CORRECTED

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO QUALITY OF CARE FOR PUBLIC PATIENTS AND VALUE FOR MONEY IN MAJOR NON-METROPOLITAN HOSPITALS THROUGHOUT NEW SOUTH WALES

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At Sydney on Thursday 18 October 2001

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The Committee met at 9.00 a.m.

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PRESENT

The Hon Dr B. P. V. Pezzutti (Chair)

The Hon Dr A. Chesterfield-Evans
The Hon R. D. Dyer
The Hon D. F. Moppett
The Hon H. S. Tsang

CHAIR: I welcome the media and members of the public to this hearing of the General Purpose Standing Committee No 2 for its inquiry into the review of monitoring of the hospital quality of care and value for money in non-metropolitan hospitals. I advise that evidence given before the Committee and any document tendered may not yet have been tabled in Parliament and may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person. Copies of guidelines covering broadcasting procedures are available on the table by the door.

KARYN PATRICIA McPEAKE, Chief Executive Officer, Greater Murray Area Health Service, 63-65 Johnson Street, Wagga, affirmed and examined, and

JOSEPH GREGORY McGIRR, Director of Health Service Development, Greater Murray Area Health Service, 63 Johnson Street, Wagga, sworn and examined:

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms McPEAKE: I am.

Dr McGIRR: I am.

CHAIR: I just warn both of you that should you consider at any stage during the evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request. However, I have to warn you that the Parliament has the capacity to discover that information by vote of the House.

We are at the stage of the inquiry where we have had the Director-General and a number of experts come before us and bring us up to date on the nature of the inquiry, how we can best go about it, the information that the department has, and we have had a very good presentation from the Director-General and especially from Dr Tridgell.

We decided to have the chief executive officers in to make some sense for us of the yellow book and what it means and what it does not mean. We asked you to come along first as a bit of a guinea pig, because we are doing the other chief executive officers three at a time tomorrow, with the aim of producing a discussion document, which we will then distribute more widely, so that the community can comment on it. We did not think that it was worth while going to the community until we had some information on local areas which could be realistically commented upon.

Today the secretary has prepared a series of questions which we will put to you and to others and that may be a bit more free ranging and we may have to modify these questions before we go to the others and in fact one of the members may see some information coming from one chief executive which we may want you to comment on later. Would you be happy to take questions on notice?

Ms McPEAKE: I am happy to take questions on notice, yes.

CHAIR: Could you provide the Committee with data on measuring each hospital's performance measure against NSW Health Department's 64 quality of care indicators identified in Table 6a of its publication NSW Health Services Comparison Data Book (otherwise called "the Yellow Book") for the years 1995-1996 to 2000-2001. We recognise that the number of those indicators has increased since 1995-1996 and some of them may not have been adequate over all of those years.

Ms McPEAKE: My understanding is that the Director-General provided a response to the Committee in relation to the questions, outlining that the tables in the Yellow Book were not quality indicators but they were more measures of activity, staff and finance, with the 1998-99 report providing some evidence of quality of care indicators.

In relation to providing a response to the Committee what we had prepared to do was an overview of the position of the Greater Murray Area Health Service with some specific reference to some examples which relate to question five, which outlines particular areas of improvement that we have undertaken over the years, that can demonstrate to the Committee how we have translated some of that information into practice.

CHAIR: Are you going to do a presentation?

Ms McPEAKE: I am going to do an overview presentation for the Greater Murray Health Service and Dr McGirr will give a more detailed outline of the three examples which demonstrate how we have applied that information in practice and the sorts of areas that we have been able to improve. For the Committee's perspective we will be able to demonstrate how we had applied our information in terms of improving health services.

CHAIR: The Director-General has indicated that the 64 quality of care indicators in the Yellow Book are not quality indicators. Many of them in fact come into the value for money category, in other words, the costing category, so against the 64 indicators which are there, which very much involve the Committee, we will see if you can provide those, because although they are not primarily drawn up to be quality of care indicators, they do go to the issue of value and cost and they have some impact on quality, particularly later than 1995, perhaps 1998 onwards.

Is it possible to update on the Yellow Book for those years, for the 64 indicators? Some of us were not there in 1995-1996.

Ms McPEAKE: That is right. My understanding from the Director-General is that the 1999-2000 information will be out and available to the Committee in November.

CHAIR: That is 1999-2000?

Ms McPEAKE: Yes.

CHAIR: You will not have those until they are out?

Ms McPEAKE: That is right.

CHAIR: And the 2000-2001?

Ms McPEAKE: The department has not collected the information but some of the information in the presentation relates to up to date information in terms of patients treated and those sorts of things, so our presentation reflects current data.

CHAIR: We want to try to get to the basis of, if you like, what it costs to run a major hospital in places like Wagga, Albury, Tamworth, et cetera, and why there are differences in those costs between them, why, for example, waiting times in emergency departments might be longer at Tamworth or Wagga and the reasons for that. We are very much aware, for example, with mental health services, that it is essentially hard for Wagga to attract psychiatrists and therefore you would give an outline in terms of provisions of services, whether they are of quality or not of quality, just a straight out provision because of that difficulty.

Just looking at the base statistics does not give you the whole picture and we are trying to ensure we are aware of those differences in terms of the numbers. Perhaps if you do your presentation first and then we can ask you some questions following that. How long will the presentation take?

Ms McPEAKE: 10 to 15 minutes and if that is okay, we will go straight on to Dr McGirr to give the detail because that takes a bigger picture and translates it into what it means in practice, so we have an example of what we have done with some of our patient management care.

If we start by providing the Committee with an overview of the area health service, to put some context around it, our population is 256,000 people. This is 1996. Our major centres are Wagga, Griffith, Albury and Deniliquin.

Our Aboriginal Torres Strait Islander population at 2.3 per cent is slightly above the State average and our non-English speaking background population at four per cent is slightly below. We have some particular pockets of non-English speaking background population, particularly in the Griffith area.

CHAIR: Is that overseas born or non-English speaking background?

Ms McPEAKE: Non-English speaking background. Our services across the Greater Murray, we are one of the larger geographical areas in the State. We have major referral centres at Wagga Wagga Base Hospital and Albury and a further base hospital at Griffith and an affiliated health organisation, which is the Mercy Hospital Albury.

There are 22 other hospitals and three multi-purpose services across the area and community health services deliver from 38 locations across nine networks, so we have essentially divided our geography into nine sub-areas.

The Hon. RON DYER: The Mercy health service is a public hospital?

Ms McPEAKE: It is a public hospital, it is a third schedule hospital.

CHAIR: Does that mean it is run by somebody else?

Ms McPEAKE: It is run by the Sisters of Mercy.

CHAIR: Do you do much kid care there now?

Ms McPEAKE: No they are predominantly doing aged care and palliative care.

CHAIR: That used to be a maternity hospital.

Ms McPEAKE: Yes. In actual fact some of that relates to changes in flows for the area, which I will mention shortly. Activities in 2000-01, so we have actually got the more recent data in our presentation, 53,278 patients were admitted with over 674,782 outpatient occasions of service were provided across the area.

To give you an overview consistent with the Director-General's presentation, approximately every day 146 patients are admitted and 888 people spend the day in a hospital bed in the Greater Murray Area Health Service and every day more than 411 people on average are seen in our emergency departments across the area.

CHAIR: That is an update of the Yellow Book for that year?

Ms McPEAKE: That is an update, yes, for 2000-01.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those figures are not comparable to any of the charts though, are they?

Ms McPEAKE: These figures are 2000-01. Your Yellow Books are 1998-99.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The number 53,000 does not correspond because they are inpatient bed days here.

Ms McPEAKE: If that is your Yellow Book data that will be 1998-99 and this is 2000-01.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand what you are saying. It is a huge jump. In 1998-99 it was 45,000 and you have gone to 53,000. Is that bed days?

Ms McPEAKE: No, that is patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is an addition of some other component in this?

Ms McPEAKE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is no isolated component that corresponds to that in here? You cannot say that is number such-and-such.

Ms McPEAKE: I cannot. This relates to the total across the area and you have the data for one hospital and so we are actually providing the overview of the area and then we will go into the specific hospitals.

CHAIR: They are all done by hospital. For that you would have to add up Wagga, Albury and so on.

Ms McPEAKE: That is for all our hospitals.

CHAIR: Do you have them for the individual hospitals?

Ms McPEAKE: Yes.

CHAIR: That is what we need.

Ms McPEAKE: That is just about the next slide. Wagga Base Hospital has 41 admissions per day, 179 inpatient bed days per day and approximately 85 emergency presentations per day. That is 2000-01. Albury Base Hospital is 24 admissions per day, 120 inpatients. That will be an error there. I apologise for that. That is inpatient bed days and 65 emergency presentations per day.

These are an update of the figures that the Director-General provided you. That was as at March. These figures are an average over the whole financial year so there will be some variance obviously.

The Hon. RON DYER: Will you be presenting any statistics during this presentation about the average stay as an inpatient and the incidence of day surgery?

Ms McPEAKE: Yes, Dr McGirr will be doing that.

CHAIR: We need to know the number of inpatient separations for Wagga and so on.

Ms McPEAKE: That is in Dr McGirr's presentation. The area's budget, or the overview of the area's position, the initial cash budget allocation for 2001-02 is $197.2 million. That is consistent with the previous information that you have been given. There is a minor variation in terms of an adjustment. It is an increase of 5.1 per cent from 2000-01. In 1999-00, the resource distribution formula we were five per cent from. The three year budget period enables us to be within two per cent of the resource distribution formula across the area.

CHAIR: So when are you expecting it to be spot on?

Ms McPEAKE: My understanding from the Director-General is that a variance of within two per cent is considered to be an acceptable position with the resource distribution formula.

CHAIR: Two per cent is a lot of money.

Ms McPEAKE: Depending upon the positions of the different areas, yes.

CHAIR: Two per cent would be $4 million. You would rather be two per cent up than two per cent down, would you not?

Ms McPEAKE: My understanding is to get within two per cent of the RDF is the achievable position across the State.

The Hon. RON DYER: It is not a large statistical variation, I would have thought.

CHAIR: It is a lot of money though.

Ms McPEAKE: We have also moved from a variation.

CHAIR: You are not up on it, you are behind it?

Ms McPEAKE: No, we are up on it.

CHAIR: You are five per cent above?

Ms McPEAKE: My understanding is that we are five per cent.

CHAIR: You have been running deficits for years. You got forgiven $40 million worth of debt a couple of years ago.

Ms McPEAKE: I am not sure that is the actual figure.

CHAIR: It was a large amount of money of debt.

Ms McPEAKE: The Greater Murray Health Service had some issues with that with the department and those matters have been resolved and that is evidenced in our previous annual reports.

CHAIR: The Minister drew up the amounts for the $2 million increase in health funding and actually forgave debt up to 1998-99.

Ms McPEAKE: He did.

CHAIR: And Greater Murray was a substantial proportion of that $40 million worth of debt. I think it was $22 million or $21 million.

Ms McPEAKE: My understanding is it was around $13 million.

CHAIR: That gives you some perspective. Despite being over-funded on the population base, the greater Murray has been running deficits for years. They had a series of CEOs to prove it.

The Hon. HENRY TSANG: You are not suggesting this witness?

CHAIR: No. Ms McPeake was not part of it. That is historical background which we have discovered at other inquiries. You are still up. You are actually looking at a drop?

Ms McPEAKE: I think that you need to look at the context of the budget allocation in the sense that the amount of allocation to the area has continued to increase. The issues perhaps for other areas that have larger populations is their rate of increase would be greater, which is appropriate to their population. That is my understanding of it. We have had a consistent increase in our allocation. That is the three year budget.

The episode funding, we thought we would make some comments. That is the mechanism by which we internally allocate the funds to our base hospitals. Our view on that is it would allow the managers to better understand the links between funding and activities. It allows the managers and clinicians to examine the quality of care and value for money issues, such as length of stay, which is mentioned in the information that you have, and it enhances the ability for peer group comparisons as well, so it enables some discussion about why there should be variations in those patterns.

We come to cross-border flows, in flows. You may be aware from the previous Director-General's presentation that he mentioned the areas having the fund holding for all of its population and we are located on the Victoria border so the influence is patients travelling to Victoria.

We have had an increase of 11 per cent from Victorian patients across that four year period but also had a significant outflow increase. To put that into context, I notice that the chair made the comment about the obstetric services at the Mercy in Albury.

In 1998-99 we transferred the services from the Mercy to Wodonga Hospital so that we actually had a large referral centre which now has approximately 1500 births, and is a major obstetric service outside the metropolitan service. That was a deliberate planning decision that we made and we have made a number of those in trying to work out the best way to provide services to a population. That is about providing services the most appropriate way.

The majority of that increase over that period of time is in fact the transfer of obstetrics.

The Hon. RON DYER: What are the funding arrangements regarding Wodonga Hospital?

Ms McPEAKE: In terms of the transfer of obstetrics?

The Hon. RON DYER: As between the New South Wales and Victoria Governments.

Ms McPEAKE: The New South Wales and Victoria agreement is that New South Wales pays on a case weighted inpatient payment basis for its patients that are treated in Victoria and in fact with the obstetric service, the Greater Murray Health Service is directly involved in that process and that is part of the Director-General setting up that fund holding over a period of time. He made a deliberate decision that those funds are specifically allocated for providing those services in Wodonga to the people of Albury and Wodonga.

CHAIR: Do you pay the same rate that the Victorian Government allows for the treatment of Victorian patients in the Wodonga Hospital?

Ms McPEAKE: We pay the agreed rate between New South Wales and Victoria. I could not directly comment on exactly what the Victorian Government directly pays Wodonga Hospital. We pay Victoria. We do not pay the Wodonga Hospital.

CHAIR: They have been on case mix for some years?

Ms McPEAKE: They have.

CHAIR: Let us say the funding gets so many dollars. I was wondering whether we are paying the same as the Victorian Government pays the hospital to provide for the Victorian patients.

Ms McPEAKE: I do not exactly know that.

CHAIR: Is it possible to find out?

Ms McPEAKE: It is possible to find out.

CHAIR: If it is close.

Ms McPEAKE: Yes.

The Hon. DOUG MOPPETT: That is all done at the departmental level.

Ms McPEAKE: That is correct.

The Hon. DOUG MOPPETT: You do not receive the cheque and you do not pay the cheque.

Ms McPEAKE: No.

CHAIR: When will you do that? That is happening very soon, is it not?

Ms McPEAKE: We hold the funds. Specifically in obstetrics there is an adjustment made to our financial allocation to the Victorians and as to the flows issue, we fund hold more sophisticated over a period of time and in fact that process will continue and I would hope that there will be some agreements reached about how that can occur.

Clearly in the case of obstetrics we reached agreement at a regional level and a departmental level that the transfer should occur, the service planning principles. The money then flowed secondarily based on the agreement that already existed between the two States. That is the process.

There were also some other changes but that is a significant one there as well. Wodonga has some of the renal dialysis services for Albury Wodonga as well, so the number of patients has increased over a period of time and they are treated in Wodonga. Those two categories of DRGs, that is, the obstetrics and the renal dialysis, occupy the majority of the changes in the flows.

There were some others further out west, where patients from the more western area travelled to Shepparton, rather than across to Albury, but that is the majority of the change of flow over the period of time.

The Hon. RON DYER: Is there any specialty located in Albury to which Victorian patients have access?

Ms McPEAKE: There are a number. Albury Base Hospital works as a major trauma centre for the north east of Victoria and particularly when you look at accident and emergency, it is the major admission hospital for Albury Wodonga.

I just bring to the Committee's attention that we have done a considerable amount of work in Albury Wodonga in terms of trying to provide those services as one health service across two campuses and that is around trying to make the services work better for the population.

CHAIR: Was that resolved at the two Premiers meeting about not having a border?

Ms McPEAKE: That is right, and the two Health Ministers have the same agreement.

CHAIR: Have you any idea of the flavour of that agreement?

Ms McPEAKE: The flavour of the agreement, we have been involved in the process. The two Ministers have agreed that a contractual arrangement will proceed between New South Wales and Victoria in terms of the provision of management of those services, commencing next year, so that will start to provide another level of getting those services integrated.

It is very clear when you look at the activity, that they operate essentially as two campuses of one hospital. Albury Base is the high level tertiary type hospital work and Wodonga does a great deal more of the day surgery, lower level work, and the obstetrics.

CHAIR: What is the quality of the infrastructure of Wodonga and is it possible over time to move all of the Wodonga to the Albury site?

Ms McPEAKE: The quality of the infrastructure in the two hospitals is excellent. This is just a comment about metropolitan flows, one of the things that we had to look at when looking at the best way to provide services is the level of, high level that is, tertiary type work, open heart surgery, those sorts of things, and emergency work done outside our area.

Whilst I do not have recent figures, I have 1996 figures for the area as a whole. We looked at Albury Wodonga recently in this process and we are treating somewhere between 85 to 88 per cent of the people from our area, in our area, so in terms of whether the work we are doing is appropriate we are able to demonstrate that it is, therefore the flows going to Sydney or Melbourne are appropriate for that to continue, because we are not offering the high level such as transplant services in Albury Wodonga.

CHAIR: Would that be consistent across all non-metropolitan areas? Is that a figure we can work on? That is a 1996 figure.

Ms McPEAKE: That is our figure for our area. I am not sure what the figures for the other areas are.

CHAIR: They would have a pretty good grasp on that too, because that would be an interesting figure to see whether, for example, Tamworth has the same figure to Newcastle and Lismore to Brisbane.

Ms McPEAKE: That is correct. It is 85 to 88 per cent.

CHAIR: You are talking about hospital admissions?

Ms McPEAKE: People from Greater Murray are actually done in Greater Murray Health Service.

CHAIR: Does that include other occasions of service, for example, an MRI or CT scan?

Ms McPEAKE: It does not include, to my knowledge, the outpatient. It will not include outpatient type services.

CHAIR: If an outpatient goes from your area to Westmead to have an MRI that is not included, it will only be hospital admissions?

Ms McPEAKE: It is hospital admissions only. I take your point. You would pick up if, for example, we did not have an MRI and had to send 5,000 people to Sydney for an MRI, you would pick that up because they would be an inpatient at Wagga Base and transferred to Westmead, and you would say why have you got 5,000 transfers and they would pick that up.

CHAIR: Sometimes a patient would be admitted to you and then admitted to Wagga. How do you count those?

Ms McPEAKE: If they are admitted to us in our public hospitals in Wagga and then transferred to Westmead, the department collects that data on where the patients at Westmead come from and gives it back to us.

CHAIR: Although 85 per cent of admissions would include the persons admitted to Wagga first, then that could be counted twice.

Ms McPEAKE: That will be counted, yes.

CHAIR: You can say 85 per cent of all of the hospital admissions from your area are treated in our area.

Ms McPEAKE: That is correct.

CHAIR: In other words your keep at home is 85.

Ms McPEAKE: That is correct, 85 to 88, and it is probably time for us. We reviewed those figures in Albury Wodonga because of the work we were doing and that gave us about 88 per cent.

CHAIR: You would include Wodonga in that, the 85, as being a local thing?

Ms McPEAKE: No, we cannot.

CHAIR: The others might be much higher, obstetrics particularly and renal?

Ms McPEAKE: That is right.

Dr McGIRR: The service planning report just conducted as part of the cross border initiative calculated a self sufficiency for Albury Wodonga.

Ms McPEAKE: My apologies.

Dr McGIRR: That figure was approximately 88.

CHAIR: That is an important figure.

Ms McPEAKE: That was looking at what services you can provide locally. The other comment there was that there are now some services in the area for which patients previously had to travel out and another example of that in Wodonga is that there is a radio therapy service that was not there previously, say four or five years ago, so some of the services are being provided.

CHAIR: Wagga has radio therapy now.

Ms McPEAKE: Wagga is about to have a radio therapy service.

CHAIR: That will change it again?

Ms McPEAKE: Yes. That will change those flows to the greater metropolitan area. We move on to consumer and community participation and how we undertake that as part of that quality process. We have nine health councils and five multi-purpose service committees. We just outline briefly some consultation processes; health councils and MPS committees report directly to the board. We have forums, which we hold a couple of times a year; newsletters, board, chair and CEO newsletters and the delegated board contact person so there are links between the board and the communities.

We also use and involve the local communities in any development work we are doing locally. We give you some examples there. At Hay Hospital we have the local steering committee, Berrigan aged care committee and Griffith health services committee. If we are looking at services in any particular area we involve communities in that process.

CHAIR: There are groups of clinicians, the community and members of the bureaucracy?

Ms McPEAKE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the people happy with those? There was some friction previously, was there not?

Ms McPEAKE: I think it depends upon what they view their role in that community as and what you are setting it up to do. We have done a great deal of work in working with our communities and trying to work in with our clinicians so we are trying to focus on them being development committees and positive. They are actually there to serve a purpose.

For the Hay Hospital steering committee that is a redevelopment of the hospital and we involve people in that process. The same with Berrigan aged care, what is the direction of services there and they are involved in that. That has worked a lot better in my view than how it worked say four or five years ago.

The Hon. RON DYER: Hay, Griffith and Deniliquin are all hospitals within your area of service?

Ms McPEAKE: Yes, they are.

CHAIR: There are more.

Ms McPEAKE: There are 29 all up.

CHAIR: Is the other little one open now, the one at Temora?

Ms McPEAKE: Temora is not one of the littlest ones.

CHAIR: What is the other one that had only one doctor and not many beds and only one patient?

Ms McPEAKE: Jerilderie, which is actually currently closed for redevelopment.

CHAIR: That is the one that had one patient in it.

Ms McPEAKE: It will be an MPS. To move on, consumer and community participation. Some of the work that we are doing, we have developed, this is just an example, some of the community participation, through the area health plan we have forums across every network. The nurse refresher program and network is an example where the community actually undertook to do a great deal of publicity locally to get nurses back in the workforce and as a result of that we ran a specific refresher program in a very small geographical area. These are places like Lockhart, Henty and Holbrook, the community consultation through a multi-purpose unit, small hospital redevelopment program. We have got mental health consumers, advisory groups and we have just established a web site for consumers as well.

The other examples of consumers' involvement in the Area Health Service include our area quality council, a priority health care steering committee, asthma, diabetes palliative care steering committees. They are the quality care program, complaints management committee and aged care advisory committee. So we have started over the years to increase the levels of consumer participation.

CHAIR: Are these affecting the various health councils at a State level?

Ms McPEAKE: I am not sure.

CHAIR: The Minister has established a series of health councils.

Ms McPEAKE: Yes.

CHAIR: Are these reflective of those health councils?

Ms McPEAKE: These were originally established -

CHAIR: Consultative groups or whatever they are called.

Ms McPEAKE: Yes, they are consultative groups that are community based on our network. We already had them in place. They have actually got more sophisticated over a period of time.

Some of our recruitment strategies around health professionals, just to outline some of the strategies that we have specifically undertaken, professional development, special education, clinical education programs. Basically that outlines some of the recruitment strategies that we have put in place for health professionals. They range from financial support for professional development to specific courses for role nurses, a refresher program for nurses and extended graduate programs in specialty areas.

In the medical workforce we have 18 of 20 area of need positions filled across the area, mostly for general practitioners. We also have a partnership approach with the divisions of general practice to recruit medical practitioners to the region. Just for the Committee's information, our smaller hospitals rely on the general practitioners predominantly. We also have a network of fly in, drive in services from metropolitan and regional centres to areas across Greater Murray, and that includes, for example, psychiatry services at Wagga which are provided from Sydney, services to Griffith, some of which are provided from Albury and Wagga and from Sydney.

CHAIR: The other health professionals workforce, do you get much advantage out of Wagga being the centre for the clinical school?

Ms McPEAKE: The clinical school development, which has just been in place for a couple of years, has enhanced and developed the region quite strongly and has been indirectly responsible for a number of practitioners coming to the area because it is about providing professional support and development opportunities for clinicians, and medical clinicians particularly.

CHAIR: You would be the only one of those currently operating?

Ms McPEAKE: We are.

CHAIR: There are a number that the Commonwealth are setting up.

Ms McPEAKE: That is right.

CHAIR: So that you are advantaged in terms of attracting a senior lecturer in surgery which, for example, would not be present in Tamworth?

Ms McPEAKE: That is right.

The Hon. RON DYER: Is psychiatry the only specialty where you have to fly in the practitioner?

Ms McPEAKE: The psychiatry service at Wagga is fully a fly in service. There is no resident psychiatrist in Wagga and has not been for ten years. Part of what we are trying to do with the clinical school is where we have particular gaps in our service, we try to encourage recruitment of those particular specialties to our geographical area, although phsychiatrists are pretty thin on the ground outside the metropolitan area anyway.

CHAIR: An academic posting is a very good come-on, is it not?

Ms McPEAKE: That is right, and we are just in the process of recruiting with the clinical school at the moment so we are hopeful we will get some assistance.

The Hon. DOUG MOPPETT: The question was are there any other disciplines?

Ms McPEAKE: Are there any other disciplines that we entirely fly in?

Dr McGIRR: We do fly in locum relief in obstetrics, drives in actually, but the same principle.

CHAIR: That is for Wagga?

Ms McPEAKE: Yes.

The Hon. DOUG MOPPETT: And anaesthetists?

Ms McPEAKE: Anaesthetists is actually the other one that we are currently -

CHAIR: Anaesthetics are a particular problem. Wagga is like the centre and the thrust of the dispute, is it not, currently?

Ms McPEAKE: Wagga appears to be the focus of some issues. If we just move on to the allied health workforce, issues affecting recruitment. These are very broad and general and you are probably aware of those, things around professional isolation and geographical isolation, some of the strategies that we have put in place there.

CHAIR: Is Wagga in a worse position than other major non-metropolitans or a better position?

Ms McPEAKE: It is probably hard. It depends -

CHAIR: In terms of the workforce isolation, professional isolation and they are the two matters you raise.

Ms McPEAKE: In allied health, in our experience what tends to happen is if you can get a critical mass of people you tend to get a larger critical mass. If for some reason you have, which we have just had recently in Wagga, a flow-through, because people are not staying, they stay for two to five years and then move on, if you have a number of them leave all of a sudden, which is one case we had with anaesthetists and recently we had with physiotherapists, it then takes you a long time to get that critical mass back up.

CHAIR: It means if you have got a critical mass, recruitment is easy?

Ms McPEAKE: That it is easier.

The Hon. RON DYER: Why are we talking about Wagga and not Albury, is there any difference?

Ms McPEAKE: The difference in these specific issues is Albury's critical mass for some of those clinicians. For example psychiatrists, Albury has always had somewhere between two to four psychiatrists. In terms of physiotherapists, Albury has always more of a proximity to Melbourne. It is the history more than anything else.

CHAIR: Both of them have got big army bases.

Ms McPEAKE: That is right.

CHAIR: But the army base at Wagga has more recruits, whereas the army base at Albury has more wives and partners who are professionals. They are very different.

Ms McPEAKE: Yes. Some of the things that we have actually undertaken in the allied health workforce is specifically looking at joint positions across a number of sites. We have got joint positions now in place with the universities, collaborations with the divisions of general practice, where we have done joint appointments with the More Allied Health Services Commonwealth program, so we have done joint appointments rather than us all being in competition with each other for staff, so staff have the opportunity to work in a number of different forums, and we provide support for staff across a number of sites as well.

The particular areas of interest Joe will go through in detail, so the next three or four slides I will just run through briefly, because Joe will go through the detail of Albury and Wagga base hospitals.

Acute care day of surgery rates - this is across the area target, Joe will do the Wagga and Albury base hospitals specifically - 84 to 80 per cent was the target for 2000-2001 and we achieved a day of surgery rate of 84 per cent. Our day only surgery rate was 64 per cent, whereas it was a 60 per cent target. Where we looked at some variations of length of stay for the top 20 admissions, all acute care sites were provided with the data on that about what is happening with their local site. They develop action plans to address the variances. What we have done with some of this data is that we have a system where each hospital has what we call a performance agreement with the area, where a number of these indicators are directly translated to their performance agreement with us and that is then monitored monthly or quarterly depending upon the site. Therefore, the site has the information in order to address those issues, particularly with areas such as length of stay.

Acute care has introduced things like clinical pathways and there are some examples there in heart attacks, obstetrics, general surgery and asthma, discharge planning processes where we have got some targets set by the Department of Health and a booked admissions working party implemented across the area that looks at treatment of patients through the hospitals.

I will briefly outline aged care services. Currently we have at any one time somewhere around 183 to 200 nursing home patients in hospital beds. The nursing home placement waiting time is an average of 3.1 months and a maximum of 5.8. It has an impact, particularly on the base hospital, of decreasing the availability of base hospital beds.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why is the placement time out? Why do the nursing home placements decrease availability of the hospital beds? To put it the other way around, if you decrease the availability of hospital beds you increase the nursing home placements. Are you talking about lost beds of people who cannot leave hospital?

Ms McPEAKE: That is correct.

CHAIR: If you walk around Wagga hospital and Albury hospital, you will find empty beds everywhere. What you mean is beds that have got nurses available to treat people in.

Ms McPEAKE: That is right.

CHAIR: And you have to have the funding for them. There are plenty of beds in your hospitals but you have to actually allocate funding for nursing.

Ms McPEAKE: That is right, and if you have a nursing home patient in a bed, that means you are not treating an acute care patient basically, and that has impacted on the base hospitals more so than the smaller hospitals because they are doing the higher level acute care work.

The quality initiatives - just briefly because Joe will provide more detail - we have a quality council across the area. We have adopted and worked with the Australian Quality Council with their business excellence framework on a process for developing quality care indicators. That is just very briefly, because Joe will provide the detailed information.

Some monitoring and compliance things that we do are day of surgery admission rates, daily surgery rates, critical incidents, and on improving quality and value for money we have a clinical review process which includes clinicians involvement in that. Joe will just go on to the three areas. The three areas we will be covering will be quality in the area, the book patient management at Wagga Base Hospital and some corporate reforms that we have done that have improved our performance as well, and they have directly translated out of some of the indicators.

Dr McGIRR: The first presentation will follow on from the last two slides of Karyn's presentation and elaborate on how Greater Murray is currently proposing to implement the quality framework for New South Wales Health.

The next presentations will deal with two examples of how we have undertaken initiatives to improve management to deliver better quality of value for money. One of those will deal with the corporate area and one will deal with patient admission and surgery at Wagga Base.

My first presentation will cover three areas: the governance and reporting in relation to quality; the performance framework, brief reference to that; and then an outline of the plan of work that the quality council are overseeing in relation to developing quality.

In relation to governance reporting, the quality council had been establish as a subcommittee of the board, chaired by the board chair, with active board involvement. Its membership is quite wide-ranging and involves both consumers and medical officers as well as administration officials and representatives of the board.

There is a range of committees that report to the council and this process is being refined, but at the moment the area nursing council which has been established at the base hospital report their quality processes to the committee. We have established clinical standards committees and clinical review processes in a number of sites with clinicians, which is a new initiative, but an exciting one.

There is also reporting of occupational health and safety indicators to control standards, as well as specific projects related to process improvement and minutes and recommendations of that committee go to the board.

The performance framework that we have adopted is the performance framework outlined in the New South Wales health document relating to quality and that, as the Committee is aware from the material that has been presented, describes six dimensions of quality and five cross-dimensions.

The six dimensions of quality, there is a range of indicators being developed to link with those which will be collected by the health services and developed over time. The five cross dimensions, as I understand them, are areas for development and we have linked our plan to those five areas, to build a system of quality and I will now talk about that.

There are five areas of competence which we have linked to our processes of improving clinical review, information management, continuity of care, which we have linked to our processes of consumer participation, education training and accreditation. I will address each of those individually.

In relation to improving competence, particularly in relation to teams, we have a number of initiatives. We have a couple of hospitals where we have engaged a process of clinical review, where the director of clinical services actually has undertaken a review of patient outcomes with the clinicians at those sites.

The nursing council has been established. Griffith Base Hospital has established a clinical standards committee which consists of the representatives of the medical staff, which review all deaths that occur in that hospital and critical incidents. That meets on a two monthly basis.

We have established a maternity services committee, the role of which is to review issues in relation to the provision of maternity services across hospitals providing those services in the northern part of the area. We have also a program of visiting speakers to meet and work with clinicians and managers and recently had Dr Ross Wilson visit and address clinicians in both Albury and Wagga in relation to the New South Wales framework and undertake discussions with the quality council.

We have also sponsored clinical practice improvement projects, one relating to pressure ulcers, where the work done by our quality manager has been recognised in a statewide initiative, and another project.

In relation to information management, the second of those cross-indicators, the phase one indicator workshop which New South Wales Health has held with area health services was held in our area on 24 September. That is their first process of developing these clinical indicators to link with the six dimensions of quality, so that the area will adopt a reporting framework around those. Examples of those would be the day only targets being reported by site and critical incidents reported to the board.

In relation to the issue of continuity of care, the area has established, under the chronic and complex care projects, three projects to better link the disparate parts of the services in relation to asthma, Aboriginal diabetes and palliative care. An example is the asthma project which is a project where we are employing people who will coordinate the care of people who present on frequent occasions to base hospitals with asthma, the idea being with their representation, people may present three or four times with one condition. They are admitted, treated, discharged and there is no follow up planning with their GP or community health, because parts of the system do not talk to each other. That project is about establishing a mechanism whereby those parts do link, so that once a person has presented to hospital, they are appropriately discharged and followed up with a plan that will clearly prevent them from re-presenting. This is about coordinating care across different parts of the system.

The consumer input was outlined in some detail in Karyn's presentation. It is a critical part of this part of our presentation. There are eight consumer representatives on the quality council. We have had a recent example of consumer input into quality care in the Albury Wodonga region where the health council of consumers in that network identified a problem in relation to the follow-up of obstetric services for patients from Wodonga. They provided a report to the board from a consumer perspective, which was an interesting perspective, given the range of providers and as a result of that, a cross-border process for review of that has been established involving consumers and that is operating successfully.

The Hon. RON DYER: When you say a problem regarding patients from Wodonga, you mean patients from Wodonga or Albury who access that service provided at Wodonga Hospital?

Dr McGIRR: The council received a number of concerns from residents of Albury about follow up care provided from the Wodonga service and brought that to our attention and it was really an issue about the different service providers not communicating, so Wodonga was providing the obstetric care but there were antenatal and postnatal care provided by the Mercy and Albury community health. The providers in each of those services believed

their services operated perfectly. The value of the consumer input is that it actually sees the continuum, antenatal, natal, postnatal and can tell you where the gaps are.

In terms of education and training, we have undertaken training for our managers in the Australian Business Excellence framework. That is a program related to the Australian Quality Council process that I will talk about in the section on accreditation.

We have sponsored a number of clinicians through the Department of Health clinical practice improvement workshops and we have plans for locally based clinical practice improvement training. The clinical practice improvement training is quite detailed. It is a week long course. It requires quite a commitment from clinicians and we believe from talking to the department that there is an opportunity for a briefer version of that training to go to a wider group of people at an area level.

CHAIR: They do not learn how to cut better, they learn how to administer better.

Dr McGIRR: The clinical practice improvement workshops are about training clinicians to, I believe, review how they work and operate, both on an individual basis and from a system point of view and, in particular, to identify variation in practice and then to think about why that variation would occur and how it can be improved.

CHAIR: Can you give me one quick example?

Dr McGIRR: You might look at the rate of hysterectomy, for example, that is being conducted. There could be multiple reasons for variations in relation to that.

CHAIR: This is the Tridgell stuff?

Dr McGIRR: Yes. That is connected to the implementation of the clinical indicators that are linked to the dimensions of quality. In addition we have had quite significant training in occupational health and safety for our staff.

Finally in this section is accreditation. We have formed a partnership with the Australian Quality Council and that has involved training in the business excellence framework but it has also involved the implementation of a guided self-assessment across the organisation, conducted in March this year. It involved focus groups with 270 staff and detailed questionnaires assessing aspects of organisational performance and the results of that survey, which have been made available to staff, have provided us with a platform for organisational improvement. A number of actions have arisen from that that have been incorporated into the area health plan.

CHAIR: So both Wagga and Albury have three year accreditation under the Australian Council of Health Care Standards?

Dr McGIRR: They are not accredited under the ACHS.

CHAIR: If I say 9,000 -

Dr McGIRR: No.

CHAIR: So you have not got accreditation, the standard, what people would normally talk about accreditation, you have not got it.

Ms McPEAKE: We are utilising the Australian Quality Council and their business excellence framework for our process for assessing quality across the area.

CHAIR: That is part of the questions we are going to ask today. What is the status of Albury and Wagga, your hospitals that we are looking at, particularly in terms of accreditation? That would appear to be the Australian Council of Health Care Standards accreditation. You are not part of that?

Ms McPEAKE: No, we are not part of that.

CHAIR: Is not that part of your agreement with the department, that you be accredited by the ACHS?

Ms McPEAKE: Our agreement with the department is our participation with the Australian Quality Council, the business excellence framework.

CHAIR: Does that cover the same stuff as ACHS covers or ISO 9000?

Ms McPEAKE: It covers a system of the way in which you go about your business.

Dr McGIRR: The Australian Quality Council has a quality framework which they have developed initially outside health, but now applies to health and addresses the same issues, as I understand it of the ACHS.

CHAIR: Is it as rigorous and effective from a community reliance point of view as ACHS or ISO 9000?

Ms McPEAKE: I think there is a level of debate about what is the most appropriate accreditation process, so part of our approach in negotiation with the department has been that we will tackle this approach and negotiate that with them on an ongoing basis. I think there is a varying degree of opinion about what is the most appropriate accreditation process.

In Paul Tridgell's presentation about the critical indicators, I understand that there are a number of indicators that the ACHS have been working on as well. Now in terms of how those specific indicators will apply to us, and we will have to report against them, we have no problem with doing that because they relate to specific areas of information that they have gathered.

As I said, there still remains some debate about what is the most appropriate accreditation process.

CHAIR: The reason for ACHS or ISO 9000 is that was a way that New South Wales Health had of displaying to the community an independent judgment of whether or not the hospital met certain standards. If you are going to the Australian Quality Council and business excellence framework, is that as rigorous and is that able to be seen by the community as the same as ISO 9000 or ACHS accreditation in terms of the department being able to say to the committee, we have had our hospitals looked at externally and they have come up trumps?

The Hon. RON DYER: I understood Ms McPeake to respond to an identical question a short time ago by saying there is a degree of debate about the systems.

Ms McPEAKE: Could I refer the Committee to a recent article from Kathy Eagar in the Australian Health Care Review which specifically talks about that issue of accreditation and about those indicators and some concerns specifically expressed about what degree a community would view in that accreditation process, so I reiterate my previous comments.

CHAIR: Have you got a copy of that?

Ms McPEAKE: Yes, I have actually brought with it me.

Dr McGIRR: That is the conclusion of our presentation about our implementation of the quality framework. I now move on quickly to a presentation of corporate, relating to some changes in corporate structure in which management changes have been linked to improving quality and value for money.

The materials management business unit was established in the Greater Murray Area Health Service in 1997 and this presentation is going to just briefly outline how the restructure was able to improve value for money but at the same time improve quality as well, so the two were actually linked. That was improved through centralisation of warehousing and streamlined ordering processes, but at the same time the employment of a clinical products co-ordinator and clinical input into product line decisions was an initiative designed to improve quality.

In terms of the centralisation, when Greater Murray began there were seven warehouses across the Greater Murray, with separate inventories for these separate components.

CHAIR: It sounds like you are running a factory here. Calling a theatre a warehouse, is this a warehouse in business terms, is it?

The Hon. RON DYER: Are not you talking about consumables for use in the hospital?

Ms McPEAKE: We are. We are talking about consumables.

CHAIR: These are actually warehouses, stockpiles, stock rooms?

Ms McPEAKE: This is our stock, yes, our supplies.

Dr McGIRR: The consumables. They are located both in warehouses and the theatres as well. There are separate stock locations.

Ms McPEAKE: If you are looking at a system approach as to how you operate your business, and that is an issue from a quality perspective, particularly it sorts how much equipment you have. When we looked at what was being used for prosthetics for example, the number of different pieces of equipment that were being used across the area was quite variable, so what we have been able to do is have the clinicians sit down with us to say what sort of equipment are we going to use, get some agreement on that so that everybody is using the same sorts of equipment, same sorts of prostheses. Not only does that give us better confidence in terms of following up what is going on with those particular prostheses, but being able to train our staff in that. That is an example of some of the work that we have done in that area.

Dr McGIRR: In terms of the restructure, the amalgamation of various units and increased buying power across the area with centralised purchasing for the 29 hospitals and 38 community health centres was able to deliver improved value for money. At the same time, the employment of a products manager and the focus of clinician involvement in issues relating to purchase of stock meant that there could be a standardisation that was accepted of lines across the service. One of the advantages of that is that it reduces a source of variation, so that instead of particular intravenous tubing being used in one hospital, a different one in another and a different one in a third hospital, having the same meant that the potential of following up for problems and training was much greater.

The Hon. RON DYER: You are referring to this on an area basis not a state-wide basis?

Ms McPEAKE: Yes, area basis, that is right.

The Hon. RON DYER: Are hospital consumables procured on an area basis or statewide?

Ms McPEAKE: There are statewide contracts for consumables as well, which we participate in and there is also a statewide peak purchasing council process which has been put in place also. We are part of that and have been seen as leading some of that because of the work that we have done in terms of streamlining some of those processes.

Whilst for some people it may not seem like a great issue but for the nurse at Deniliquin, or Griffith, or Albury, or Wagga Base Hospital who are in the theatre, if we are trying to track what is happening with a particular piece of equipment, or intravenous fluid, or there are particular issues for us, it is much more support for them if they know (a) where it has come from, (b) that there is consistency, (c) that they can get backup if they need it. All that sort of process is important and stops errors as well.

CHAIR: They do not need to go through their stock to throw out the stuff that has gone out of date because nobody has used it?

Ms McPEAKE: There are issues around that as well.

Dr McGIRR: That is referred to in the second point about redeploying the surplus stock, having it managed centrally, as well a system for direct pharmacy electronic ordering.

CHAIR: That pharmacy ordering, are you still using that Department of Health system? What is it called? The system for ordering stuff.

Ms McPEAKE: I could not tell you off the top of my head.

CHAIR: The one that people got in trouble with at Canterbury Hospital? It does not matter.

Ms McPEAKE: I could not tell you. It is a very good tracking system in terms of direct ordering and it has been much better for us to be able to follow up what is what happening with our pharmacy and our drugs.

Dr McGIRR: This is talking about further quality initiatives that the materials management unit are undertaking and the development of a centralised service with its clinical links to clinicians has been a process that can deliver value for money as well as improved quality of care.

An example of that would be the prosthetic tender that we have recently undertaken for orthopedic hip and joint replacements, where we were able to get Albury and Wagga Base Hospital to agree on the type of prostheses that they would use. That meant that we could go to tender to reduce the price for that.

Dr McGIRR: Just to follow up on that example, not only was the area able to negotiate a better price through tender for those pieces of equipment, but it also meant that the staff in theatres were not managing multiple stock lines with multiple consignments and multiple sets of operating theatre equipment. It reduced hence the potential for error associated with each of those and I think has been well received by them. It is a good example of the link between good quality and value for money.

The final presentation relates to some changes in relation to the way admissions and theatre have been handled at Wagga Base Hospital since participation in the National Hospitals Demonstration Project which began in 1995 but which has continued to develop at that hospital and has meant that the hospital has been able to perform at improved levels. What I will just do in this talk is describe some of the changes that have been implemented and some of the results from that.

Ms McPEAKE: And this is reflected in the issues around things like length of stay being reduced.

Dr McGIRR: And at the end I have some data, I have some graphs in relation to current separations.

Ms McPEAKE: At Albury and Wagga.

Dr McGIRR: The first part of the reform process began with changes to the admission booking form which meant that arrangements were made for people to have blood tests done before they came into hospital, that plans were made for their discharge prior to them coming into hospital, so time was not wasted while people spent time in hospital waiting for those things to be organised. It also enabled people with specific problems to be identified prior to admission because their pre-admission forms had a list of questions where you could tick if you had a particular problem and they were reviewed by a nurse and anaesthetist, and consent forms were also filled out by the surgeons in their rooms and not done by junior medical staff in the hospital.

The next development was to develop a set of pre-admission clinics, particularly in relation to paediatric patients and patients having joint replacements, so that instead of waiting for people to come into hospital and then discovering they have a range of medical illnesses and needed to have blood taken for transfusion, equipment needed to be ordered, that that could all be planned well in advance by them attending a clinic at which there was the orthopaedic team representative, as well as the anaesthetist and discharge planners and physiotherapist who would be undertaking the post-op follow-up. For paediatric patients such a clinic also provides them with a shorter length of stay in hospital and reassurance about the hospital program. We also, because of the nature of our area, the fact that half the population assessed in the base hospitals comes from quite a considerable distance away, have involved general practitioners in assessment prior to them coming into hospital.

CHAIR: Do you pay for that or does the Commonwealth?

Dr McGIRR: I am not certain of the current arrangements. Under the NBHP program there was an arrangement, it may have been as a special allocation, it may have been a pre-admission test.

Currently, Wagga base has established more formally at anaesthetics clinics with participation of VMO anaethetists an ambulatory care program which has expanded the role of care for people who are post-operative of orthopaedics and cardiac rehabilitation for example, but also a venesection clinic, so that tests can be performed on discharge and prior to coming into hospital, as well as providing an avenue for the initiative I mentioned earlier in relation to co-ordination of care and continuity of care for patients outside the clinic.

The Hon. RON DYER: I am sorry, I do not know what the term venesection means.

CHAIR: Taking blood from a vein.

Dr McGIRR: I apologise for that. If you look at the annual throughput per bed at Wagga Base Hospital over the period under review and the period through which those changes have occurred it is pretty clear from this trend line that there has been substantial improvement in that, and a substantial improvement in our average length of stay. There is an example of a situation where we have also been able to improve our same day surgical separation rates from between 40 and 50 to in excess of 50 per cent, and currently we have reached 59 per cent in that area at Wagga base. Those changes that I have described are a result of the initiatives put in place to improve the quality of care and value for money, and that is a graph describing the per centage of separations that are same day separations.

CHAIR: The question I was going to ask is are they going home quicker but sicker? In other words, you can look at the financial basis, as you would look at it from an area health service point of view, but in terms of the costs for the patient in terms of follow-up care by the GP or community health services or by physiotherapists, they have got to still do that, community nursing and whatever.

Ms McPEAKE: One of the issues I noticed in Paul Tridgell's presentation in the information that was presented to us is the information around re-admission rates is one indicator about what is happening with people as well. So they are the things that you need to monitor to make sure that if there is any trend in terms of people getting sicker, that you actually have that.

Dr McGIRR: I guess the comment I would make would be that the advantage of the approach I have just described at Wagga base, so that there was not simply an edict to discharge people early, there was a process whereby there was a focus on the quality of care that people were receiving, meant that you could reduce the length of stay and come to grips with some of the problems you have described, but the focus was on ensuring that people were prepared for hospital admission and that problems likely to impact on their discharge were identified early so that support processes can be put in place to enable their timely discharge, not sicker, and into circumstances where they could cope. So by focussing on the quality of care being provided, rather than simply focusing on length of stay as a financial measure, we are actually able to improve or in a sense address both issues.

The Hon. RON DYER: I am sure that in appropriate cases there are very good reasons for day surgery, such as the avoidance of cross-infection in hospitals.

Dr McGIRR: Absolutely.

Ms McPEAKE: And it is clear generally speaking from the information that the less time you actually spend in hospital, the sooner you can get people home, it is better from their health perspective.

CHAIR: At least you would be able to see that in the Yellow Book's figures on infection rates and re-admission rates.

Ms McPEAKE: That is right.

CHAIR: And as you see re-admission rates falling and same day surgery increasing, that will show an increase in quality. The reason for saying that is that we really do want these questions answered. We do need to have those questions answered. I really appreciate your presentations because it gives a good feel for really 6 and 5 and I think that is really commendable, and you have got a very different area from most other areas. Your Albury is a bit more like Tweed Heads and your Wagga is more like Tamworth. Could I ask one further question about flows? Have you seen any flows to the Sydney area?

Ms McPEAKE: I would have to find that out. I am not aware of that off the top of my head.

CHAIR: They said they were going to provide a catch-up and a service of excellence. If you go to have your knee done, sure there are all these experts to do it but unfortunately it gets paid for by the area health service from which they come. I am interested in how successful they have been in attracting patients from Wagga and from Albury and how much money is flowing.

Ms McPEAKE: They are unlikely to attract, just anecdotally, anybody from Albury because of referrals but we can check whether there have been referrals from Wagga.

CHAIR: It is not something you can control.

Ms McPEAKE: No, that is right. We do not control that, the clinicians control that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With the quicker and sicker discharge, and why that term quicker and sicker, if you do the same amount of surgery and cause the same amount of trauma, presumably the person would have the same amount of pain post-operatively, whether in hospital or not, and have the same difficulty in getting to the bathroom without pain and so on. Therefore, if you are sending them home quickly and there is less support than there would be if they were in a bed and had some nurses around the place, you are actually saying and the GP does or does not do whatever, and even if the GP tries to do something, they are not going to be there as a nurse would be there.

You are actually reducing the quality of care, and although the fact that they had more pain and more difficulty getting to the bathroom is not recorded in any statistical fact, the fact that they do not come back is a pretty crude measure of the comfort of their stay. I do not know if you are familiar with the NCOSS study on rural transport. The same people, if they are admitted for day only, they have to come to the town the day before and that may cost them the overnight stay for the person and their family, or if they are discharged late in the day, they may have to stay until they get the bus the next day.

This amounts to a capital transfer from what you call efficiency, to a community that either has a lower quality of care or has other expenses generated which are passed on to the consumer. What do you say about that? We have not heard in all of these presentations, and they have been fairly elaborate it must be said, all of these wonderful graphs, et cetera, do not seem to have said: we have put extra money into general practice; yes, we have two more community nurses; yes, we have studied all these people and they have that, they did not have to stay overnight because the bus service from Woop Woop is wonderful.

These are things, it seems to me, that have not been addressed by you or by the people from head office.

Dr McGIRR: I would not say, to start with, that we have got the system right where we are, and I would say that the issues that you raised are very valid, but I would make a couple of points if I can. I think that if you do prepare people well for hospital and you make sure that you have the other conditions, the other illnesses that they have got, well treated, and that they are appropriately cared for post-operatively, you can improve how well they are post-operatively sooner. You make sure that people have appropriate transfusion, that their diabetes is controlled, as well as the other aspects of their illness. You can actually have them in hospital for a shorter stay and you can discharge them better, not sicker, if you prepare properly, so the focus of having people attend pre-admission clinics and pre-anaesthetic clinics is partly to ensure that that happens. I am not saying that it always happens but I am saying that there is the potential, if you do it well, to improve that quality of care.

CHAIR: Do you do any surveys of patients who have left, either to the GPs of the patients, or the patients themselves, about how they felt about being discharged on day two, day one, whatever and if they managed?

Ms McPEAKE: We would not have to hand a number of surveys but I could certainly check with the department and I understand that there is a number of people probably better qualified than us to make comment on what is an appropriate discharge time for an appropriate illness. Part of this is being driven by clinicians as well. It is not something that we have gone around to say that we have made up a figure about that process. We can talk to the department and see if they have any information to hand on that.

CHAIR: The clinicians make the decision about when they go home and they have been driven by Tridgell to get the clinical pathways going, so that they conform to a reasonable mode. It is up to the clinicians when they go home, but they are being driven more towards the centre of the distribution graph, but what the members of the Committee will hear when we go to the community for comment, is that mum came home but she was on seven tablets and she had all these dressings on and a drain in and she was comfortable but we were not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or she had pain.

Dr McGIRR: I agree. The second comment I wanted to make in relation to this issue is that there is a range of services available. We have in our area, for example, as people have noted, 29 hospitals so that there is a range of services already funded that can support people once they are discharged, even if they are discharged to communities some distance away, provided it is planned and there is communication with the GP and communication with those nurses. It is an issue not around resources but around getting the system to link and communicate better. I am not saying we do that well. I am saying our focus on quality can produce those benefits.

The Hon. DOUG MOPPETT: Given that the main focus of the inquiry is the major hospitals and what goes on for people who have experienced an episode in hospital, the fundamental question I would like to ask you is you have a complaints receiving centre. What is the rough nature of that? Is it actively used and what are they complaining about?

Ms McPEAKE: We have a complaints registration system and that is also based on a statewide collection system. Off the top of my head it is a bit hard. I can certainly give you a summary, or provide you with a written summary which summarises the key areas of complaint. I can provide to the Committee a written summary of the complaints and where they came from in the last 12 months. That goes to a committee and is reviewed on a regular process.

Generally speaking, the complaints are around information and how people - a general view, without going into specifics, is that most complaints are about information they have been given about understanding what has been happening to them, those sorts of bases, and we categorise them, but I am happy to provide that.

The Hon. DOUG MOPPETT: My colleagues have talked about quicker and sicker. The complaints I hear anecdotally are that in the delivery of modern medicine it is inevitable that your care, when you go into hospital, is highly segmented. There is someone who is responsible for cleaning the floor. There is someone who is responsible for coming and taking your temperature. There is someone who is responsible for seeing you have a meal and there is a huge spectrum of people applying, someone to get a blood test, someone to do something else, but there is no one in charge of you. There is no one that the patient feels is in charge. If one of those goes wrong, you are in a vacuum waiting for something to happen. If something goes wrong, a nurse does the wrong thing, puts an intravascular thing into your muscle, it ticks away for hours because no one is coming in and asking how is Mr Moppett. That is somebody else's role, it is not my role, not my role, not my role.

People tend to have these experiences in hospitals today and you may say "ha ha", but they tend to say that in the past they would have felt more comfortable with a matron who came in and saw them and their GPs who came in and saw them regularly and managed their stay in hospital. Do you think that there is reality in that?

Ms McPEAKE: I think that from the patient's perspective that part of the issue is the complexity about what we are doing to people as well. If you talk about 20 years ago when the matron came in and the GP came in, they were the people who provided the whole spectrum of care for patients in the community, but the issue around technology and the change in the way health services are provided have meant that has become much more sophisticated in terms of that process.

There would be an acknowledgement that the complexity takes away some of the personal view of what is happening. At the same time what we are trying to do, particularly with chronic and complex care patients, who are the patients who come in and go out and have a very high role in managing their own care, and that is in areas such as asthma, so that is why we try to put care coordinators in and try to involve the GP and a whole range of providers in what happens to that care with the consumer being the focus of it.

With the chronic care patients we want them to manage their care with the other providers backing them up as needed. That is the sort of work that we need to focus quite strongly on because that is where we tend to leave people out of the loop. They front up to accident and emergency with shortness of breath, they get a bit of Ventolin, or an antibiotic, or something and they go back home again, and two weeks later they come back and get a bit of oxygen, when in fact we need to ask has their status been properly assessed and do they need prevention treatment.

CHAIR: Do they actually go to a GP on a regular basis at all?

Ms McPEAKE: That is exactly what we are doing in our asthma program, looking at the chronic care management. That is the sort of work that we need to do better. That is done within the divisions of general practice.

The other area that we have started to do quite a bit of work in is mental health, with the divisions of general practice. Our interface is, at the end of the day they are only in hospital for a short period of time. It is their ongoing care that is important.

The Hon. RON DYER: To deal with the complaint issue which Mr Moppett raised, do you have patient advocates in all major hospitals?

Ms McPEAKE: With mental health there is a State-wide visiting program for the hospitals. The health councils do not work strictly as patient advocates.

CHAIR: No, a physical person in your hospitals who is a patient advocate.

Ms McPEAKE: Not to my knowledge, no.

CHAIR: I am about to go to the Health Care Complaints Commission Joint Committee. I am on that and that is one of the essentials.

The Hon. RON DYER: I have served on a hospital board for a fairly large metropolitan hospital in Sydney in the past and there was a patient advocate designated officer within the hospital to whom patients could resort if they were unhappy about treatment in any respect.

Ms McPEAKE: If people are unhappy in a hospital there is a complaints process and they can go to the health services manager in every hospital in our area and put up a concern and they regularly do that.

CHAIR: Is there somebody who goes with them?

Ms McPEAKE: Generally speaking that would be the social worker of the hospital. We have had instances where people wished to make complaints and we do facilitate providing somebody to enable them to put that forward if they choose.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the social worker formally designated as the patient advocate? Do complaints go to them through a mechanism? Are they informed when they are admitted, or going to be admitted, that the social worker can act as their advocate?

Ms McPEAKE: We have a patient information folder which has information about how to provide complaints and who to provide complaints to, so they identify a number of people and I can give you a copy of one of those information sheets.

CHAIR: A list of complaints is published in your annual report, is it not?

Ms McPEAKE: A list of complaints in terms of detail are not.

CHAIR: The number of complaints, how many have been settled, how many have been referred to the Health Care Complaints Commission, that sort of thing?

Ms McPEAKE: I will need to check the detail.

The Hon. DOUG MOPPETT: There is an apprehension amongst the vast majority of patients that if they make a complaint they are gone.

Ms McPEAKE: We have a designated area person as well that people can contact and that is also on the information of every hospital, so particularly the concern that you raised about not wanting to raise it, we have someone they can ring every day. We have a number in our office where we have a complaints officer that anyone in the area can ring and they can initiate the complaint with them and they are outside that hospital process.

CHAIR: The Health Care Complaints Commission has not provided you with what is called a patient support officer, have they?

Ms McPEAKE: Not to my knowledge.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mentioned support, but NCOSS have been very concerned about the lack of community services and the increasing amount of health budget being taken by treatment services as opposed to community support services. In all this early discharge there has been no mention of community nurses and home visitors and services such as that, which are not necessarily doctors, not necessarily GPs, but which are community based. Have you looked at those? What they are doing? Have they increased at all in response to this early discharge policy?

Ms McPEAKE: They are involved in that process about care management in terms of asthma care. They are involved in those areas. If you look at community support services generally, there have been increases in particular

areas in particular programs. The Government action plan's focus on that rural group is looking at a community reinvestment strategy that is looking at opportunities to provide more services on the ground as a result of increasing throughput through the hospitals. My understanding is that Ian Webster is looking at that as part of the process and the areas are participating in that. We have a representative on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has that resulted in any changes on the ground in your area?

Ms McPEAKE: At this point in time it has only just commenced, so the answer is no.

CHAIR: Can you please provide us with answers to the questions that we have given you so that we have something to compare? We really do have to have something from which we can compare one area with another, and where there are deviations, can you give us the reasons, because those reasons will be very different across the State. We have to publish these things and we need to have the best information for them and it is a good opportunity to you to get in touch with your community in a way. We will publish these without editorialising.

You will be leaving that source material behind with the secretary?

Ms McPEAKE: We will be providing all the overheads.

CHAIR: When you get a budget, your budgets come in various line items, but you are able to move that around in a rather free way in agreement with the department?

Ms McPEAKE: Yes, it depends on specific allocation funding.

CHAIR: For mental health you cannot, but for example a kid overnight, you can transfer that to community based services if you wished.

Ms McPEAKE: Yes, that's correct.

CHAIR: You are free to do that. That is a judgment the board has to make and justify it to the department and the department is quite happy as long as they understand what you are doing.

Ms McPEAKE: Yes.

CHAIR: I ask of you today why the Health Care Complaints Commission has not provided you with a health support officer, that is an independent person who they can complain to confidentially and can get help from, which will help your policy. I am surprised that you are not doing any surveys.

Ms McPEAKE: Surveys of?

CHAIR: Of people who have been discharged.

Ms McPEAKE: We do surveys.

CHAIR: That is what I asked before and you said no.

Ms McPEAKE: We do patient satisfaction surveys. We do. I probably misinterpreted the question. I thought you mean a broader survey across the whole area.

CHAIR: No. Do you follow up on patients?

Ms McPEAKE: Yes, we do.

CHAIR: What sorts of results are you getting?

Ms McPEAKE: I could not tell you off the top of my head.

CHAIR: Are they generally favourable or do you pick up quality improvement points?

Ms McPEAKE: We do pick up points. Probably the most important things people talk about are meals, how people treated them, those sorts of things.

CHAIR: Plus and minus.

Ms McPEAKE: Yes, both plus and minus at a hospital level.

(The witnesses withdrew)

(The Committee adjourned at 10.45 am)