The Hon Jillian Skinner MP
Minister for Health
Minister for Medical Research

The Hon Melinda Pavey MLC
Chair
General Purpose Standing Committee 2
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Chair

Attached are copies of answers to Budget Estimates questions on notice taken during the GPSC2 hearing into the Health portfolio on 18 August 2014.

Also attached are the answers to the supplementary questions on notice.

Yours sincerely

Jillian Skinner MP

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Northern Beaches Hospital

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Dr HAMMETT: Mr Donnelly, coming back to your earlier question, I have been advised that we can let you know that the fourth proponent was Macquarie University Hospital operations who responded to the expression of interest [EOI].
The Hon. GREG DONNELLY: When did they withdraw?
Dr HAMMETT: I would have to check the exact date but they did not proceed to the RFP stage.
The Hon. GREG DONNELLY: It would be appreciated if you could take that part of the question on notice. Going back to my question in relation to the documentation that was put to the final two proponents who were active in this bid, has it been put into the public domain?

ANSWER:

I am advised:

Macquarie University Hospital Operations submitted an Expression of Interest in July 2013, but were not selected by the State to proceed to the Request for Proposals.

An Executive Summary of the Request for Proposal is in the public domain.

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Dr JOHN KAYE: I was not asking you about fitness and propriety; I was asking about the shareholdings within the company. Who owns Ramsay Health Care, for example?
Dr HAMMETT: Perhaps I could just add that the evaluation of both of the bids put in as part of the RFP process includes a detailed assessment of their commercial ability to meet the terms of service provision over a long-term contract so the evaluation team certainly has looked at the commercial structures that both the proponents are proposing to ensure that the project can operate successfully.
Dr JOHN KAYE: Would that include looking at who owns shares in these entities?
Dr HAMMETT: I would have to take that on notice.

ANSWER:

I am advised:

Ramsay Healthcare is a publically listed company, information can be obtained about stakeholders and directorships through ASIC and ASX.

The Request for Proposals applied the standard NSW Government position on change of control within listed entities.

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Dr JOHN KAYE: You therefore would not be aware of the difference between the modern award rate and the rate paid in the public hospitals in New South Wales.
Ms CRAWSHAW: No, although I do know that some private hospitals in New South Wales pay above the minimum award arrangements, or the modern award arrangements.
Dr JOHN KAYE: One would definitely hope so. Ms Crawshaw, could you take on notice and get back to us through the Minister what the modern award rate would be, since that is what you mentioned—you said that would be part of the negotiation—and could you give

us a document that compares what the annual income for a nurse on a modern award rate would be to a nurse on the State wage rate?
Ms CRAWSHAW: Okay, yes.

ANSWER:

I am advised:

NSW rates are 'paid rates' and the Fair Work Modern Awards are generally expected to sit under enterprise agreements. The enterprise agreement pay rates for Ramsay Health Care and Healthscope Limited are provided as examples.

The *Public Health System Nurses' and Midwives' (State) Award* is made by the NSW Industrial Relations Commission and applies to nurses and midwives employed in the NSW public hospital system.

The *Nurses Award 2010* (sometimes referred to as a "Modern Award"), is an industry based award which contains the minimum employment standards set by the Commonwealth Fair Work Commission and applies to nurses and midwives employed in enterprises covered by the Fair Work Act. Together with the ten National Employment Standards ('NES'), the *Nurses Award 2010* provides a safety net of minimum pay rates and employment conditions.

Comparison of Registered Nurses' annual pay rates* 2014

Registered Nurse	NSW Public Health System	Nurses Award 2010 (Modern Award)	Ramsay Enterprise Agreement	Healthscope Enterprise Agreement
1st Year	$56,723	$42,421	$55,982	$56,457
2nd Year	$59,807	$43,298	$59,030	$59,484
3rd Year	$62,896	$44,357	$62,072	$62,562
4th Year	$66,209	$45,531	$65,348	$65,849
5th Year	$69,497	$46,935	$68,573	$69,137
6th Year	$72,768	$48,291	$71,829	$72,424
7th Year	$76,504	$49,690	$75,508	$76,129
8th Year and T/A	$79,656	$50,984	$78,628	$79,259

*Rounded to the nearest dollar

Manning Hospital

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The Hon. GREG DONNELLY: I have a letter here that I will provide to you through the chair. It is a piece of correspondence directed to the staff. I will allow you to read it.
Mrs JILLIAN SKINNER: It is signed by Tricia Bulic, general manager of the hospital and states: I write to inform you of the directions to be taken by the … Hospital in response to a number of major avoidable catastrophes involving our obstetric service. It goes on to state: These events have prompted investigations in the form of Root Cause Analysis ...

The Hon. GREG DONNELLY: At about point three on the page there are four points listed.
Mrs JILLIAN SKINNER: Yes. The part you have highlighted outline a number of problems: • Poor adherence to coordinated care… • The guidelines for management of obstetric patients are at the same time incomplete… • There is a lack of agreement on the correct way to manage patients, both between midwives and obstetricians … • There has been a disconnection…
Dr JOHN KAYE: Can we have copy of that letter?
CHAIR: I ask the Hon. Greg Donnelly to formally table that document.
Mrs JILLIAN SKINNER: It states at the top of the second page: I will not accept another avoidable death due to petty personality issues and inter professional disputes. This is the first I have seen of this and it certainly was not raised with me.
The Hon. GREG DONNELLY: You visited the hospital that day.
Mrs JILLIAN SKINNER: Remind me of the date I visited the hospital?
The Hon. GREG DONNELLY: You visited the hospital, as I understand it, on 3 April.
Mrs JILLIAN SKINNER: That would be correct.
CHAIR: I ask the Hon. Greg Donnelly formally table that document.
The Hon. GREG DONNELLY: Yes. **Document tabled.** **The Hon. GREG DONNELLY:** The tone of this letter is very serious. **Mrs JILLIAN SKINNER:** It is, yes.
The Hon. GREG DONNELLY: The letter refers to "major avoidable catastrophes". Is anyone at the table able to enlighten us with information about matters to do with this issue?
Mrs JILLIAN SKINNER: No. Mr Whelan, that would be your bailiwick.

Mrs JILLIAN SKINNER: *No. Mr Whelan, that would be your bailiwick.*
Mr WHELAN: I am very surprised by the tone of the letter. Given that I manage performance, I would have expected that something as serious as this would have been brought to the attention of the chief executive of Hunter New England Health.
The Hon. GREG DONNELLY: Who would normally bring that to their attention?
Mr WHELAN: I would expect the general manager who wrote the letter should be discussing that with the chief executive of Hunter New England Health. I would then expect at our performance meetings where we meet regularly with chief executives of the local health districts [LHD] that this matter would have been discussed, but it has not been.
The Hon. GREG DONNELLY: This issue has not got out from the hospital; it has been festering. Is that what you are saying?
Mr WHELAN: To the best of my knowledge it certainly has not been raised with the Minister in a performance meeting.
The Hon. GREG DONNELLY: Does anyone at the table have any knowledge of this matter?
Ms CRAWSHAW: No. We do have an incident management system and if it was of the nature that is described there of "avoidable deaths" it would normally be something that is reported to us and be a severity assessment code one requiring a root cause analysis. We would have to take it on notice and check with the Clinical Excellence Commission that has responsibility for that.
The Hon. GREG DONNELLY: This is talking of "avoidable deaths due to petty personality issues and inter professional disputes", which is a pretty serious claim.
Mrs JILLIAN SKINNER: It is, and for that reason I would like to take it on notice because how do we know the accuracy of that letter? **Mrs JILLIAN SKINNER:** You said, "on the face of it". I would like to verify the accuracy of the claims in that letter. I would like to correct your record. You said I was there on 3 April, but I was there on 4 April. In order to make those

visits I am provided by the local health districts with a brief about matters relating to the hospital. I have checked that brief and there is nothing in the brief to suggest there was any disquiet on the part of the general manager. I have undertaken to check this and to provide a written answer.

ANSWER:

I am advised:

At the Budget Estimates hearing, the Hon. Greg Donnelly cited an internal memorandum dated April 2014 to Manning Hospital maternity staff and visiting medical officers written by the General Manager of Manning Hospital Ms Tricia Bulic.

Neither myself, the NSW Ministry of Health nor the Hunter New England (HNE) Local Health District Chief Executive had sighted the memorandum prior to it being raised by the Hon Greg Donnelly at the Estimates hearing.

Ms Tricia Bulic subsequently confirmed to the HNE LHD Chief Executive that, rather than multiple incidents, her memo to staff referred to the RCA recommendations following a single incident that occurred in January 2014 which had been reported and investigated according to NSW Health policy. Ms Bulic also confirmed that recommendations arising from the incident were being implemented at the hospital.

NSW Health has in place a comprehensive and systematic approach to managing and investigating incidents in the public health system. Direction for a consistent approach to managing these incidents is contained in the recently re-issued NSW Health Policy Directive PD2014_004 “Incident Management Policy” (attached and available on the NSW Health website at http://www0.health.nsw.gov.au/policies/pd/2014/PD2014_004.html).

Where a question of individual clinician performance or competence arises, management is in accordance with NSW Health Guideline GL2006_002 “Complaint or Concern about a Clinician – Management Guidelines” (attached and available on the NSW Health website at http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_002.html).

The incident management system is underpinned by a state-wide electronic Incident Information Management System (IIMS) allowing the NSW public health system to capture reported incidents. Reported incidents are reviewed, so that remedial action and education can be applied across the whole health system. The system enables staff to report confidentially and without fear of reprisal. This provides the NSW Clinical Excellence Commission and local health districts with reliable data from which lessons can be learned and improvement strategies developed and implemented to prevent recurrence of incidents and to continuously improve the quality and safety of patient care.

Incidents entered into the system are rated against a Severity Assessment Code (SAC) that plots the consequence of the incident against the risk of it happening again. There are four SAC ratings, with SAC 1 being the most serious.

All incidents notified in the IIMS system require some level of review or investigation in accordance with the Incident Management Policy. A framework for prompt and honest communication with patients about clinical incidents is also established by the NSW Health Open Disclosure Guidelines. There are also legislative provisions in relation to more serious clinical incidents. All clinical SAC 1 incidents require the carrying out of a Root Cause

Analysis (RCA) in accordance with the provisions of Division 6C of the Health Administration Act 1982. The RCA is a process analysis method used to identify the systemic factors that cause adverse events. The RCA team is comprised of members who have not been directly involved in the incident or in the care of the patient.

The statutory provisions set out requirements for the conduct of RCA investigations, and contain protections for RCA teams and participants in RCA investigations that have the objective of encouraging full and frank participation by clinicians in these processes. Non-SAC 1 incidents may also be subject to an RCA investigation under the statutory processes if the Chief Executive of the health agency is of the opinion that the incident may be the result of a serious systemic problem.

Local Health Districts take appropriate action following any serious adverse event to avoid recurrence. Following the RCA review, local health services consider and implement recommendations.

The Reportable Incident Brief (RIB) system is designed for the immediate reporting of serious or significant health care incidents within 24 hours of notification of the incident in IIMS. RIB notifications are made to designated state-wide committees appointed by the Minister for Health under the *Health Administration Act 1982*. All clinical incidents reported in RIBs are referred to the NSW Health Clinical Risk Action Group (CRAG) which is managed by the Clinical Excellence Commission. RIBS involving specific kinds of incident or disciplines may also be referred to other specialist committees such as the NSW Maternal and Perinatal Committee, the Special Committee Investigating Deaths under Anaesthesia, or the Collaborating Hospitals' Audit of Surgical Mortality Committee. These processes also have statutory protections under the *Health Administration Act.*

CRAG is responsible for examining and monitoring serious clinical incidents via a number of mechanisms, including RIBs. CRAG's role includes:

- Accessing information relevant to serious clinical incidents and incident trends
- Identifying unsafe practices or systems issues which may compromise patient safety and impact on morbidity and mortality
- Ensuring appropriate action occurs to manage identified risks, minimise the impact of their consequence and prevent future occurrence, and
- Advising the NSW Ministry of Health Senior Executive Forum on measures to address clinical risk and patient safety.

The NSW Clinical Excellence Commission (CEC) is responsible for reviewing public health system incidents and developing strategies to reduce recurrence, and for working with Local Health Districts to improve quality and safety. The CEC conducts their work independently and reports publicly.

Under the *Coroner's Act 2009*, hospitals and medical practitioners or any other person, who has reasonable grounds for believing that a death or a suspected death would be examinable by the Coroner (a 'reportable death' under section 6) must report the death or suspected death to the police (who will then report it to the Coroner) or a Coroner or assistant Coroner as soon as possible.

Where clinical incidents raise serious potential issues about clinician conduct or performance, local health districts as employers of staff have a legislative duty to report concerns in certain circumstances to the relevant state health professional council or to the Australian Health Practitioner Regulatory Agency (APHRA).

For example, under the *Health Services Act 1997*, Local Health District Chief Executives have an obligation to report to the relevant health professional council any conduct of a member of staff (including visiting medical officers) that the Chief Executive reasonably suspects may constitute professional misconduct or unsatisfactory professional conduct. Under the Health Practitioner Regulation National Law, a Local Health District must notify APHRA if it reasonably believes a clinician has engaged in "notifiable conduct", which is defined to include such matters as practising while intoxicated by drugs or alcohol, or where a clinician places the public at risk of substantial harm due to an impairment or significantly departing from accepted professional standards.

In NSW complaints concerning registered health practitioners are co-regulated by the relevant state health professional council and the NSW Health Care Complaints Commission (HCCC). The NSW Health Care Complaints Commission also has the power to receive, assess and resolve complaints relating to health service providers in NSW, as well as to investigate and prosecute serious complaints that raise questions of public health and safety.

Bourke Maternity Services

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The Hon. PAUL GREEN: Obviously, we have been on the road with other inquiries and one issue was about Bourke not having the maternity services it once did. Is there any chance of that being reopened in the future?
Mrs JILLIAN SKINNER: Yes.
The Hon. PAUL GREEN: Does the Government have some reply to that inquiry?
Mrs JILLIAN SKINNER: Yes. As I understand it, the maternity staff there are engaged by an organisation outside of the local health district.
Dr CHANT: There has been a response provided. We just have to check its current status. Western NSW Local Health District is working collaboratively with Ochre Health to secure appropriately qualified medical staff to enable birthing services to resume in Bourke. But we would have to take the question on notice.
The Hon. PAUL GREEN: You can take it on notice. The main thing we are hearing in the field is that it is just unreasonable that mothers have to travel to Dubbo or somewhere.

ANSWER:

I am advised:

The Western NSW Local Health District must at all times ensure the safety of mothers and babies and this can not be guaranteed without the support of appropriately qualified medical staff. In the interim, the available midwives continue to work closely with the community to ensure appropriate antenatal and postnatal care is provided.

The Local Health District has engaged Prof Lesley Barclay, from the University of Sydney's Centre for Rural Health, North Coast NSW to conduct a review of the Bourke Multi-Purpose Service and undertake extensive community consultation in light of the remote rural midwifery research work she is conducting on similar services in Australia. Professor Barclay will be working collaboratively with Western NSW LHD and advising on the most appropriate birthing services for the Bourke and surrounding communities to ensure a safe service is provided.

Women with identified at-risk pregnancies are required to birth at a facility that has the appropriate specialist services to provide care for women and babies. In Western NSW LHD this is Dubbo or Orange.

Asbestos

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The Hon. GREG DONNELLY: I now turn to an issue that has received some publicity over the past few days. As recently as 25 July this year NSW Health provided the following advice on loose-fill asbestos installation in houses, and I quote: In 1993 the New South Wales Government evaluated the level of risk proposed by loose fill asbestos in the seven homes identified at the time in Queanbeyan, New South Wales, the assessment concluded that exposure to asbestos is likely to be very low provided the asbestos is undisturbed and sealed off from the living areas. Does the Government still stand by that position or has its position altered?
Mrs JILLIAN SKINNER: A government response is being coordinated by the Heads of Asbestos Coordination Authorities [HACA], which is chaired by WorkCover NSW. NSW Health is represented on that body and the Chief Health Officer is part of that body. I will ask Kerry Chant to answer.
Dr CHANT: NSW Health's position is that asbestos is hazardous to human health and it is very important that we limit exposure to asbestos. In relation to the particular point raised in your question, the advice from NSW Health is that the exposure pathway; that is, people are not being exposed to the asbestos fibres, removes risk to their health. In 1993 we were involved in providing advice in relation to some work done in the seven homes identified at the time in Queanbeyan, New South Wales. That was following a call where I believe in the order of 350 homes had come forward for testing and there was a small number of homes tested. The level of exposure in those homes in 1993, which was some 15 years after the loose-fill asbestos was put in place, indicated that the risk was very low in the seven homes that were tested. As I said, there were only in the order of 13 homes identified—
Dr JOHN KAYE: You tested for fibre density, did you?
Dr CHANT: Airborne fibres. The report is actually on the HACA website, and I am happy to make available the website details and the details of that report. The other component is that I have a standing expert advisory committee that looks at air pollution issues and broader environmental risks. I have asked for that to be reconvened so that the independent expert panel, with a range of experts such as Professor Bruce Armstrong, Professor Guy Marks—
The Hon. GREG DONNELLY: That is separate to what the Minister just mentioned?
Dr CHANT: Yes, that is the expert panel. I have reconvened that to review all of the information that is becoming available. The Committee will be aware that on Friday, as part of the whole-of-government response, three initiatives were announced by government—
Dr JOHN KAYE: Dr Chant, will you please put those three initiatives on notice. This is now my time to ask questions.
Dr CHANT: Yes.

ANSWER:

I am advised:

The NSW Heads of Asbestos Coordination Authorities general website is at http://www.workcover.nsw.gov.au/newlegislation2012/asbestos/Pages/hacamembers.aspx

Information regarding the loose-fill asbestos investigation, including the 1993 NSW Health report 'Queanbeyan study – asbestos in private homes' can be found at: http://www.workcover.nsw.gov.au/formspublications/publications/Pages/loose-fill-asbestos-investigation.aspx

Northern Beaches Hospital

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Dr JOHN KAYE: My next question arises from a question asked by Mr Green to do with the nursing hours per patient day ratios. Mr Green asked if they would be transmitted to the new hospital. The answer is that they are currently protected in the State-based award, which means that the new hospital will not be operating under the State-based award—
Mrs JILLIAN SKINNER: For the two years for those employees they will be.
Dr JOHN KAYE: For those two years, but beyond those two years they will not be. Will the contract contain a nursing hours per patient day ratio constraint or—
Mrs JILLIAN SKINNER: As part of the request for tender we stipulated the workforce requirements, and that that would be considered in the final analysis. What happens beyond that two-year period is a matter that has already been disclosed between the hospital operator and the staff: They will go back to the Commonwealth provisions of Fair Work.
Dr JOHN KAYE: There will be no protection on nurse—
Mrs JILLIAN SKINNER: Fair Work protections.
Ms CRAWSHAW: There is the Fair Work protection, which for transferring conditions is up to five years, and I can confirm that is the case. The rider on that is if more than 50 per cent of the staff enter into an enterprise bargain with the new employer after the two years—
Dr JOHN KAYE: Enterprise agreement.
Ms CRAWSHAW: Yes. That overrides the ongoing maintenance of terms and conditions for the next part of that five-year period.
Dr JOHN KAYE: Terms and conditions that are within the State-based award or the modern award?
Ms CRAWSHAW: No. There is a provision in the Fair Work Act that if you—
Dr JOHN KAYE: That the State award continues for five years.
Ms CRAWSHAW: That is correct.

Ms CRAWSHAW: *That is correct.*
Dr JOHN KAYE: But at the end of five years there would be no protections beyond what was agreed to in the enterprise agreement?
Ms CRAWSHAW: Correct.
Dr JOHN KAYE: In effect the State will no longer have any control over nursing hours per patient day ratio in the new hospital?
Ms CRAWSHAW: After that period.
Dr JOHN KAYE: So after five years it is whatever the hospital thinks it can get away with within the constraints set by the performance. I presume the contract will specify certain levels of performance.
Ms CRAWSHAW: Yes, but it will also specify certain levels of safety and, like any other

employer, workplace health and safety law will also apply. So there is a framework over and above nursing hours per patient day that does provide some safeguards to staff working in hospitals. Can I just—
Dr JOHN KAYE: But you understand that that was not necessarily a matter of nurse safety; it was a matter of patient safety and patient recovery?
Ms CRAWSHAW: There is patient safety and then there is staff safety. Clearly if you provide hours that are onerous to the point where it affects health and safety then you are running afoul of workplace health and safety obligations.
Dr JOHN KAYE: Because we are running short on time, would you mind providing the Committee with some details on what that would be on notice?
Ms CRAWSHAW: I can give you the details, yes.

ANSWER:

I am advised:

The Public Health System Nurses and Midwives (State) Award is legally enforceable and sets reasonable workload principles which apply to all nurses and midwives covered by that Award. There is an Award obligation not to give nurses and midwives an unreasonable workload. There are also mechanisms identified in the Award for resolving disputes about workloads locally as they arise.

Both public and private health organisations have management structures in place setting out the responsibilities at various levels in the organisation for ensuring appropriate patient care, staff safety and that staffing is appropriate to patient needs.

With regard to safety, NSW Health has an obligation to both patients and staff.
The National Registration and Accreditation Scheme (NRAS) contributes to patient safety by ensuring that only suitably trained and qualified practitioners are registered.

In NSW all Persons Conducting a Business or Undertaking have the same obligations under the Work Health and Safety Act 2011 to protect the health, safety and welfare of all workers at work (and of other people who might be affected by the work). These obligations extend to ensuring that workers have safe systems of work and a physical work environment that is free from risk.

Enable NSW

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Dr JOHN KAYE: I turn now to the issue of EnableNSW and patients in hospital who are ventilator dependant and maybe waiting to be discharged but cannot be discharged because there is not a ventilator in the home for them. Minister, are you aware that there are such patients in New South Wales?
Mrs JILLIAN SKINNER: No, I know that there are occasionally questions asked about EnableNSW and its capacity to deliver all of the equipment help that is needed. Let me see if I can find out some further details.
Dr JOHN KAYE: So you are aware of what I am saying here, and I probably did not express it as well as I could have. I am talking specifically about patients who are unable to leave hospital because they cannot get home ventilation equipment under the EnableNSW Home Ventilation Program, and for whom discharge would be the appropriate course of action.

Concerns have been raised with us that the EnableNSW budget is constrained and that there are patients who are effectively trapped in hospital because of that constraint.
Mrs JILLIAN SKINNER: I am aware that there has been an increased demand for equipment through EnableNSW. As a result, there have been increased waiting times. I am advised that the increase in demand has since plateaued, and there has been a recent $5 million enhancement of the Aids and Equipment Program that will assist in reducing waiting times. If you have specific examples of patients who are still in hospital because of a lack of equipment then I am happy to take those on notice.
Dr JOHN KAYE: I am sure I can get that to you, Minister. Can you tell us how many patients there are in that category?
Mrs JILLIAN SKINNER: I cannot off the top of my head.
Dr JOHN KAYE: Could you get that to us on notice?
Mrs JILLIAN SKINNER: Yes, I will.
Dr JOHN KAYE: Could you get to us on notice the number of patients and how much funding would be required to clear that backlog? What is the longest known time that those patients have been waiting in hospital from point of clinical discharge to point of actual discharge?
Mrs JILLIAN SKINNER: I will certainly take that on notice. Of course I have to provide a rider that it is not always a lack of equipment that prevents them from being discharged from hospital. Certainly it could be an element. I will provide that information.

ANSWER:

I am advised:

The process for alerting EnableNSW to a person's need for a ventilator comes from their clinical team.

EnableNSW has not been alerted to any patients in hospital who are eligible for the Home Ventilation Program and who are not able to leave hospital because they cannot get home ventilation equipment.

Ventilators are also supplied to patients through the Home Respiratory Program at the request of the person's treating clinical team. There is no waiting time for the supply of ventilators through this program.

Suppliers on the Government contract are required to loan complex ventilators to allow the clinical team to trial the equipment with the person to ensure it is appropriate.

Mrs JILLIAN SKINNER: I am aware that there has been an increased demand for equipment through EnableNSW. As a result, there have been increased waiting times. I am advised that the increase in demand has since plateaued, and there has been a recent $5 million enhancement of the Aids and Equipment Program that will assist in reducing waiting times. If you have specific examples of patients who are still in hospital because of a lack of equipment then I am happy to take those on notice.
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Mrs JILLIAN SKINNER: I will certainly take that on notice. Of course I have to provide a rider that it is not always a lack of equipment that prevents them from being discharged from hospital. Certainly it could be an element. I will provide that information.

ANSWER:

I am advised:

There is no waiting period for people who are eligible for the Specialised Equipment Essential for Discharge program. Equipment required to meet a person's short term needs or to facilitate discharge is generally provided through Equipment Loan Pools operated by the Local Health Districts.

The Specialised Equipment Essential for Discharge (SEED) program, operated by EnableNSW, provides necessary equipment for eligible patients who have sustained a spinal cord or brain injury (and who are not eligible for the Lifetime Care and Support Scheme) so that they can be discharged from hospital in a safe, effective and timely way.

Junior Medical Officer positions

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The Hon. PAUL GREEN: I am aware that NSW Health is in the process of looking to fill more than 3,600 junior medical officer positions available through the State's public hospitals and health facilities. When will this process be finished and what are you doing to try to get many of these positions into rural areas?
Mrs JILLIAN SKINNER: These are the junior medical officer positions. I am very proud of what we have done in terms of workforce—for example, we now have 4,600 extra nurses by headcount. That is, 3,400 full-time equivalent [FTE]. In terms of doctors, we have had 979 intern positions this year, which is up 20 positions from last year. We are leading the country in terms of not only numbers but also funds allocated for this purpose. We also fund a further five intern positions in the Australian Capital Territory. An intern recruitment process is currently underway, with the first offers made in July 2014 for this year.
The Hon. PAUL GREEN: What percentage will be going to rural areas?
Mrs JILLIAN SKINNER: I cannot give you that answer off the top of my head.
Ms CRAWSHAW: We will take that question on notice.
Mrs JILLIAN SKINNER: Yes, we will take it on notice.

ANSWER:

I am advised:

The annual junior medical officer (JMO) recruitment for the 2015 clinical year is currently underway. For those who applied during the main recruitment round, the majority of interviews will take place - and preliminary offers will be made - during September 2014.

For positions that remain unfilled, a second round of applications, interviews and offers will take place between 22 September and 10 October 2014. The positions commence at the beginning of the 2015 clinical year (2 February 2015).

NSW Health medical speciality training networks are coordinated by the Health Education and Training Institute (HETI) to ensure coordinated training pathways for specialty trainees and quality education experiences. HETI links large teaching hospitals with rural training positions to provide both diverse training experiences and an experience of rural practice. HETI currently coordinates five speciality networks and supports other speciality training programs moving to networked training based on similar principles.

Local Health Districts continue to grow medical specialist training positions in rural and regional NSW and have established a further 29 speciality training positions since 2011 with funding assistance from the Ministry of Health.

In addition, over $4 million per annum has been invested in 30 advanced skills training positions at rural facilities that provide training in anaesthetics and obstetrics for Rural Generalist trainees. The NSW Rural Generalist Training Program is a state-wide training program with the aim of producing doctors who are general practitioners with advanced skills able to deliver services to rural communities.

Based on JMO recruitment for the 2014 clinical year, rural and regional positions accounted for 28.9% of positions advertised and 23.0% of positions filled.

These rural and regional acceptances are in addition to rural intern placements and networked position acceptances, where trainees accepted into a training program rotate between the participating rural, regional and metropolitan facilities within each network.

CSIRO

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The Hon. GREG DONNELLY: Yes. Minister, this is a serious question. It goes to the question of: Are there any projects that the State may be involved in that might overlap with this and therefore there is a matter of concern that the CSIRO—
Mrs JILLIAN SKINNER: We do have projects in partnership with the CSIRO. I do not know whether they are affected by any changes.
The Hon. GREG DONNELLY: That is what I am getting at.
Dr CHANT: In my portfolio area, I am aware of some cooperation or collaborations with CSIRO. I am not sure of the nature of those or the funding parameters around that, so I will have to take that on notice. But we do work with the CSIRO where they have relevant expertise for us.
CHAIR: So you are taking that question on notice?
Dr CHANT: I will take it on notice.
The Hon. GREG DONNELLY: In regard to any potential impact, you will take that on notice. On the issue of the science strategy for this country—and obviously we have a deep interest in this for New South Wales, being the size it is—the Chief Scientist, Ian Chubb, has been very outspoken about the need to have a national science strategy. Is this a matter that you believe in your role as the New South Wales health Minister on which you wish to engage the Federal Government over a national science strategy?

ANSWER:

I am advised:

There are no partnership programs with the CSIRO affected by CSIRO changes.

Coal Seam Gas

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The Hon. GREG DONNELLY: Has that committee produced any response, perhaps even a preliminary response, about some of the issues you have asked it to look at in terms of coal seam gas exploration or not?
Dr CHANT: All the Chief Scientist's work is available and has been publicly released. It would be captured in the minutes where there have been particular issues around coal seam gas. I think the expert panel—I will have to double-check—was just asked to comment on the relevance of health studies in this field.

ANSWER:

I am advised:

Information regarding the NSW Chief Scientist and Engineer Independent Review of Coal Seam Gas Activities in New South Wales can be found at http://www.chiefscientist.nsw.gov.au/coal-seam-gas-review

The Chief Health Officer's Expert Advisory Committee met to review the Chief Scientist's report. The minutes of this meeting are available online at http://www.health.nsw.gov.au/environment/air/Pages/apeac.aspx

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The Hon. GREG DONNELLY: Yes, but that was not my question. My question was: Have you been in contact and dealing with Queensland Health over its work on the coal seam gas issue?
Dr CHANT: I believe—I would need to confirm this directly—and have the firm understanding that in health protection New South Wales has engaged with Queensland around its experience with coal seam gas.
The Hon. GREG DONNELLY: If you would not mind taking that question on notice and provide also any relevant information or insights provided to New South Wales from Queensland Health on this issue?
Dr CHANT: I will. Thank you.

ANSWER:

I am advised:

NSW Health is a member of the Environmental Health Standing Committee (enHealth), which involves representatives from Commonwealth, and State and Territory health departments. Through this forum, QLD Health has shared their experiences around coal seam gas activities in Queensland with NSW Health and other members.

Coal Dust

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The Hon. GREG DONNELLY: What work has NSW Health done and what recommendations and advice is it providing those interested to find out about how particulate dust, specifically with respect to coal, is best dealt with and managed?
Dr CHANT: We have had a lot of information on this issue. The Air Pollution Expert Advisory Committee chaired by Professor Guy Marks basically has done a lot of work on what are the important aspects we need to understand in relation to the impacts of coal dust on the community. Several studies have been initiated in partnerships, one of them with the CSIRO and the Environment Protection Authority [EPA], to look at speciation of coal dust. One issue for us is to better understand the nature of the causes of the pollution, particularly in Singleton and Muswellbrook. Through a speciation method they can actually determine the source of that, which then will allow us to better characterise and better understand what are the controls that could be put in place to manage that. That report is being publicly available and provided back to the community. There also has been an analysis. Initially, there were some calls for some health studies in the Hunter and New England area and there were a range of different methodologies looked at by our expert advisory committee. The conclusion at the outcome of that was that health studies were not relevant and risked finding no effect because of one of the issues of the sample size. We have a good understanding of the impacts of air pollution and they are drawn from very large international studies. Once we know the level of particulate pollution we then can attribute that to the population. Hence, it can actually be misleading to try to do studies on small populations because you risk finding no effect when, in fact, there is actually a small level of effect. We have done some other work, which is all on the website and the minutes of the expert advisory committee and all its deliberations are available. I would be happy to provide the web link for that.

ANSWER:

I am advised:

Minutes from the Chief Health Officer's Air Pollution Expert Advisory Committee can be found at http://www.health.nsw.gov.au/environment/air/Pages/apeac.aspx

Health Star Rating

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Dr JOHN KAYE: I take the interjection; it certainly is not my only obsession, but certainly has been one of them. How do we now respond to that given emerging evidence that the total quantity of saturated fats in a diet is not an indicator of health or otherwise but, rather, and in fact, it is the energy density of one's diet. How does NSW Health respond to that?
Dr CHANT: We do it as part of the clinical community. We engage in discussions with our clinician colleagues who often are giving that advice, be it in general practice or our diabetes clinicians. Creating the forums for having those discussions and, clearly, for any new evidence we have there are a variety of forums in which we can discuss the relevance. Some of the initiatives, such as the 8700 kilojoule campaign, have started to give some sense to kilojoules, getting some perspective: people understanding if they buy the muffin how many kilojoules it has. Whilst the 8700 is a generic number and can be criticised because it is not relevant to everyone's particular circumstance, it gives a ballpark sense for the community

to recalibrate that concept of energy in, energy out.
Dr JOHN KAYE: The classic situation is somebody who is in a supermarket who wants to buy yoghurt, which is traditionally understood as a whole food and a healthy food. They see it is low fat. I am certainly not trying to pick on anybody or on what we have done in the past, but because we have been programmed that saturated fat is bad, we go for low fat. The current evidence is suggesting that if the low fat has more sugar in it, we should stay away from it and if the full fat yoghurt has no sugar in it, it is probably a better choice for you than the low-fat yoghurt.
Dr CHANT: They are valid points. What I will undertake to do is to go back and see how the health star rating deals with those things. The new initiative is the health star rating. The good thing about that is presumably over time that can be a receptor for changes in science. I will go back and look at that new emerging evidence. Having said that, it is important that often one study alone—

ANSWER:

I am advised:

The Australian Dietary Guidelines, developed by the National Health and Medical Research Council (2012), recommends limiting the intake of saturated fat. For dairy products specifically, the advice is to consume mostly reduced fat milk, yoghurt, and cheese. This advice is consistent with Dietary Guidelines in the USA, UK and Europe.

The link between dietary saturated fat, serum cholesterol and cardiovascular disease is well established. However it is important to note that the evidence relates to replacing dietary saturated fat with healthy unsaturated fats and not carbohydrates. In practice, this means replacing foods containing butter, cream, coconut and palm oil with foods containing other vegetables oils, spreads and nuts.

Saturated fat in Australia exceeds recommendations, contributing to 11.4% of energy intake, higher than the recommended level of not more than 10% of energy. Dairy products are a significant source of saturated fat in the Australian diet providing around 23% of saturated fat intake. While emerging evidence suggests that saturated fat from dairy products may not have the same cardiovascular impact as saturated fat from meat, it is too early to draw any conclusions and the recommendation to continue consuming reduced or no fat dairy products remains.

Nutrient density is a key consideration when assessing the healthiness of a particular food product. While managing kilojoule intake is important to maintain a healthy weight, the quality of the diet (less of the negative nutrients such as saturated fat and sodium and more of the positive nutrients such as calcium and fibre) is an independent factor in preventing diseases such as heart disease and diabetes. Foods with a high nutrient density provide the best nutrition for the number of kilojoules. Low fat flavoured yoghurt is a good example of a nutrient dense food. It tends to have a similar sugar and calcium content to full fat flavoured yoghurt but is significantly lower in saturated fat and kilojoules.

The Health Star Rating system was developed in response to the *Food Labelling Review Report, Labelling Logic* that recommended introducing an easy to interpret, front-of-pack labelling system to help consumers to make healthier choices. Foods are given a Star rating from half a star to five stars to indicate their relative healthiness. The voluntary system was launched on 27 June 2014 and products carrying the Star Rating are expected to appear in the market in the next six months.

The System takes into account nutrient density by rating the product against four negative aspects of a food associated with increasing the risk factors for chronic diseases (energy (kilojoules), saturated fat, sodium and total sugars) and positive aspects of a food associated with decreasing the risk factors for chronic disease (fruit, vegetable, nut and legume content, fibre and protein). In the case of yoghurt, those products lowest in saturated fat, sugar and kilojoules and highest in protein receive the highest Star rating. However given that yoghurt is a core food in the Dietary Guidelines and an important source of calcium, many products will have a Star rating of 3 of above.

Research

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Dr JOHN KAYE: Is it possible to get the number of dollars that were in the budget that went specifically to strategic research last year compared to this year? I appreciate what you are saying about the IHPA and the change in coding but in the end there is a certain number of dollars that went into research.
Mrs JILLIAN SKINNER: I can give you some specific information about some of it. Some of the money that you are talking about would be for the research that doctors and others do on their rounds in a hospital so it is within their obligations as an employee of the hospital, but there are other specific programs such as the Medical Research Support Program that I mentioned, which has had a substantial funding increase this year. One of my favourite programs is the genomic research program that has been established in consultation with the Garvan Institute. Recently we called for submissions for grants. There is money set aside for research hubs. A substantial amount of money has been spent on the National Cancer Institute Program, the career support program and the research infrastructure program. There is a transitional support program.
Dr JOHN KAYE: Minister, will you take on notice the following question? You have mentioned six—
Mrs JILLIAN SKINNER: I can keep going.
Dr JOHN KAYE: You mentioned the Medical Research Support Program, the Cancer Institute and your favourite, the Sydney Genomic Collaborative Program. You were probably about to talk to the medical device seeding fund.
Mrs JILLIAN SKINNER: Absolutely.
Dr JOHN KAYE: Rather than going through the numbers here, could you get back to us with those?
Mrs JILLIAN SKINNER: Yes, I would be delighted.
Dr JOHN KAYE: What was the funding for those in the 2013-14 year and what is the funding in 2014-15, broken down initiative by initiative so that we can get a handle on what is happening with research?
Mrs JILLIAN SKINNER: Yes. Of course some are new programs or initiatives altogether.
Dr JOHN KAYE: It would be good for you to include those as well.
Mrs JILLIAN SKINNER: Yes, absolutely.
Dr JOHN KAYE: And indeed programs that have not been funded this year but that were funded last year.

ANSWER:

I am advised:

Managing Branch / Pillar	Program name	Purpose / scope of program	Budget 2013-14	Budget 2014-15 (published)
OHMR	Medical Research Support Program	The NSW Government established the Medical Research Support Program (MRSP) to provide infrastructure funding to independent health and medical research organisations.	$33.8M *NB: $5,030,251 was rolled over from 13/14 to 14/15.*	$44M
OHMR	Medical Devices Fund	The Medical Devices Fund (MDF) is a $5 million per annum ($8 million allocated in first year) competitive technology development and commercialisation program funded by the NSW Government, through the NSW Ministry of Health. In its inaugural year, the Fund committed $10.3 million to 5 projects.	$10.3M	$7.7M
OHMR	NSW Medical Device Commercialisation Training Program	The Office for Health and Medical Research has provided funding for the delivery of medical device commercialisation training.	$200,000	Nil
OHMR	NSW Medical Device Fellowship Program	Funding for up to 2 researchers to participate in the QB3 Rosenman Institute scholar program - to learn from leading medical device commercialization experts, and develop a medical device technology.	$222,222	$224,000
OHMR	Medical Research Commercialisation Fund (MRCF)	The Medical Research Commercialisation Fund Collaboration was established in 2007 as an investment collaboration that invests in early stage development and commercialisation opportunities originating from medical research institutes and allied research hospitals in Australia.	$300,000	$150,000
OHMR	Sydney Genomics Collaborative	An initiative of NSW Health to establish a national leadership role for NSW in genomic research and genomic medical research.	Nil	$6M
OHMR	Breaking the Cycle of Heart Disease	Funding to support the Victor Chang Cardiac Research Institute campaign to raise $20 million over 5 years to fund key research programs in: organ transplantation, congenital heart disease, epigenetics (how genes behave), molecular cardiology, stem cell biology and sudden cardiac death.	$2M	Nil
OHMR	Networks and Clinical Trials	OHMR support six (6) state-wide clinical research networks and is investing $125,000 in 13/14, 14/15 and 15/16 to support the Australian Advanced Treatment Centre (AATC).	$810,000	$800,000
OHMR	Research Hubs	The Research hubs receive funding to provide administrative support and assist in coordination of hub activities	$1.6M *NB: $1.6m was*	$800,000

Managing Branch / Pillar	Program name	Purpose / scope of program	Budget 2013-14	Budget 2014-15 (published)
		to enhance collaboration by facilitating the efficient sharing of expensive equipment, accommodation and support services.	*distributed in 2013-14 ($800,000 from 2012/13 was rolled over due to the Hub Strategy being released in 2013/14).*	
OHMR	Neurological Conditions Research Grants Program	The Neurological Conditions Research Grants Program (NTP) provides fellowships that promote translational research into spinal injuries and neurological conditions.	$25,360	Nil
OHMR	Research Capacity Building Program - Bioinformatics	Two grants to the value of $750,000 were awarded to innovative projects that will demonstrate the benefit of integrating and analysing state-wide data to enhance research and evidence-based healthcare.	$750,000	Nil
OHMR	Bioinformatics Training	The Office for Health and Medical Research has announced bioinformatics training for researchers, clinicians, health professionals and academics in NSW.	$250,000	$250,000
OHMR	Research Capacity Building Program – Biobanking Transition Fund	The NSW Government is implementing a ten-year Strategic Plan for Health and Medical Research that includes a commitment to develop a state-wide biobanking framework.	$57,000	$500,000
OHMR	Research Capacity Building Program – Pathogen Genomics	The NSW Government is implementing a ten-year Strategic Plan for Health and Medical Research that recognises that access to research assets, including genome sequencing capacity, is an important contributor to research excellence that enables world class research.	Nil	$1M
ACI	ACI Research Funding Scheme	To fund research that meets ACI's strategic objectives	$211,450	$146,869
ACI	Primary Care and Chronic Services Research Support	To support initiatives that realise ACI PCCS's research objectives	$65,000	Nil
ACI	Acute Care, Blood and Marrow Transplant Research support	Research approach to assess latent effects of Blood and Marrow Transplant	10,000	Nil

Obesity Program

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The Hunter program was a pilot program where there was a significant investment of money ahead of the NPA on prevention, which enabled us as a State to scale-up the title

program.
Dr JOHN KAYE: NPA being the national partnership agreement?
Dr CHANT: Yes, on prevention. That enabled the State to scale-up the programs and draw on the experience of the Hunter. In the Hunter a 1 per cent year-end decline on childhood obesity was found. Again, that report is on the web and I am happy to make it available to you. The programs we then scaled across the State drew on the experience in the Hunter. So we are confident that next year we will see a decline. We have got some data—I think you are aware of the limitations of a population health survey where there is self-reporting—but because children are a small subset of the population health survey it does blip around a little bit. We have seen a decline from 2012 to 2013 but we do not want to oversell that. That was actually a 5 per cent decline, which is unlikely to be real. Again, we are hoping that gives us some early indication that the trend might be going in the right direction but you will see some careful words if you go to Health statistics where that report is also available. We would be happy to make that available to you.

ANSWER:

I am advised:

Good for Kids, Good For Life was an initiative jointly funded by the NSW Ministry of Health and Hunter New England Local Health District and conducted between 2006 and 2010. The initiative targeted children aged two to 12 years and aimed to reduce the prevalence of child overweight and obesity in the Hunter New England region and build evidence for policy and practice related to the prevention of child obesity in NSW. The evaluation of the initiative found that the prevalence of overweight and obesity decreased by approximately 1% per year on average for all children in the Local Health District.

A full report is available at http://www.health.nsw.gov.au/research/Documents/Good-for-Kids-report.pdf

Get Healthy Information and Coaching Service

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The Hon. GREG DONNELLY: To finalise this part of the question, in relation to the contract itself, the contract that Healthwise Australia has is a $2.5 million contract as I understand it. Is that right?
Dr CHANT: I will have to take that on notice.
The Hon. GREG DONNELLY: If you would be good enough, whilst you are doing that, to check the expiration date of the contract. You said it was four years?
Dr CHANT: My recollection is that there was something around four years, with some ability to extend beyond it, if all parties were agreed. But I would have to double check because that is just my recollection.

ANSWER:

I am advised:

The contract with Healthways Australia is managed through a Service Definition Management Order, under the Umbrella Funding Agreement with Healthdirect Australia. The contract value is $3 million per annum from 1 January 2014 to 31 December 2016.