Are you suggesting there would be nights where there would be nil patients?

Mrs JILLIAN SKINNER: Correct.

The Hon. PAUL GREEN: And the doctor would be hired?

Mrs JILLIAN SKINNER: Correct.

Dr JOHN KAYE: Hired or on call?

Mrs JILLIAN SKINNER: On call.

The Hon. PAUL GREEN: Would he be on call or would he be in the accident and emergency section?

Mrs JILLIAN SKINNER: He would be on call.

The Hon. PAUL GREEN: He would still be receiving a fee?

Mrs JILLIAN SKINNER: An on-call payment, yes, and if the doctor is on leave or whatever you would hire a locum.

The Hon. PAUL GREEN: I am aware of the locum issue because we know in regional and rural New South Wales they live for some great locums to come out and give them a break.

Mrs JILLIAN SKINNER: Yes, and there will always be a need for locums. It is how you use them.

The Hon. PAUL GREEN: I would be interested in the payment for locums.

Mrs JILLIAN SKINNER: They are good questions, so I am very happy to take this on board.

The Hon. PAUL GREEN: Dr Foley was going to explain some initiatives to address bed blocking, so I might give her the liberty of sharing those initiatives.

Dr FOLEY: Can you just bear with me for a moment?

The Hon. PAUL GREEN: While Dr Foley searches for that information, I will ask a simple question that will not need a long answer. On page 98 of the NSW Health Admitted Patient Report 2012, Health Statistics New South Wales, under Illawarra Shoalhaven Local Health District Residents: hospitalisations in public and private hospitals by service related groups 2010-11, in the service related groups there are several topics. The one I am interested in talks about the number of patients seen. It has renal dialysis at 19,506. Cardio was around 7,522. Can you clarify why renal dialysis would be something near 20,000? Maybe there needs to be clarification of what renal dialysis pertains to, because I would have thought that was a lot of renal cases.

Dr HAMMETT: I can perhaps clarify that. Every time a patient who has kidney failure comes in for their dialysis in their chair, and they come in three times a week, that is counted as one patient. That is why those counts are so high.

The Hon. PAUL GREEN: They are tremendously high. Thank you for that clarification. Dr Foley, do you have the information?

Dr FOLEY: In terms of bed block or access block, the pointy end of that issue is the emergency department and also the ambulance service delivering patients to the emergency department. There is a whole range of initiatives and practices to improve that transfer of care from ambulance to emergency department and to support the flow of patients within the emergency department, but the most critical issues overall to this issue go to a whole-of-hospital and whole-of-health system set of issues in that it goes to patient flow throughout the hospital, coming into hospital and leaving hospital, the sort of investment that we make in out-of-hospital-care and the sort of connectivity we develop with other services available within the community that are funded and regulated by other levels of government—for instance, general practice, aged care and so on.

In terms of this winter, we have just come through a particularly heavy peak. Any State health system plans for winter because it is always a more severe time for presentations, and unfortunately you cannot predict it, but every so often there can be a particular spike. This year we had the biggest spike in activity, I am told, since the swine flu of 2009, so particular pressures, and during that time we have been able to keep performance measures close to the sorts of ideal performance measures that we set. In terms of the range of initiatives, it goes

from those front-end issues about very practical things of ensuring that there is a senior person available for every service, a 24-hour, seven-day-a-week person to address patient access issues, protocols between ambulances and hospitals to escalate issues, so rather than issues piling up at the front door of hospitals there is early identification and senior communication about how those things are going to be managed.

The Hon. PAUL GREEN: That is a good point, and that is my next question. One of the major sticking points is the Ambulance Service is unable to get back in the van and go. It has to wait until there is a handover. What are you doing to quicken that process?

Dr FOLEY: That is part of the process of escalation and looking at the mobilisation of further staff resources within the hospital to take over the patient sooner, and being able to flexibly staff up for those kinds of peaks. We also have a tool that has been developed called the patient flow portal, which is proving to be extremely valuable. It is a real-time computer-based linked system on which you can see the patient flow right through the hospital relating to bed occupancy and the flow through the emergency department into the wards.

You can model it according to emerging demand patterns so that you can anticipate when you are going to have a squeeze point with inpatient beds being full and the flows in the emergency department backing up, and it enables pre-emptive action to be taken to look at how to get better flow out of the beds to appropriate care. Sometimes patients can be in bed because they are waiting on the results of tests or the availability of a discharging doctor over the weekend and practical issues like that. It is a matter of using the bed portal and having strong processes to review patients and see how we can facilitate the tail end of their care.

In New South Wales there is also what I think is a very innovative program called ComPacks, or community packages. Sometimes what stops a patient from being discharged is there is no-one at home to provide not health care but basic support to get the patient's shopping done or help him or her in the shower—that kind of care—as well as nursing care or even Hospital in the Home at higher levels. We have a system by which arrangements have been made with non-government organisations which provide personal care or home support services, not health care services, so that a district can avail itself of packages and, if they are appropriate to the patient, get them home support. That frees up inpatient capacity, which then allows better flow through the emergency department.

Having got through this winter spike we have asked all district boards to review their districts and to come back to us by the end of November on what additional measures are needed, using these and any other innovations and developments by staff, to position ourselves for next winter so that we can anticipate even better how we can get those flows working.

The Hon. PAUL GREEN: What are you doing to make medical officers accountable on a daily basis to communicate with the nursing unit manager, the bed manager or the person allocated to that in the hospital so that they know what is happening in the system? That is where the crack is, from what I understand and certainly from practice, and it is a big crack. The medical officer needs to spend a little time in the morning summarising the situation, addressing the issues and looking at the flow chart. I agree they are all complications, but if the medical officers will not look at any of that stuff and they think their outcomes are the most important aspect of the day, that stuffs up the whole system. What are you doing to keep them accountable about their day, their patient numbers, bed availability and bed usage?

Dr FOLEY: There is a whole raft of things going right back to Commissioner Garling and his review. He identified handover and communication as absolutely critical issues. If you look at the international literature you will see they are one of the critical weak points in modern healthcare systems. In New South Wales over the past few years significant progress has been made. It is not just a matter of exhortation and asking people to do better; you have to provide systems that support people to do this well.

A significant number of systems have been developed—again, we are happy to provide further information and examples—for handover of care, documentation of care and being able to have disciplined processes around handover and exchange of information about management of patients. The flow portal I mentioned is one. The Clinical Excellence Commission has taken this on board as a key element of safety and quality. We are using our IT developments and clinical support systems combined with teaching best practice and embedding that through the Clinical Excellence Commission and working with districts. They are some of the examples and we could give you a comprehensive account.

The Hon. PAUL GREEN: I am sure you can.

Dr FOLEY: We are seeing improvements in that regard. I am very impressed that New South Wales has probably made more inroads and more ground in these whole-of-system disciplines and how you roll them out in a consistent way in what are very big systems and train staff. We have 100,000 people rostered 24/7 handing over about patient care. We are starting to see those systems being put consistently in place and they are starting to move the performance needle.

The Hon. PAUL GREEN: You have all the processes but you cannot move the needle if you do not have a doctor who is helpful. Basically it breaks the whole system. You talked about out-of-hospital care and Hospital in the Home, which I think is the way to go because you do not have to supply the infrastructure. Is the Government looking to use hotels or motels around hospitals to alleviate some of the cost of daily bed use? For instance, what is the average cost of a hospital bed?

Dr FOLEY: The average acute bed cost in New South Wales this year is $4,741. Is that right, Dr Hammett?

Dr HAMMETT: It is $4,472. That is the State's average.

Dr FOLEY: For a weighted patient case.

The Hon. PAUL GREEN: Is that the daily cost?

Dr FOLEY: No, that is for an episode of care.

The Hon. PAUL GREEN: What would it cost to have patients in casualty all day on a bed waiting for their blood results because they are not sure whether they have a cardiac condition or the enzymes are not pumping around when you could put them in a hotel for a few hours or overnight?

Dr FOLEY: We have a whole scale system—

The Hon. PAUL GREEN: Just roughly.

Dr FOLEY: If we take 0.6 of that—

Dr HAMMETT: I think we would need to take that question on notice.

The Hon. PAUL GREEN: My point is there could be a hotel down the road in regional and rural Australia, particularly where they are around hospitals, where the occupation rate is through the floor. You would be stimulating the local economy and fixing your problem. You would be fixing their problem by spending the dollars and probably getting better outcomes in health care because the patients are out of the clinical area and in a place where they would probably recover a little quicker because of their ambient environment.

Dr JOHN KAYE: Minister, you spoke before about Hospital in the Home and efficiencies of the health system in getting people out of hospitals and into their homes. I understand that the home ventilation program of EnableNSW is currently at capacity. There are people in hospitals at the moment who cannot leave hospital because there are no more dollars in the EnableNSW adult home ventilation program. Is that correct?

Mrs JILLIAN SKINNER: This is the old Program of Appliances for Disabled People [PADP].

Dr JOHN KAYE: That is correct.

Mrs JILLIAN SKINNER: It provides assistance to 21,000 people living with permanent disability in various ways such as through equipment and aids, incontinence products, wheelchairs and walking aids. The demand is steadily increasing but the average waiting times are low, at four to eight weeks compared to six months. I am coming to the bit about—

Dr JOHN KAYE: We acknowledge that for other aspects of the old PADP there has been an increase, but I am specifically interested in the unmet demand for the ventilation program.

Mrs JILLIAN SKINNER: On the Children's Home Ventilation Program one child is waiting.

Dr JOHN KAYE: I am using the adult one.

Mrs JILLIAN SKINNER: Two people are waiting for assistance through this program.

Dr JOHN KAYE: Two people are waiting for assistance. Those two people currently are in hospital as we speak.

Mrs JILLIAN SKINNER: Are they? I am not sure where they are.

Dr JOHN KAYE: Well, presumably they are on a ventilator somewhere. This is ventilation, so—

Mrs JILLIAN SKINNER: No, not necessarily.

Dr JOHN KAYE: This is the Adult Home Ventilation Program.

Mrs JILLIAN SKINNER: Yes, but you do not have to be on a ventilator.

Dr JOHN KAYE: But you need access to a ventilator.

Mrs JILLIAN SKINNER: No, you need access to oxygen.

Dr CHANT: It is oxygen.

Dr JOHN KAYE: You need access to oxygen. Sorry, I am confused. This is not the Home Oxygen Program; that is a separate program.

Mrs JILLIAN SKINNER: Sorry, yes.

Dr JOHN KAYE: I am talking about the ventilation program. Presumably these are people who have high-level spinal cord injuries. Those two people are in hospital at the moment. They cannot leave because there is no money for home ventilation. What happens if somebody else turns up in the hospital and that person needs ventilation?

Mrs JILLIAN SKINNER: Because two people are waiting for assistance to go home I do not think that means there is no capacity in hospital to treat them.

Dr JOHN KAYE: Let us go to those two individuals. About what is it costing?

Mrs JILLIAN SKINNER: It is very expensive.

Dr JOHN KAYE: Would it not be cheaper to have them ventilated at home?

Mrs JILLIAN SKINNER: It may well be. I cannot answer the specifics about why these people are waiting. It might be that they are not appropriate candidates for ventilation at home. I do not know; I have to take that question on notice.

Dr JOHN KAYE: Is not the issue that the budget is now fully expended? Is it purely a budgetary problem?

Mrs JILLIAN SKINNER: I am not so sure that that is the case, but I will take that question on notice.

Dr JOHN KAYE: My understanding is that it is a budgetary problem. Minister, you are implying that is it is a clinical issue and that there are clinical reasons for holding them, but these two individuals are on a waiting list which means they have been cleared by their clinicians to leave the hospital. What they are waiting for is access to ventilation at home. They cannot go home without ventilation because they will not survive.

Mrs JILLIAN SKINNER: I will find out more detail.

Dr JOHN KAYE: Minister, in the hospital savings that you identified surely this would be an excellent place to begin, to put more money into EnableNSW and get these two poor individuals out of hospital where they are likely to survive longer.

Mrs JILLIAN SKINNER: It is always my desire to have these patients treated in a more appropriate place. That would be something in which I would be very interested. I will ask for advice. I have just had it pointed out to me that part of the problem is that in principle two newly injured ventilator dependent adults and one child currently in hospital have been accepted onto the program. However, the operating costs have increased as a result of the increase in the Federal award for community workers, so there is a budget issue there. I will find out more detail.

Dr JOHN KAYE: What I am interested in is the cost of holding them in hospital and the cost of treating them at home and why it is that you cannot just transfer money—it is all within the Department of Health—to get them out of hospital and get them home.

Mrs JILLIAN SKINNER: I will make inquiries because I agree with you.

Dr JOHN KAYE: Will you comment also on co-payments while we are on the issue of EnableNSW? There does not seem to be a lot of clarity about the issue of co-payments. I understand that some clients have been sent letters asking for $100 worth of co-payments while others make no co-payments at all.

Mrs JILLIAN SKINNER: I will have to make inquiries about that. I cannot answer that off the top of my head.

Dr JOHN KAYE: Will you take that question on notice?

Mrs JILLIAN SKINNER: Can you answer that question Dr Roach?

Dr ROACH: I cannot tell you the difference. I think it has to do with co-payments relating to people on higher incomes. People on higher incomes pay a co-payment, whereas if they are on lower incomes they do not.

Dr JOHN KAYE: So you are suggesting it is means tested?

Dr ROACH: It is a Commonwealth arrangement. It is a co-payment through the Aids and Equipment Program and AGRP.

Dr JOHN KAYE: We are talking specifically about EnableNSW.

Dr ROACH: That is through EnableNSW, but EnableNSW is the organisation that runs those programs.

Mrs JILLIAN SKINNER: It is income-related; means tested.

Dr JOHN KAYE: I go back to the northern beaches hospital, which we have agreed is in Frenchs Forest. We were discussing the public-private partnership.

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: Minister, as you will recall, I was asking you how many public beds would be in this hospital. We landed at a position where it was greater than zero and possibly fewer than 500. Can you be more specific? At the point of start-up, how many beds will there be?

Mrs JILLIAN SKINNER: The tough part to answer is what component is private and what component is public.

Dr JOHN KAYE: Yes, that is what I am asking.

Mrs JILLIAN SKINNER: The total number I can give you.

Dr JOHN KAYE: Which is 500?

Mrs JILLIAN SKINNER: Yes, roughly 500.

Dr JOHN KAYE: And that includes—

Mrs JILLIAN SKINNER: That includes subacute on the Mona Vale site, largely, and then acute at the Mona Vale site.

Dr JOHN KAYE: At the risk of reagitating Mr Foley's questions, are we talking about beds as in overnight beds in your figure of 500?

Mrs JILLIAN SKINNER: Subacute beds in Mona Vale are overnight subacute beds.

Dr JOHN KAYE: The intention is to maintain Mona Vale as a 24-hour hospital?

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: It will have an emergency department?

Mrs JILLIAN SKINNER: It will be have an urgent care centre 24/7 and it will have subacute beds. In fact, 20 new subacute beds are being built right now as we speak. We anticipate that the focus of that campus will be more aged care, rehabilitation and palliative care. It has money for a new palliative care suite and there is some scope to do day surgery and to have clinicians. It depends on the market interest.

Dr JOHN KAYE: Are you going to air-condition the hospital?

Mrs JILLIAN SKINNER: There will be a new hospital; the old hospital will not remain.

Dr JOHN KAYE: You are talking about building a new hospital at Mona Vale?

Mrs JILLIAN SKINNER: A new facility.

Dr JOHN KAYE: A new facility at Mona Vale?

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: Can we go back to the Frenchs Forest campus, as it were, at the northern beaches hospital complex, as I now understand it.

Mrs JILLIAN SKINNER: Yes, it is a complex.

Dr JOHN KAYE: At what stage will we know how many public hospital beds there will be at the beginning of the project?

Mrs JILLIAN SKINNER: It is all in train, as we speak. Just to clarify, because I think you cast some doubt about whether it would proceed, there is work on the site right now.

Dr JOHN KAYE: It might have been wishful thinking on my behalf, Minister. Go ahead. I do not doubt your word on that.

Mrs JILLIAN SKINNER: The work is proceeding as we speak. I would expect that by the end of this year we will have a clearer picture of the breakdown of the—

Dr JOHN KAYE: Work is proceeding on the site, but the State does not yet have a private partner?

Mrs JILLIAN SKINNER: The site preparation will proceed; however, it is built. It is about dealing with all those environmental issues.

Dr JOHN KAYE: Which are not trivial, given—

Mrs JILLIAN SKINNER: No, it is not trivial, and preparing the site, et cetera.

Dr JOHN KAYE: Some time before the end of this year you will have settled on a private partner?

Mrs JILLIAN SKINNER: We would anticipate by the end of the year we will have a private partner. Am I right? Perhaps Dr Hammett could elucidate.

Dr HAMMETT: Perhaps I could elucidate the process.

Mrs JILLIAN SKINNER: Dr Hammett is now leading this for us.

Dr HAMMETT: We are about to commence the process of more detailed market sounding, particularly with private hospital operators that might be interested in partnering on that site to determine exactly the appetite of the private market to do that. The facility will be required to treat the needs of public patients on the northern beaches, and those clinical service needs have been well-defined by the local health district. Whatever is built on that site will need to be designed to meet the needs of public patients. We are going to do market sounding. Based on that, an expression of interest will be prepared in the 2013 new calendar year and it is anticipated that there will be clarity by the end of 2013 about the partners that will be involved in building the facility.

Dr JOHN KAYE: From what you have just said, we will not know the number of public hospital beds until the end of 2013, not the end of 2012?

Dr HAMMETT: It depends entirely on the nature of the configuration of the bill in the northern beaches.

Dr JOHN KAYE: I understand that but I am trying to get a date on this. Is it the end of 2013 when you will have a partner?

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: And a bed mix?

Dr HAMMETT: I think that is likely.

Dr JOHN KAYE: You refer to the clinical services needs of the northern beaches. Presumably there is a clinical services plan for the northern beaches?

Dr HAMMETT: The whole of the Northern Sydney Local Health District does a clinical services plan and that takes into account the northern beaches.

Dr JOHN KAYE: It is not specific to that plan. How should I put this? For example, that plan does not necessarily discriminate between Royal North Shore, Hornsby hospital and the northern beaches hospital?

Dr HAMMETT: Yes, it factors in the needs of all the different populations and which of the facilities in the local district they access.

Dr JOHN KAYE: That plan specifies what services need to be provided at the northern beaches hospital?

Dr HAMMETT: No, that plan would stipulate what other services are required for the people of the Northern Sydney Local Health District, and also articulate the facilities—

Dr JOHN KAYE: We are going around in circles. As I said, it does not discriminate between the different providers; it simply states the total service needs of the local health district.

Dr HAMMETT: But within the plan it will identify which facilities are providing which types of services.

Dr JOHN KAYE: I am afraid that we are not converging in this conversation.

Dr HAMMETT: We are not.

Dr JOHN KAYE: Does it or does it not specify what services need to be provided by the northern beaches hospital?

Dr HAMMETT: It would specify that the northern beaches hospital should be a level 5 facility.

Dr JOHN KAYE: That is not my question. What services need to be provided by this hospital?

Dr HAMMETT: That is not specified—

Dr JOHN KAYE: So it is not specified.

Dr HAMMETT: —in the clinical services plan.

Dr JOHN KAYE: So we will not know what services will be provided by the hospital until we find out what the private partner is prepared to provide?

Dr HAMMETT: I think a fairly good indication would be the nature of the services that are provided at Manly and Mona Vale hospitals.

Dr JOHN KAYE: That is an indication, but that was not my question. I want to know how you are going to determine and when it will be determined what services will be provided at the northern beaches hospital.

Dr HAMMETT: Dr Kaye, I appreciate that you are trying to get that detail. However, we will not have that level of detail until we can assess what the market is prepared to provide. Also, based on that information, we must factor in what the State needs to provide to meet the needs of the population. How that balance plays out cannot be defined with the level of granularity that you are talking about until more is known about what sorts of private sector opportunities are out there.

Dr JOHN KAYE: In effect you are saying that the health services provided on the northern beaches will be at the whim of the profitability of whatever private partner you can pin down to this project.

Dr HAMMETT: No, that is not what I am saying.

Dr JOHN KAYE: It is what I heard you say. It is the implication of what you are saying.

Dr HAMMETT: I was trying to explain that within the context of the local health district's service plan, which articulates the needs of the population, we are looking for opportunities for the private sector to provide some of those services. Clearly, our responsibility is to meet the service needs of that population. If the private sector can provide some of them, that is an opportunity for us. However, we are ultimately responsible to ensure that the people of northern beaches have the best possible health care, and that is what we will be doing.

Dr JOHN KAYE: I think there are two contradictory concepts in what you are saying. One is what the private provider will provide and the other is what the population needs. Unless I take it that you will allow the private provider to cherrypick the cheap stuff and the public sector will do the expensive stuff, your statement does not make a lot of sense.

Dr HAMMETT: Perhaps I have not been clear enough. Generally in looking to partner with the private sector we will have a conversation through an initial market sounding to assess the level of willingness in the private sector to provide any services. Based on an initial assessment of how that fits in with the clinical needs, we would then issue a formal expression of interest that articulates what services we want to buy from the private sector or in partnership with the private sector. The level of detail will be much greater when we go out to an expression of interest.

Dr JOHN KAYE: When will that be?

Dr HAMMETT: We hope to have an expression of interest document drafted in the first half of 2013.

CHAIR: I return to the hospital efficiencies and innovations we were talking about earlier. I refer in particular to the excellent model that you used in the emergency department at Westmead Hospital and the clinician who saw the need and the opportunity and who made suggestions years ago but who has only now been able to implement his proposal involving other doctors in the hospital triaging patients and clearing patient backlogs. Dr Foley also referred to flow portals. Do these innovative models proposed by clinicians flow on to others? Are they analysed and implemented? Clinicians and nurses working in tandem are driving many good initiatives. I would like to hear about them.

Mrs JILLIAN SKINNER: You are correct; many good things are happening. One of the challenges is communicating them to the system so that other people can implement them. An innovation symposium that will be held soon will allow for more communication to the districts and to those who are interested. Other hospitals have heard about the Westmead model and they are implementing individual elements or the total package. The patient flow portal to which the director general referred is an amazing tool. Access to it is restricted because it contains patient information. Of course, we remove that information so that unauthorised people cannot access it. That tool can change patterns of behaviour.

The Clinical Excellence Commission and the Agency for Clinical Innovation facilitate the spread of information. They were established after the Garling report was handed down and the Coalition has enhanced them substantially since it came to office. They are doing amazing work. I was recently with the Chief Executive Officer of the Clinical Excellence Commission, Professor Cliff Hughes, when he launched a couple of initiatives at Sydney Hospital. One was a sepsis phone app. The sepsis program was launched last year. A blood sepsis is an infection that can kill. Reports on events in hospitals where patients had died or there had been serious consequences indicated that many involved undetected deterioration of the patient, and sepsis in particular. A program was developed to alert hospital staff to sepsis and to highlight the need to act very quickly. The sepsis app, which was trialled in emergency departments, can be used on a mobile device—an iPhone, iPad or any other mobile device. It contains a directory of antibiotics that are relevant to a particular infection. I am speaking in lay language.

An infection of the gut is different to an infection in a cut on someone's leg. The app provides information about the different antibiotics that are appropriate in each case and addresses the different co-morbidities and conditions. It advises how much of the drug to administer, how frequently and so on. Of course, one should remember when treating sepsis that time is of the essence. I do not have the statistics in front of me, but lives are saved when minutes are saved. Having the directory on a phone app means that staff can very quickly access information about what they need to do. It is a lifesaver. The app involves a lot of data entry, but it is simple to follow. It means that staff are not required to find a book, look up the information and so on. What would happen if they could not find the relevant book? It is an amazing new model of care that is saving lives. The Clinical Excellence Commission has also been involved in the hand hygiene program. New South Wales leads the country in hand hygiene.

Dr JOHN KAYE: What percentage?

Mrs JILLIAN SKINNER: It is a very high percentage.

Dr JOHN KAYE: What is it?

Mrs JILLIAN SKINNER: On the ward that I visited it was up to 85 per cent or 90 per cent. Dr Kaye will be pleased to note that the doctors had beaten the nurses for the first time. The nurses thought that was a great achievement because that was their aim. Staff were interviewed about improvements that might be made. Everyone who visits a hospital knows that bottles of alcohol rub are everywhere. Visitors are encouraged to wash their hands as they come in the front door.

I was visiting an eye ward and it was decided to move the bottles of alcohol rub from the foot of the beds to the head of the beds because that is where examinations are done when one is treating eyes. They have also been provided in many more places. That has resulted in a percentage increase in the take-up rate. The next step in the program has been the development of posters showing the steps involved in good hand hygiene. The posters also have a chart that can be updated regularly and printed indicating the hand hygiene results for a ward each month.

We were talking earlier about putting information on the website. Nothing changes behaviour more than going onto your ward and finding out that you are worse than the one next door. Another program I saw when I was at Mona Vale Hospital recently was in relation to emergency department performance. A little whiteboard chart was put up on the wall by the staff which showed their performance each day of the week in relation to getting patients through within the eight-hour target. As the staff said to me, "We know who is rostered on those days". There is now a little bit of a carrot for those staff to do better.

That is the whole idea about these posters. They are quite simple posters. The bottom half is electronic so that it can be updated and printed to show how well the ward is achieving. Hand hygiene is the greatest barrier to infection spread in a hospital and it is a really very important initiative. I am very pleased that fantastic initiatives like that are getting a better outcome for patients and preventing further hospitalisations and terrible consequences for patients who can get infections that do not get treated properly.

The Hon. JENNIFER GARDINER: Minister, previously you provided an update on the renovation and rebuilding of hospitals in western Sydney. Would you update us in relation to regional New South Wales?

Mrs JILLIAN SKINNER: Recently I was at Dubbo Hospital, and I am going there again this week. We will be starting the dig for the early works of the new $79.8 million redevelopment at that hospital. The New South Wales Government has provided $73 million and the balance has been provided by the Commonwealth under the Health and Hospitals Fund round four. It will provide six new operating theatres, a new maternity ward with 17 additional beds, birthing rooms, 12 special care nursery cots, a 15 bed extended day surgery unit, a 15 bed short stay unit for medical and surgical care and 14 extra renal chairs. There is great rejoicing at Dubbo Hospital because it has been long awaiting this development.

This week I also will attend Werris Creek in the Tamworth electorate to open the $11.2 million multipurpose service. I will be attending with the Director General whose mother came from Werris Creek, so it is a return voyage for her. We are then going on to Tamworth where we are announcing the tenders and start of early works on the $222 million redevelopment there, for which the New South Wales Government has provided $100 million and the Commonwealth $120 million. Again, it is a round four commitment from the Commonwealth. The Commonwealth Minister for Health was generous enough to say at the time when we announced that outside the hospital—with the newly elected member for Tamworth, I might add—that that money would never have been made available except for the State Government making its commitment. We put in the money and attracted Commonwealth funds to that hospital. That will provide more medical, surgical and inpatient beds, day surgery in paediatric units, emergency upgrades, including a new emergency resuscitation bay, a renal dialysis unit and an oral health unit.

I also have visited Wagga Wagga Base Hospital on a number of occasions, and I will be going back there soon to see progress on the $270 million hospital redevelopment for which the State Government provided $215 million. The balance again came from the round four funds. We have already built the car park. The mental health service is nearing completion and the acute overnight inpatient capacity will be extended in the next part of the redevelopment, as will the expanded emergency department and a new renal facility. As I have said, we have already got additional parking for patients and staff.

Other rural and regional infrastructure projects are the $170 million Bega Hospital. That one is largely Commonwealth funds but we have made a contribution of $10 million. Port Macquarie has received $110 million from the Commonwealth and $14 million from the State Government and construction is due to commence this month. In the latest round of the Health and Hospitals Fund, Lismore Hospital will receive $80 million, $20 million of which is from the State Government. Early work is due to start next year and that will replace an urgently needed new emergency department. It is really a shocker, one of the worst I have seen in the State, and that emergency department redevelopment is well overdue.

I recently attended Armidale Hospital to announce a $6.3 million ambulatory care and cancer care project, $5 million of which comes from the New South Wales Government. In addition, Kempsey Hospital received funding in the last round of the Health and Hospitals Fund for a much-needed extension of works there, particularly ambulatory care and other services that are very much needed for that very low socio-economic community.

The Hon. DAVID CLARKE: Will you advise how much extra funding has been provided to local health districts this year?

Mrs JILLIAN SKINNER: That is a very good question because much has been talked about savings and cuts but the reality is we have a record Health budget that has gone up this year across the system by 5.4 per cent. It is $17.3 billion in recurrent funding and just over an extra $1 billion in capital works over the four-year period—$4.7 billion, a record infrastructure investment. In terms of growth funding for local health districts, on the Central Coast the budget is now $638.9 million, an increase of nearly $32 million, or 5.3 per cent. This is after all the labour expenses cap. These are net growth figures at the end of all of that.

The Far West has increased by 7 per cent to $86.4 million; Hunter-New England $1.8 billion, increased by 3.2 per cent; the Illawarra-Shoalhaven $710.8 million, increased by 4.5 per cent; Murrumbidgee $446.7 million, increased by 2.9 per cent; mid North Coast $466.9 million, increased by 4.2 per cent; Nepean-Blue Mountains $579.9 million, gone up by 5.2 per cent; Northern New South Wales, about which the Director-General has been asked, $611.7 million, gone up by 4.7 per cent; Northern Sydney $1.2 billion, gone up by 2.9 per cent; Sydney Children's Hospital $589 million, increased by 2.9 per cent; south-east Sydney $1.4 billion, gone up by 3.4 per cent; Southern New South Wales $303 million, gone up by 6.3 per cent; the St Vincents network $308.5 million, increased by 3.9 per cent; South Western Sydney $1.3 billion, gone up by 6.2 per cent, Sydney $1.3 billion, gone up by 3.1 per cent; Western New South Wales $717 million, gone up by 3 per cent; and Western Sydney $1.4 billion, gone up by 4.2 per cent.

Those percentages in the growth are calculated on patient activity, by demographics and by the new services that are coming on line. We have invested in new buildings and therefore we need to provide additional money to provide those services. They are all carefully calculated and part of the service agreements that have been signed up by the Director General and each of the board chairs. I think the majority of them are on the website now for all to see and the rest will be there very soon.

The Hon. DAVID CLARKE: From listening to those figures I get the impression that there has been a real emphasis particularly in regional areas.

Mrs JILLIAN SKINNER: It is fair to say that there has been pretty well a substantial increase in the regions but also in the population growth areas—western Sydney, south-west Sydney—and there are new services coming on board. You will see as we go ahead with our investment in those capital works that I have just announced that there will be growth in those areas as well to accommodate that new growth. It is all carefully worked out; there is nothing by chance. The Director General has a habit of explaining how the budget worked in the past was a big black hole with last year's budget plus growth, which depended on who was the best lobbyist.

The reality is now that these budgets are calculated very carefully based on the activity—so we are purchasing activity from the local health districts. They will be reported and that table you have seen there shows some of it. It is early days, it will get more and more sophisticated as the Council of Australian Governments activity-based funding becomes more mature and we will be purchasing more of those services based on those Commonwealth-State agreed efficient prices. Then, of course, on top of that will be the growth of the new services and population growth and so on.

The Hon. DAVID CLARKE: Do you get around to all of these health districts?

Mrs JILLIAN SKINNER: I think I have visited every hospital in New South Wales as shadow Minister for Health—

The Hon. DAVID CLARKE: How many hospitals are there?

Mrs JILLIAN SKINNER: Not all as Minister, as shadow Minister for Health I visited every one and many of them I visited many, many times. As Minister I have visited many—

The Hon. HELEN WESTWOOD: It is the same answer you got last year, David.

CHAIR: It is the Hon. David Clarke's favourite question. It is a good question.

The Hon. DAVID CLARKE: I am interested to see the progress as opposed to the years under Labor.

Mrs JILLIAN SKINNER: The interesting thing is what I call "long" visits, where I do not just whip in, make an announcement and then disappear. It is going in, walking around, talking to people in the hospital,

sitting down with the division heads, with the nurse unit managers, with the NSW Nurses' Association representatives—and boy are those interesting conversations because I learn such a lot about what the front-line, hands-on patient caring clinicians want.

The Hon. DAVID CLARKE: These are not flying visits as we have seen in past years?

Mrs JILLIAN SKINNER: No.

The Hon. DAVID CLARKE: These are in-depth visits?

Mrs JILLIAN SKINNER: They are. Occasionally I will do a flying visit. Some of my colleagues did a flying visit recently to a hospital emergency department to thank the emergency staff for the wonderful effort they made over winter despite the huge increase in demand. I will be doing one of those flying visits this week, unannounced, no fanfare, no media; just going in to say thank you to the staff for the wonderful work they are doing. On other occasions it is half a day or more. I am very pleased to say that I have taken all of these people at the table with me I think—no, John you have not been—and that has been terrific as well. The Director General does it on a regular basis. It is fantastic to have them accompany me.

The Hon. DAVID CLARKE: I daresay it is a morale booster as well and they appreciate seeing their Minister on a regular basis?

Mrs JILLIAN SKINNER: They do. It is very unusual.

The Hon. DAVID CLARKE: It is probably something reasonably new for them.

Mrs JILLIAN SKINNER: It is a bit new; they have not had this access before. It is also where you find out what is happening with Dr Matthew Vukasovic out at Westmead hospital. If you do not go and talk to these people you do not know what fantastic ideas there are out there. I think last time I told you about the clinical nurse consultant at John Hunter Hospital who has done this wonderful program with nursing homes in the district. He worked up a protocol so that they can get in touch with the emergency department if they have a patient they are not sure about who might have an infection.

Instead of putting that elderly patient in the back of an ambulance and taking them to an emergency department—the worst place for them to be if they do not really need to be there—providing the support for them to treat the patient in situ, which is much better all round. I learn about things like that when I go round the hospitals. I also learn about things that need fixing. I think we have been able to provide some additional money to give emergency departments a couple of extra computers that they were short. So things like that, things that I think are really terribly important and make a huge difference.

CHAIR: Minister, you were talking about population growth areas such as north-west, south-west, generally western Sydney. Are we increasing front-line staff in these areas of population growth? What is happening with front-line staff?

Mrs JILLIAN SKINNER: The answer is yes, absolutely.

The Hon. GREG DONNELLY: What is "front-line", Minister?

Mrs JILLIAN SKINNER: Well of the 2,900 more nurses head count—they are front-line nurses—in regional New South Wales we have had more than 1,200, on the Central Coast more than 400 and western Sydney more than 300. These are population growth areas where there is a real demand for additional services and they are reflected in the figures I just gave you for the growth in the budgets there. Since I have been the Minister we have increased the number of other staff: 1,500 full-time equivalent additional staff, including medical staff, allied health professionals, clinical support staff, oral health professionals and ambulance staff. We have had a record number of intern training places. Some 920 positions this year, sorry for 2013—that is up 70 positions from last year—and a record last year of 850 spread across 49 hospitals.

We are taking seriously our obligation to provide intern places in New South Wales. We are leading the country in terms of the numbers that we are providing training places for. In fact, we are taking some 80 interns from universities in other States. So we are really pulling our weight. Those front-line staff will be working at hospitals such as Dubbo, Tweed, Port Macquarie, Albury campus of Albury-Wodonga hospital, Lismore,

Wagga Wagga, Tamworth, Manning Rural Referral Hospital, Maitland, Coffs Harbour Health Campus and Orange Health Service. So they are right across the system.

CHAIR: Minister, you mentioned interns. Getting these interns trained and through the system has been a very important issue for the Australian Medical Association. What you have done in New South Wales is very good. Can you outline a little more the support you are giving to these interns and how that compares with other States and perhaps the Commonwealth?

Mrs JILLIAN SKINNER: We are providing by far the greatest number of intern positions in New South Wales and, as I have said, we are taking on some interns from other interstate universities. An intern still requires supervision and mentoring by experienced doctors. It is not just about putting an intern in and saying goodbye; it is about the senior staff being given the time to help nurture them as the next generation of doctors. There has been talk at the Commonwealth level—all the States and Territories have been trying to persuade the Commonwealth to provide additional places for interns.

Just to put this into perspective, this year we are spending $100 million on interns and across the country there are 180 full-fee-paying interns in our universities that are not placed. The Commonwealth has offered $10 million to provide places for 100 of them—$10 million compared to our $100 million—across Australia and there are offering them in private hospitals. In New South Wales we do not have a sophisticated level of private hospital cover for interns. The San Hospital, Hornsby, is coming on board—it has opened its first clinical school in a private hospital. As part of our arrangement with them they will take on six intern places each year for 10 years—is that the figure?

Dr FOLEY: Yes.

Mrs JILLIAN SKINNER: I do not think they are quite up to speed; we are trying to help them come forward with that.

Dr JOHN KAYE: Do we have to pay for that?

Mrs JILLIAN SKINNER: Yes, we have paid for it but there are no other hospitals accredited so even with the Commonwealth offer of 100 places in private hospitals the fee-paying international students in New South Wales will have to go interstate. We have been putting a position to the Commonwealth that it should bring on board the capacity for all of those 180 students to be covered—I think $18 million it would cost—and then give time for the universities, the Commonwealth and the States to develop the business case for developing them.

I have a view that we should be providing training for those students who have accepted places in our universities, paid for them to get to the point of registration, which is one year of internship. The person accepting the money should be obliged. We did it last year. We paid for all the international students but what happens is we do the right thing; we provide it and everyone says, "Oh well, they can keep doing it." It has honestly come to a time where we need to sit down with the Commonwealth and say, "Enough. You encourage the universities to take full fee-paying students. You now have to sit down with them and work out a scenario where it is fair. We are partners in the scheme and we should all be making a contribution."

CHAIR: Because it has a flow-on effect if they cannot become fully qualified?

Mrs JILLIAN SKINNER: Exactly.

CHAIR: Then they cannot qualify for specialties and it goes on and on and on?

Mrs JILLIAN SKINNER: Yes. The Commonwealth argues that we should pay fruit because they are going to go out and instead of international doctors we bring into the country, they can go out and fill our area of need positions. You do not have a one-year out or two-year out doctor—and Dr Kaye will know this—going out to an area of need hospital.

CHAIR: You know that Dr Kaye is not a medical doctor.

Dr JOHN KAYE: I will clarify that. I have a PhD in engineering, Minister.

CHAIR: In case you had to resuscitate someone.

Dr JOHN KAYE: Dr Chant would be better at anything like that than me, I am sure.

CHAIR: I would rather have Dr Chant than Dr Kaye, thanks.

Mrs JILLIAN SKINNER: I can tell you that anybody who knows anything about rural New South Wales—Jenny Gardiner will know this—that you cannot expect a one-year out medical graduate to take on the role of running a hospital without proper supervision. That is not on.

CHAIR: We will now take a five-minute break before we commence the Medical Research portfolio.

(Short adjournment)

CHAIR: I open the portfolio area of Medical Research for examination and the remaining time will be 15 minute segments, with 7½ minutes for crossbench members.

The Hon. HELEN WESTWOOD: Could you tell the Committee what research has begun in the sobering-up centres that have been announced?

Dr CHANT: Sobering-up centres are a drug and alcohol initiative. That falls within the portfolio of David McGrath's area in the Division of Drug and Alcohol in the Ministry so I am not particularly aware of it, but I would be happy to take it on notice and get that information from him. It may also be an opportunity to raise that question in Minister Humphries' estimates, but I will take it on notice.

The Hon. HELEN WESTWOOD: Could you provide the Committee with some estimates about levels of staffing and training that will be required. I assume there are safety issues that have been researched?

Dr CHANT: This particularly relates to the Kings Cross initiatives?

The Hon. HELEN WESTWOOD: Yes, for the sobering-up centres in particular. I know it was announced by the Premier, but clearly the sobering-up centres have to be related to health, and drugs and alcohol.

Dr CHANT: Yes, certainly there are a number of issues associated with sobering-up centres that would need to be risk managed, so I will provide advice in relation to those matters.

The Hon. HELEN WESTWOOD: Earlier we spoke about clinical nurse consultants and the research they do. Could you identify some of the research projects they are currently undertaking?

Dr CHANT: There would be many clinical nurse consultants throughout our system. I could take it on notice to give you a suite of it. I can provide some examples that I am familiar with in my own portfolio, but it would be a very biased area.

The Hon. HELEN WESTWOOD: I would be particularly interested in those areas that lead to evidence-based nursing, and to clinical excellence and leadership in nursing within our public hospitals.

Dr CHANT: To not take up time it is probably best if I take that on notice to get you an appropriate list that reflects that area.

The Hon. HELEN WESTWOOD: Could you advise the Committee of whether or not those positions will actually be quarantined from the cuts?

Dr CHANT: I am happy to that on notice in preparing the response.

The Hon. GREG DONNELLY: With respect to medical research, the new Government, after coming to office, restructured the Office of Health and Medical Research; it is now the Office of Medical Research.

Mrs JILLIAN SKINNER: Office of Health and Medical Research.

The Hon. GREG DONNELLY: I apologise. What was the total expenditure of the office for 2011-12? Do you have that?

Mrs JILLIAN SKINNER: I should have that figure. Do you have the details, Dr Roach?

Dr ROACH: The 2011-12 budget was $32 million, which included a $5 million election commitment that was for the budget for Medical Research and Science.

Dr CHANT: Just to clarify the question, because John has actually answered the question in relation to the Medical Research Support Program.

Mrs JILLIAN SKINNER: Which is run by the medical office.

Dr CHANT: So there are a number of various programs as well as the core funding for the office, so we would be able to prepare you a total budget that covered the Medical Research Support Program funding for some of the clinical research networks.

The Hon. GREG DONNELLY: Okay, and provide me with an aggregate number.

Dr CHANT: And the actual funding for the office, so there are a number of different discrete programs.

The Hon. GREG DONNELLY: If you could do that, thank you. For the financial year 2012-13 do we have a total budget for the office?

Dr CHANT: We do have that, but again it is important to look at perhaps we can provide the response for 2011-12 and 2012-13. A number of the projects are underway so our expenditure of those in the financial year will be clear at this stage.

The Hon. GREG DONNELLY: If you could take that on notice. In terms of the number of full-time equivalent staff employed in the office, do we have those numbers for the financial year 2011-12 and 2012-13?

Dr CHANT: I can make those available. We have been recruiting. You may be aware that last year we did undertake the Wills review so during the Wills review there was a small number of staff, but there was also a number of contractors and other secondments; staff seconded from another section in the Ministry. There was also informing the Office of Medical Research a reconfiguration, so there were staff that covered ethics functions within another branch and they have been moved and joined, so it is perhaps easier if we outline new staff, existing staff, contractors and the existing staff now. We are also in the process of recruiting another five new permanent staff to the office.

The Hon. GREG DONNELLY: Which brings me to the point you just alluded to, the Wills report. In terms of the recommendations of that report, is the Government going to be acting on all of the recommendations or some of the recommendations, and if it is some of the recommendations, which ones are they?

Dr CHANT: The Government prepared a response to the Wills review that identifies the Government's response to the report. Substantially it accepted the majority of the recommendations of the Wills review and I am pleased to say that we have made progress against all of those things outlined in the Wills review. We have gone out for this round of the medical research infrastructure support program and we are in the process of sending out the letters to the applicants in that program. We are in the process of calls for tender in relation to the medical devices program, which has been set up with $8 million this year and $5 million recurrently. We are committed to developing a biobanking framework for the State and we have had a number of preliminary meetings as a prelude to bringing all the stakeholders together, and a date has been set for that.

We have also had discussions in relation to Bioinformatics, which was one of the key themes under the Research Capacity Building program, which was identified by Bioinformatics as a strategic priority. We have had some discussions with the university sector and some of the institutes as to the best way in which to configure that capacity-building infrastructure grant and pleasingly the groups really wanted to have a collaborative approach. Bioinformatics is an area that, whilst the skills also are applied in medicine, it is actually interesting that it is applied in other areas such as agriculture so it is going to be a novel process of bringing

together expertise from other disciplines apart from the traditional health fields in growing that capacity in Bioinformatics.

There is support for $800,000 for research hubs in the Government response to the Wills review and we are just developing a consultation paper to go out in relation to what we see is the vision for research hubs. There has obviously been a lot of extensive consultation with a number of stakeholders in putting out that discussion document. There is also some funding that the office provides to clinical and research networks, in particular. We are currently in the process of providing some interim funding for those groups, but are doing a further piece of work that looks at how better to connect the research network to the clinical network and working and engaging through the Agency for Clinical Innovation.

The Hon. GREG DONNELLY: With respect to labour expense cuts, which we will discuss in some detail later this afternoon, will there be a specific target set for the office to meet a particular expense cap?

Dr CHANT: The office is a very small one, so I am not expecting it to be impacted by that.

The Hon. GREG DONNELLY: I am sorry, could you repeat that?

Dr CHANT: I am not expecting us to accrue any savings to the agreed structure in relation to the office. It is a very small office, but it does control a number of program grants and those moneys will be expended as outlined in the government response document.

The Hon. GREG DONNELLY: I understand that your answer is no?

Dr CHANT: No.

The Hon. GREG DONNELLY: Will the office be expected to meet efficiency savings targets that will be set?

Dr CHANT: The office is a very small office and I am not anticipating that there will be any specific efficiency savings applied to the office.

The Hon. GREG DONNELLY: So no to both of those?

Dr CHANT: No.

The Hon. LUKE FOLEY: I am wondering about grants to non-government organisations conducting medical research. I note in last year's budget there was $32.3 million worth of grants. Could you give us an update on the grants to non-government organisations in this financial year?

Dr CHANT: I will give you an encapsulation that some of the money that goes out through the non-government organisation program is for research, some of it is for service delivery and some of it is for other promotional activities. Just to make that point clear, the total non-government organisation program does not go to research, but a component of it does.

The Hon. LUKE FOLEY: Some of it does?

Dr CHANT: Some of it does, yes.

Dr HAMMETT: In the 2012-13 budget the ministerial grants program for non-government organisations is $149.6 million.

Mrs JILLIAN SKINNER: That is the total non-government organisation program.

The Hon. LUKE FOLEY: Do you have any estimate for us on what portion of that $149.6 million would go to medical research?

Mrs JILLIAN SKINNER: Do you mean to independent research hubs or institutes?

Dr CHANT: I think the question relates to the fact that some of the non-government organisation funds—funds that are paid out through the non-government organisation program—do go to institutes or organisations conducting research.

Dr ROACH: I think you are referring to last year, when $32 million-odd went to medical research.

The Hon. LUKE FOLEY: Indeed.

Mrs JILLIAN SKINNER: That is the Medical Research Support Program.

Dr ROACH: That was the medical research grant. Some people refer to them as non-government organisations as well, but they are not necessarily.

Dr FOLEY: They are a mixture.

Dr ROACH: They are a mixture of universities and the like.

Dr FOLEY: There are independent institutes that receive funding and some of them are independent institutes established by statute of this State. For example, the Centenary Institute at Prince Alfred and the Garvan Institute on the St Vincent's campus are statutory bodies with their own legislation but independent of government. A number of them, such as the Victor Chang Cardiac Research Institute, for instance, would be a company limited by guarantee as part of the St Vincent's research campus. So you have a mix of companies limited by guarantee and independent institutes created by statute, which under the Wills review meet the eligibility criteria for infrastructure funding that is for institutes that are independent of universities and public hospital services, albeit these institutes have all come about by collaboration between those kinds of entities.

The reason that the requirement for independence is there is to avoid double dipping with these precious funds, so it is clear the sorts of medical research institutes that they are for, and so the other activities of a university, for example, cannot be dressed up as being eligible for that funding because that sort of research is funded through university research funding structures.

The Hon. HELEN WESTWOOD: Are these grants being reviewed in the same way that the grants for non-government organisations are being reviewed?

Mrs JILLIAN SKINNER: No.

Dr CHANT: No. This process was a call for tender. So there was a call for applications, there was an application process, there were criteria and an expert panel was created to look at their eligibility versus the criteria. The successful applicants have now been advised and there has been some transition funding applied to those that do not meet the eligibility criteria to allow them to consider how they might want to address those eligibility criteria over a period of three years.

The Hon. HELEN WESTWOOD: Do they face the same sorts of issues as, for example, the women's health centres—they have no guarantee of funding?

Dr CHANT: No.

The Hon. HELEN WESTWOOD: They are all being reviewed at the moment?

Dr CHANT: No. There are probably a number of programs that we are talking about here, and I think it is important to be clear. The program that the director general just spoke about is the Medical Research Support Program. This was the Government's commitment and it is now $37.3 million. That program has now moved to four-year funding cycles with a mid-term review. The idea is that that provides certainty of funding over that period. It is meant to compensate for the fact that when you put in a National Health and Medical Research Council [NHMRC] grant you just get funded for the nurse's or the doctor's time. You do not get any infrastructure or support—the unfunded cost of research—so this money is meant to fund that. The idea is that large organisations will get 40¢ in the dollar for their eligible research funds and the smaller tier two will get 30¢ in the dollar. That was to drive and promote collaboration and sustainability in the sector.

The Hon. LUKE FOLEY: And this is year one of the four years?

Dr CHANT: This is year one of the four years, so there will be certainty for the four years and it is in alignment with the Government's commitment of $37.3 million.

The Hon. PAUL GREEN: Research results from adult stem cells have been consistently promising for the treatment of a number of debilitating diseases. How much money has been allocated to stem cell research in general?

Dr CHANT: I will have to take this question on notice. It is actually quite a hard question to answer because there are a number of medical research institutes, such as the Garvan, where a proportion of their research would be utilising stem cells—as there would be in the university sector and as there would be potentially some translational research conducted in our research hubs in the public health system. I think it is hard to answer that question but we will have a go at it, if that is okay with you?

The Hon. PAUL GREEN: Yes, but as part of that, how much has been specifically allocated to adult stem cell research?

Dr CHANT: As I said, as to adult stem cells, our funding would be indirect in terms of our support for the Medical Research Support Program. We provide funding for the stem cell research network and, as I mentioned in my previous response, we are looking at how to get greater connectivity between our research networks and our clinical networks through the Agency for Clinical Innovation [ACI]. But there is some funding that came from the spinal cord fund, so I would have to go back and look at what that specifically went towards. There were some initiatives that went to research fellowships and I have to see what their specific area of research was to answer that question.

The Hon. PAUL GREEN: What is the Government contributing, or likely to contribute, over this term of government to cancer research?

Mrs JILLIAN SKINNER: Cancer research has been mostly the domain of the Cancer Institute. It is substantial. This year we announced $30 million over four years for translational cancer research. These are various projects that usually are collaborations between different institutes, hospitals, universities and so on. They are leading to the most amazing developments and go across a whole lot of institutes. I will get you the details of the full amounts and what they are for, but what has happened is that the Cancer Institute previously reported to a separate Minister. It has now come into the Health family, so to speak, and we are working much more collaboratively and reporting that as part of the research commitment as well.

Ms CRAWSHAW: I can say in relation to the stem cell research that whilst there is no specific funding, I would have to check in relation to the spinal cord and previous endeavours in noting that we have some rollover funds to apply in that area this financial year. There are 25 groups in New South Wales that conduct research using stem cells and eight of those receive funding through the Medical Research Support Program for the indirect cost of research. That is the Anzac Research Institute, the Centenary Institute, the Children's Medical Research Institute, the Garvan Institute, the Hunter Medical Research Institute, the Victor Chang Cardiac Research Institute and the Westmead Millennium Institute, and the NeuRA. I suppose that goes to the complexity of teasing it out, but we will have a go at answering that question.

The Hon. PAUL GREEN: The Government is building many cancer care networks, but are there plans to fund them in a micro-research capacity?

Ms CRAWSHAW: I would have to ask specifically David Currow, the Chief Cancer Officer, but there is a lot of support for cancer registries and cancer outcomes data. We are using Data Linkage to look at outcomes. We are reporting on performance and compliance with best practice clinical care. Using those initiatives, David has been able to highlight a number of key points around where to get the best outcomes for particular types of cancer. He is particularly concerned about lung cancer and the fact that we are not seeing people present for treatment for lung cancer. We are really concerned about screening rates for cervical cancer and breast cancer, particularly in those socio-economic and hard-to-reach communities. We need to address that. The Cancer Institute has set up a lot of support with its registries to look at the data and raise those questions and prompt us to think about how best to improve cancer and health outcomes.

Mrs JILLIAN SKINNER: It also has done some very interesting work. I attended a seminar recently that debated surgical outcomes for people with complex and rare cancers. These were oesophageal and

pancreatic cancers. A dozen highly respected clinicians and others were on the panel. The research from New South Wales and Australia replicated research from overseas that showed huge variations in outcomes depending on where the surgery was performed. A person is 46 per cent more likely to die if he or she has surgery in a place where few of these surgeries are done.

Dr JOHN KAYE: It is not surprising.

Mrs JILLIAN SKINNER: It sort of stands to reason, but it has not driven reform of practice. It is timely that we have these sorts of debates. It is about getting those treatments at places with expert teams. They have the expert clinician but also the team around them. It might be cancer researchers and others related to that team. It will drive role delineations for those kinds of services to be delivered in specific places.

The Hon. PAUL GREEN: Is it put on the internet where those surgeries are performed for people to get some performance-based idea?

Dr JOHN KAYE: That is not needed.

Mrs JILLIAN SKINNER: No. This is highly technical medico stuff that, when you look at it, is really logical.

The Hon. PAUL GREEN: A bit of an American system where surgery performance is put on the internet.

Ms CRAWSHAW: I suppose this follows on my earlier comments that in 2012-13 local health districts will administer $3.32 million provided for clinical cancer registry program managers and cancer information managers from the Cancer Institute as well as $3.6 million allocated through the clinical trials staff grants to local health districts. It gives you a flavour of the support the Cancer Institute provides to enhance our knowledge base. I believe that report about the performance is publicly available. We would be happy to make that available as well in the differences in outcome for pancreatic and oesophageal cancers.

The Hon. PAUL GREEN: It would be worthwhile, thank you.

Dr JOHN KAYE: Minister, you just put the big surgical bullet on the table. Are you going to bite it? Are you going to begin the process of making sure that people receive the best possible surgery for those rare and unusual cancers and other conditions?

Mrs JILLIAN SKINNER: Yes.

Dr JOHN KAYE: That is on your agenda?

Mrs JILLIAN SKINNER: That is on the agenda and I am very happy to say that it has been put on the agenda by those specialists. The Agency for Clinical Innovation is a key part of the health reforms. It is about networks of specialists in a field of experts who are determining that this is the safest and best possible outcome for patients. Everything we do should be about outcome selections.

Dr JOHN KAYE: I refer to the tobacco strategy and high-rolling and private game rooms. During the debate on the bill you are aware that the Labor Party and The Greens tried to move amendments to lift the exemption from the smoking ban for high-roller rooms. At the time it was put to us that this could not happen because other States—notably Victoria, Queensland, Western Australia and the Northern Territory—ran casinos and we would be disadvantaged. Have you begun negotiations with your counterparts in each of those States and Territories?

Mrs JILLIAN SKINNER: No I have not, but I would not mind doing it, to tell you the truth. But the truth of the matter is that we have moved further afield in our smoking legislation. Since I became the shadow Minister for Health in 1995 it always has been said that it has been incremental. We started off even before then when Peter Collins, I think, or even the Minister before him, introduced no smoking in public buildings. The response was shock, horror: Everyone thought we could never implement that. Gradually we have moved it along so that now we have the latest round, of which I am very proud, in being able to get legislation through that bans smoking in outdoor areas.

Dr JOHN KAYE: Eventually.

Mrs JILLIAN SKINNER: Yes, some of it will be eventually but it always has been like that. Sometime in the future we hopefully will go the next step, but it is not there yet.

Dr JOHN KAYE: Do you give us a commitment that you will attempt to negotiate with your colleagues in those other States?

Mrs JILLIAN SKINNER: I will give you a commitment that I will raise it with my colleagues in other States, yes.

Dr JOHN KAYE: Will you report back to the Parliament on those negotiations?

Mrs JILLIAN SKINNER: I will report to the Parliament, yes. You can ask me the same questions next year about how I have gone.

Dr JOHN KAYE: I probably will. My next question may be better addressed to Dr Chant, on an allied matter in some sense. The George Institute—I must admit that I have not read the report—this morning talked about the 9 per cent increase in sodium content in products available in supermarkets over the past four years. It suggested that that would result in a 4 per cent increase in heart attacks and strokes across New South Wales. It suggested also that reducing sodium at source would be somewhere between 50 and 100 times more cost effective than the drugs that treat hypertension. What is this Government doing to address the rising sodium levels in packaged foods? We will start with packaged foods.

Ms CRAWSHAW: I am pleased to say that NSW Health was in a partnership grant with the George Institute around salts.

Dr JOHN KAYE: That is right. It was too.

Ms CRAWSHAW: We certainly understand the implications of salt and we want to work with the community to lower its salt intake. I had the pleasure also of being on a panel two Saturdays ago at the George where this was discussed with industry stakeholders. This issue is on the agenda. We need to educate the community to use products that contain less salt. It is about working with industry. It is always prudent to consider the role of regulation. However, we must take a number of other steps before we get to that point. I am also very keen that we make the salt message cohesive when the new National Health and Medical Research Council dietary guidelines are released and that we give consumers a package rather than simply be nutrient specific. Consumers are confused about diet messages.

Dr JOHN KAYE: The industry has vigorously opposed traffic light front-of-package labelling. Surely some simple message about salt, saturated fat, sugar and calories on the front of a package is called for?

Dr CHANT: The NSW Food Authority and NSW Health were working together on food labelling. As you would appreciate, it is taken up in a national context. Work is being done, but there is a lot of debate about what the label should look like. We are all committed to making information available to consumers so that they can make positive food choices. The argument we are having is about the exact nature of front-of-package labelling that will convey information easily to consumers. Interestingly, the George Institute also presented an app that allows consumers to scan products to find out the salt content. Some of these initiatives will make it easier for consumers to understand.

Dr JOHN KAYE: I have the George Institute app and it is very good. It effectively provides traffic light warnings. However, one must have a smartphone to access it. People like me generally read the back of the package anyway to find out how much salt, saturated fat and sugar a product contains.

CHAIR: You are unique.

Dr JOHN KAYE: No, I am not. However, we are talking about people who generally do not have the funds to buy a smartphone.

Dr CHANT: I strongly support good front-of-package labelling. However, we need evidence about the best way to make that information meaningful. In the end, we want to inform consumers and empower them to make healthy food choices.

Dr JOHN KAYE: I refer to the vexed issue of Lyme disease. I understand that an expert panel was convened in your division, Dr Chant. The panel found that there was no conclusive evidence of locally acquired Lyme disease. You would be aware that that is a controversial finding. Who was on the panel? Was that decision unanimous? Is the department prepared to revisit that decision in light of the increasing evidence that locally contracted Lyme disease is a reality?

Dr CHANT: It is important to point out that we are always happy to reflect on new evidence. The panel's summary is on our website, but I will provide the information about the membership on notice. I am happy to consider any new evidence that emerges.

Dr JOHN KAYE: The website does not say who was on the panel.

Dr CHANT: I am happy to provide that information on notice.

Dr JOHN KAYE: Thank you.

Dr CHANT: There is no conclusive evidence of transmission of Lyme disease. The treatment is readily available and we have diagnostic capacity at Westmead Hospital. Conflicting views have been put about Lyme disease and we are happy to explore them. Jeremy McAnulty, the Director of Communicable Diseases, and I met with members of the Lyme disease group to talk through the issues and we agreed to take their concerns on board.

CHAIR: Minister, you referred to examples of Medical Research Support Program funding. Can you provide some highlights of the program and outline what has been achieved?

Mrs JILLIAN SKINNER: As indicated by Dr Chant, the Medical Research Support Program is a manifestation of the State Government's obligation to support the clinical researchers who are funded through bodies such as the National Health and Medical Research Council. For years the program's funding base was relatively low at about $17.3 million and top-up funding of $10 million was provided each year at the eleventh hour. It ended up being about $32 million, but there was no funding certainty.

The independent research institutes that we have referred to told me that they were losing fantastic researchers or they could not recruit researchers from overseas despite the fact that they were interested in returning to Australia because there was no funding certainty. A researcher doing work in a laboratory in California, for example, who wanted to return to Australia to work at the Garvan Institute would not do so if funding were available for only one year. The Coalition made a commitment to ensure certainty by providing four-year funding, increasing the funding base to $37 million and providing a $5 million top-up. As Dr Chant and Dr Foley said, this financial year's funding allocation of $37.3 million to the Medical Research Support Program is provided primarily to large institutes.

When visiting the Garvan Institute and the Victor Chang Cardiac Research Institute, which is part of the St Vincent's Hospital network, one sees the huge range of very expensive equipment they have. It is also expensive to maintain, to service and so on. If they did not have this support funding to keep them going they would miss out on some of the National Health and Medical Research Council funding they receive. Many of these institutes also have very generous supporters, but the Medical Research Support Program is very much needed and well supported. The allocation has been increased substantially this year with tier 1 research bodies getting more than $10 million and tier 2 research bodies getting less than $10 million. As I said, the total funding this year is $37.3 million and next year it will be the same or more. As I also said, the fund provides certainty for these research institutes.

This is part of the fulfilment of the Coalition's election commitment to establish a portfolio of Medical Research—I am the first Minister for Medical Research in this State—and to create an office of medical research. The Wills review recommended that it be an office of health and medical research to accommodate the expectation that it would also look at new ways to treat patients. It is about the workforce and new models of care as well as clinical research. As part of that, the Coalition made an election commitment to increase funding.

In response to the Wills recommendations, the Government is focusing on the independent research institutes to avoid double-dipping.

That was always the intention but it was never implemented. As part of allowing those institutes that were still attached to a university time to come up with new governance arrangements—all of them are—we have given them transition funding to enable them to make the new arrangements. It is a substantial increase in the Health budget. It is the largest area of increase and it is paying off. The research institutes are attracting incredible people. The Garvan Institute has recruited Professor John Mattick back from Brisbane. He told me personally that one of the reasons he came here is because he thought New South Wales was the next home of major advances in medical research, particularly the area he works in, which is the whole area of genetics but particularly looking at cancer research.

The Hon. JENNIFER GARDINER: Minister, could you give the Committee an update on what is happening in relation to medical research in the Hunter and specifically at the Hunter Medical Research Institute?

Mrs JILLIAN SKINNER: I was up at the Hunter Medical Research Institute last week because they have just moved into their new building. It is truly magnificent. It is a great success that started as a cooperative. Originally it was an institute without walls. It was a collaboration of a group of independent researchers. Eventually they had a home as part of John Hunter hospital and now they have a separate home. They are the recipient of a substantial medical research support program. They are also acting as a hub. It is a continuation of how they were as a cooperative. They are a hub so they pull in researchers from different facilities around the Hunter-New England area and I believe they will make huge inroads into patient care, not only for that area but as time goes by further afield.

The Hon. DAVID CLARKE: Minister, a while back you referred to "amazing developments" taking place in medical research. That was the expression you used. It is important that people hear about the developments that do take place because it encourages in the community an awareness of the importance of medical research and the results from medical research. Can you share some of the amazing developments that have been taking place?

Mrs JILLIAN SKINNER: Doing the rounds, as I do, of some of the institutes and meeting the researchers is awe inspiring. I met a young woman at the Victor Chang Institute who is doing epigenetic research. Her project is the study of a woman's diet before pregnancy. For a woman expecting to become pregnant diet can have an outcome that down the track can forecast diabetes in a person.

Dr JOHN KAYE: In the mother or the child?

Dr FOLEY: The child.

Mrs JILLIAN SKINNER: Yes. In the first instance it is an effect on the child. What she does changes the genetic makeup of the child. It goes on to obesity in the child and so on and so forth. That will have amazing results if you understand the research and consequences of that kind of research.

John Mattick makes a bold statement that no child born today need die of cancer. He believes it will be treated as a chronic illness in most cases and there will be new treatments tailored for the individual person and the individual person's cancer. It is far too complicated for me to give the learned description that I have heard these researchers give but it is about understanding the genome of the human body, having a look at the implications of the mutant genetic makeup of a person with cancer and tailoring treatment to that particular mutant gene to give them an outcome that some years back would have been impossible.

I spoke about leukaemia cancers in children with people at Sydney Children's Hospital at Randwick. It is a translational research project that the Cancer Institute funded with the Lowy Institute which is also connected to the University of New South Wales. When I was a child if there was a family with a child with leukaemia it was not talked about because that child was doomed—they died. Nowadays 80 per cent of children with cancer are cured. The researchers described to me what happens: The leukaemia progresses very rapidly and then when it is detected and treated it reduces—in lay terms—just as rapidly and in 80 per cent of patients will reduce to the point of cure. But in 20 per cent of patients it turns the curve and goes back up again progressing rapidly. The researchers are now looking at what happens at that point. Why do 20 per cent of patients not continue on to cure?

There are other projects doing research on what particular drugs, in what quantity and at what times will be more effective in treating patients. I have seen some of the equipment that has been designed by researchers here in New South Wales, manufactured overseas and brought back and used here to test thousands of samples against various combinations of drugs to find the most effective regime to treat that patient. The inroads that have been made are amazing—I am talking about cancer at the moment—but there are similar results for other diseases as well.

The Hon. DAVID CLARKE: How would medical research in New South Wales be seen when compared to research overseas, are we holding our own?

Mrs JILLIAN SKINNER: We are. Previously the investment in medical research in New South Wales was overtaken by other States. Victoria always had a very strong base and some years ago we were overtaken by Queensland because there was a big burst of investment. That is when Professor John Mattick was enticed to Queensland from California. New South Wales really did not make the big investments needed to compete with those other States. Professor John Mattick has said he thinks this is where the work is now going ahead and I am very excited about it.

One of the key words that researchers use is collaboration. A researcher in New South Wales will work with their counterparts in other establishments in New South Wales, around Australia and overseas. Some of the researchers that I have been talking to are collaborating with researchers at Harvard. The world is now a small place when it comes to the willingness of some researchers to collaborate. The genome project which burst on to the scene a few years ago has changed the face of research, the possibilities and encouraged that international collaboration.

The Hon. DAVID CLARKE: That growing international collaboration brings about a multiplication effect in outcomes and a quickening of positive outcomes?

Mrs JILLIAN SKINNER: Yes, and not only with a greater understanding of disease and new medicines and treatments but in how people are treated. I recently opened an international symposium of paediatric neurosurgeons. At the conference there were 400 international neurosurgeons from 40 countries. It was hosted by Dr Charlie Teo, who is known to many people as an amazing neurosurgeon. I thought the theme of the conference was fantastic. It was "What went wrong?" It was about looking at how they could learn about new ways to treat patients from things that did not work. All of these different specialists were in the room from all of these countries talking with each other about what they did that worked best; it was just phenomenal. The Governor hosted a function for them and she was also in attendance. She said that this is part of a true international collaboration because also present were surgeons from developing countries who can learn from us, just as many wonderful researchers from around the world were learning from each other. [*Time expired.*]

(**The witnesses withdrew**)

The Committee proceeded to deliberate.