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

———

At Sydney on Friday, 19 October 2001

———

The Committee met at 9.00 a.m.

———

PRESENT

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

The Hon. Dr A. Chesterfield-Evans
The Hon. R.D. Dyer
The Hon. Jennifer Gardiner
The Hon. G.S. Pearce
The Hon. Janelle Saffin
The Hon. H. S. Tsang
The Hon. I.W. West

CHAIR: It has been resolved on a motion of the Hon. Ron Dyer that in accordance with a resolution of the Legislative Council of 11 October, the Committee authorises sound broadcasting and television broadcasting of its public hearing proceedings held here today. I have to notify any media here that they are responsible for what they print and they have to take full responsibility for that. I also notify persons before the Committee that if at any stage you need to give us evidence which is of a secret nature, or which you do not want to publicly broadcast, you should notify that and we will deliberate and decide whether we do or not. If we do decide to take it in as confidential information, I have to further warn you that the House, by resolution, can uncover it.

The guidelines for publication and broadcast are available should anybody wish to have them.

TERRANCE JAMES CLOUT, Chief Executive Officer, Mid North Coast Area Health Service, 97 Moruya Drive, Port Macquarie,

GEORGE PETER BEARHAM, Acting Chief Executive Officer, Mid Western Area Health Service, 175 George Street, Bathurst, and

STUART MERVYN SCHNEIDER, Chief Executive Officer, New England Area Health Service, Bora, Bora Creek Road, Quirindi, sworn and examined:

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

Mr CLOUT: Yes, I am, Mr Chairman.

Dr BEARHAM: I am.

Mr SCHNEIDER: Yes, I am.

CHAIR: We had a meeting yesterday with Ms McPeake from the Greater Murray Area Health Service and she was by way of trailblazer. What she did yesterday, which was acceptable to the Committee, she made a brief presentation addressing the terms of reference, and I wonder if each of you can do so in turn and we will limit interruptions for clarification, as we did yesterday.

I think we now know a bit more about the process and we can be a bit more comparative. As you understand, we are really looking to compare like hospitals. We would ask you to concentrate more on your hospitals. Of course you have to bring into account some of the area health service needs. We can make some comparisons about value for money and quality, which are the terms of reference. There may be some questions which we would like you to take on notice, of which we will notify you at the end of the hearing.

It may be as a result of yesterday and today's hearings that further questions will crop up in the next series of hearings that may be of interest to the Committee and applicable to all, and we will relay those questions to you.

Mr CLOUT: Kathy Buckley will be assisting me. I will be followed by Dr Bearham and Mr Schneider. The approach we are taking is not to duplicate information that has been provided by the Director-General or other people who have been before the Committee and we are concentrating on the terms of reference, particularly in relation to quality and value for money.

Really what I want to cover this morning in this presentation is governance, quality initiatives, quality performance, service enhancement briefly, financial management, which is the value for money side and some background about the area health service.

If we look at the Mid North Coast Area Health Service, this financial year we will treat 53,700 patients. They will be admitted and we will provide in excess of 700,000 occasions of service. A quick look at it, each day on average we will see 147 people admitted who will spend a day in a bed. 342 people every day will be seen in emergency departments across the area. Every hour 14 people will be seen in those emergency departments and there is almost 9,500 extra people being treated as in-patients each year, as compared to seven years ago.

If you look at our three base hospitals, drilling down into the base hospitals, in the area health service we have three base hospitals and one middle sized hospital.

The Hon. Ron DYER: Can you identify for reasons of clarity the names of the base hospitals you are referring to?

Mr CLOUT: Yes I can. I apologise for the abbreviations. I will keep going and if there is further information you require, I will provide it. There are three base hospitals. Coffs Harbour Base Hospital is the first, Port Macquarie Base Hospital and Manning Base Hospital, which is in Taree. As you can see, most of those, two out of three of those, patients admitted 13,600, 10,400 and for Manning Base Hospital nearly 11,000; 10,900.

Occasions of service - a bit of a difference here and this is to do with the way that the services are configured. 231,000 occasions of service at Coffs Harbour Hospital, almost 79,000 at Port Macquarie base and 84,000 at Manning Base Hospital.

CHAIR: Why is there a variation there?

Mr CLOUT: It is the way that we collect the figures and this is something we are improving on considerably. In Coffs Harbour Base Hospital we have a lot more occasions of community base services still captured under our hospital figures. I apologise for not being able to pull those out at this stage.

The Hon. RON DYER: Why are the occasions of service so markedly lower at Port Macquarie?

Mr CLOUT: Because in Port Macquarie and Manning a lot of the community health services are not captured under the heading of the hospital. We have a distinct stream of service called primary and extended care which, if I talk about Port Macquarie specifically, the community health services have, since the arrangement with Port Macquarie Base Hospital in 1994, been quite separate from the hospital, whereas in Coffs Harbour until very recently we had a sector which was called the northern sector and all of the occasions of service were captured under the sector and that was basically under Coffs Harbour Hospital.

The Hon. HENRY TSANG: What is occasional service, the outpatient service?

Mr CLOUT: They are a combination of all services provided to patients or clients, other than when they have to come into a bed of the hospital.

The Hon. HENRY TSANG: That is when it is necessary to stay for the night?

Mr CLOUT: Yes. If they stay for the night basically it is an admission.

CHAIR: That includes a community nurse visiting somebody.

Mr CLOUT: That's correct, as it would an outpatient casual service.

CHAIR: Why is that not reflected at the southern sector, which I assume would be Manning Base Hospital, which is exactly the same as Port Macquarie?

Mr CLOUT: Traditionally in the southern sector it too has had them separated out.

CHAIR: Can you make Coffs Harbour look like Port Macquarie and Manning?

Mr CLOUT: Yes, Mr Chair, I can provide that information to you.

CHAIR: In other words, take out the stuff at Coffs which would make it look like the other two.

Mr CLOUT: We will provide that information. Patients seen in the emergency department of Coffs Harbour, this is each day, 98; Port Macquarie 50; Manning Base Hospital 81. The figures underneath that are just the hourly equivalents of that. One of the interesting things to look at is the percentage of inpatient services per annum. 14 per

cent Coffs Harbour, 21 per cent Port Macquarie and a fall over the years from 1996 at Manning Base Hospital.

One of the reasons for that is that we have quite markedly been moving to seeing very many more people outside of the hospital setting. We are still looking at exactly what the differences are between those three areas over that period of time.

The Hon. RON DYER: Are you going to present subsequent statistics to the Committee about the incidence of day surgery?

Mr CLOUT: Yes I am. That will be covered in this presentation.

The issue of quality really comes from the board down. It has to come from the department where we get guidelines under the Government action plan. It then has to look at the board level. What we have done very recently is we have broken the board's governance roles into two components. One is corporate governance, which really looks at the efficiency and value for money side of the equation and then we have concentrated very much on the clinical governance.

We have created, as have all area health services, a quality committee and we have looked at how we can involve the clinicians in that and the community in that. You will notice that under the line we have established three clinical councils in the last 12 months, a medical council, a nursing council, and an allied health council as a deliberate strategy to involve clinicians very much more in the quality program and we have provided a clinical indicators working group, which is specifically aimed at looking at a lot of the clinical type information that you would have seen from Professor Gibberd and Dr Tridgell in terms of getting clinicians involved in that material.

Board committees that particularly look at our clinical governance are our quality planning and services committee, our medical and dental appointments and credentials committee, obviously a high level quality issue to make sure we have the right staff, that their credentials are correct, and we also consider that involving the community and having a community liaison committee as a committee of the board is an important quality measure. As to management committees, we have the three clinical councils I have mentioned and the Clinical Indicators Working Committee.

Community and consumer participation is again a major Government Action Plan initiative, and we have reviewed in the last twelve months within our area health service how we are structuring the involvement of the community and how they want to be involved at all levels within the organisation.

The Board has a subcommittee which is a consumer and community liaison committee, and it is made up of representatives from community based run and owned community and consumer health forums. We have also appointed a community and consumer liaison officer to work with the community based groups to ensure their involvement at all levels within the committee.

The quality and initiatives that we have commenced, and these are some examples, are set out before you. I will not, Chairman, go into these, but the most important issue is that we are following the indicators that we are getting out of the material from our Clinical Indictors Working Committees. We are engaging the clinicians in very significant programs of use.

CHAIR: How do these get validated as indicators? Say for example one of your committees meets and they decide they are going to have this indicator, and you adopt it, we have got every area health service doing all sorts of things.

Mr CLOUT: One of the important initiatives coming out of the Government Action Plan is that there is a lot of guidance at a State level involving a lot of clinicians in terms of exactly what indicators should be used across the State.

CHAIR: Which indicators are State-wide indicators and which indicators are not State-wide indicators? I can understand that any hospital looking at quality will do a whole range of things, but I am interested in what you are all doing which is comparable. As briefly as you can; I am interested in the issue rather than the actual.

Mr CLOUT: I understood there was a document provided to the Committee called the Phase One Indicators for Appropriateness and Effectiveness. That document provides a suite of standard indicators that should be used and adopted across the State. They are not the totality, but they are the ones that at a State level are the minimum set.

CHAIR: Sedation is one of them, is it not?

Mr CLOUT: Yes, it is, as is caesarean section, falls, infection rates, day of surgery, all of those.

CHAIR: And manual handling is one too, is it not?

Mr CLOUT: Yes, it is. What we do at an area level is, with our clinicians and our staff, look at the ones where the indicators for our base hospitals or our area health services are aberrant outside of range, and then work out which ones we need to target.

CHAIR: How do you find out what the range is?

Mr CLOUT: A lot of the information that we have, particularly the information provided by Professor Gibberds and Dr Tridgell, provides some very, very good information that enables us to see very quickly whether or not our hospitals are aberrant.

CHAIR: For example, in falls reduction, is there a publication for each area health service and each hospital of the number of falls?

Mr CLOUT: I am not sure about that. I would have to take that on notice.

CHAIR: Because it is one of the indicators across the State. It is picked up at random.

Mr CLOUT: Yes. I am not sure about that; I would have to provide that information to you.

CHAIR: The other two might have some view on that. It is one of the indicators which are being used; where do you get to find out whether you are good, bad or indifferent?

Mr SCHNEIDER: That is provided by the department in the statistical data collected by them, the particular range.

CHAIR: That is more a community activity, is it not, preventive work, or is it just fall reduction inside your hospitals?

Mr SCHNEIDER: Within the hospitals.

CHAIR: Thank you.

Mr CLOUT: I had an example of one of the improvement projects that we have been working on that has involved a lot of the clinicians. It is the Manual Handling Improvement Project. You might at first glance say that that does not relate to clinical quality, but it definitely does. With the involvement of the clinicians, the doctors and the nurses, and consumers, we have been able to develop some policies and significantly reduce the falls, by about 92%. That has obviously got very significant dollar and social benefits.

One of the advantages of this is that that program has been picked up. It has won the New South Wales Premier's Award. It has been picked up by a number of other area health services, and indeed interstate. My colleagues will give some more examples from their hospitals.

One of the significant initiatives that we are in the middle, or perhaps at the front end of, is looking at detailed clinical indicators that are now being provided at a State-wide level and workshopping those with our clinicians. We have had Maureen Robinson from the Department, Dr Tridgell and Professor Gibberd up to assist our clinical staff and our managers in doing that. We have got a Clinical Indicators Committee now formed

involving all of our clinicians, and we are really at the front end now of picking out those major quality issues for our base hospitals and involving the clinicians in working through them.

CHAIR: These are not State-wide, are they?

Mr CLOUT: No, because while there is a State-wide set, the information we now get from the department gives us at an area level some very good indicators of the ones we particularly should look at. In themselves they are but flags.

CHAIR: How do you get them, for example? This comes out of the Tridgell stuff, does it?

Mr CLOUT: Yes, and it also comes out of Professor Gibberd's stuff.

CHAIR: His, of course, is much older.

Mr CLOUT: Yes, and that is why they are but triggers. We need to then get our clinicians to say first of all, is there an explanation why our hospital is outside of normal range? There may well be a very good reason for that. On the other hand, it may be out of date, it may have been addressed.

CHAIR: But you are developing new clinical indicators, are you not?

Mr CLOUT: No, we are using the indicators that have been set.

CHAIR: So these are all within the set?

Mr CLOUT: That is correct.

The Hon. HENRY TSANG: How do you reduce the weight lifting? Do you have machines or do you have different practice?

Mr CLOUT: A combination of both, both in terms of nurse practice, doctor practice, and also mechanical equipment that assists in reducing what people actually lift. This really goes, Chair, to your last question. I have indicated on this slide some of the areas where in the mid north coast, out of the standard set of data that is available we have particularly picked out and sat down with our clinicians. These are the ones we now need to examine in great depth. I do not need to go through them, I do not think.

CHAIR: In other words, you are looking at the indicator for caesarean section and then burrowing further down, saying, "Does age have an impact? Should we adjust this indicator for age?"

Mr CLOUT: Correct. This information on the next slide comes straight out of information provided from the State working group. It is in the standard set, and it would indicate at first glance that Coffs Harbour hospital is outside a normal range in relation to caesarean deliveries. It is outside the cone, if you like, as Professor Gibberd explains it. We then take it back to our clinicians at Coffs Harbour hospital in a multi-disciplinary team, and say to them "Can you look at that and see what it tells us, see what explanation there is for it. If there is no explanation for it, work as a multi-disciplinary team in terms of trying to find ways to improve it so as to bring us back into what would be considered the average".

CHAIR: The three lines there are the average and the separation from the mean, is that right?

Mr CLOUT: I would have to get information on that.

CHAIR: But you would have pictures like that?

Mr CLOUT: Yes, and they will be different for each.

CHAIR: Of course. So when you age adjusted it, what happened?

Mr CLOUT: If you look at the next one, this is actually for hysterectomies, but it breaks it down into those different age groups and allows us to look at that, and you can see that in terms of hysterectomies it does not matter whether it is for those less than 35, or between 35 and 59. The Hastings on this occasion is outside what would be considered the average of the norm, or the acceptable range. So again, the clinicians at that hospital have to look at this particular indicator.

CHAIR: In terms of clinical governance, the board's committee might look to see whether the practices are appropriate or not appropriate?

Mr CLOUT: At the first stage our Clinical Indicators Working Group will continually monitor that and ask for feedback, and reports from that feed through to our quality committee and then to our board.

CHAIR: So the board gets the picture and then they get the reasons behind it, and then make a judgment whether the reasons are appropriate?

Mr CLOUT: Yes, and they would also expect to get a plan as to what is going to be done to address it.

CHAIR: Or not address it?

Mr CLOUT: Or not address it, as the case may be.

The Hon. RON DYER: Might there not be other input, such as the age distribution of the population of that feeder area for the relevant hospital?

Mr CLOUT: All of those could influence whether or not it being outside the cone is acceptable or not. By itself it does not tell you that there is a quality problem. It is but a flag to say you need to investigate it very much more, and know what the explanation is, if it is going to be outside the cone.

CHAIR: It may be, for example, that everybody should be up where Port Macquarie is, that everybody else is out of sync. Is that possible?

Mr CLOUT: Yes, statistically possible.

The Hon. RON DYER: But the point of my question is there may well be valid reasons why a given area is out of sync.

Mr CLOUT: Absolutely. The last one is an interesting one for our area health service because it is expected cataract procedures, and I have included here some of our areas outside of the base hospitals and looked at the communities that they service, and a number of our local government areas are considerably out of that, and it is an area obviously for priority investigation by our area health service.

CHAIR: So that is observed versus expected, so the line zero would be the expected?

Mr CLOUT: Yes, but anything within the cone would be one that we frankly would not look at. We would not investigate that.

CHAIR: That is the State norm, is it not?

Mr CLOUT: That is correct.

CHAIR: So the observed versus the expected, in other words, the people above the line are more than expected?

Mr CLOUT: They are receiving services at a higher rate per head of weighted population.

CHAIR: That is provision of services, is it not?

Mr CLOUT: Yes.

CHAIR: That is not the needs, that is the provision of services?

Mr CLOUT: Quite correct.

CHAIR: Again, compared to, for example, the Campbelltown/Penrith area, where you would not expect to see too many older people as a proportion of the population, you have a higher proportion of the population which are aged in the Mid North Coast and the Northern Rivers, and you would expect it to be a bit different.

Mr CLOUT: You would, but my understanding is that this data does take into account age distribution.

CHAIR: It is age corrected?

Mr CLOUT: That is my understanding.

The Hon. RON DYER: You are saying there are some corrective factors to take into account, for example that there might be a higher than State average older component of the population in Port Macquarie, to give one example?

Mr CLOUT: That is true, certainly right across the Mid North Coast.

CHAIR: Does this take into account the number of cataracts done privately?

Mr CLOUT: Yes, it does. In fact, a point I was going to make was that this information includes both public and private provision of services.

CHAIR: Across the State?

Mr CLOUT: Yes.

CHAIR: So in other words, the State Government has a way of finding out how many private cataracts are done at the Eastlakes clinic, for example? It is something I can ask the department.

Mr CLOUT: Yes, I think that would be better directed there. I am pretty sure that that is correct, but it would be better directed to the department.

CHAIR: In your area you can find that out by ringing Port Macquarie private?

Mr CLOUT: I think this information is available to us. It is another reason why you then have to investigate it further when looking at base hospital provision of these services.

One of the other quality indicators which was sought
earlier was around same day surgery and day of surgery admission and I again apologise for the highlights. I will go through them. Coffs Harbour Hospital you can see is on the same day surgery 57.5; Port Macquarie 66.5; Manning at 71.2. The area health service as a whole at 69.4, against a State benchmark of 60.

Day of surgery admissions where the State benchmark is 80, Coffs Harbour Hospital at 94.1; Port Macquarie at 88.9; Manning at 76 and the area service as a whole at 88.

What we then do is work with again all the clinical staff and our managers and say, "Okay, let's take the day of surgery rate. If it can be at 94.1 at Coffs Harbour Base Hospital then let's talk across the area with the clinicians and see if we cannot get Port Macquarie Base, Manning Base also at 94.1".

CHAIR: Why do you not look at getting them all back down to the benchmark of 80? In other words, is super optimal better, or is optimal good enough?

Mr CLOUT: That is something upon which the clinicians have to provide the area health service with advice. It may in some cases be that 80 is better but as a general rule in our service we think that 90 or 94 is achievable.

CHAIR: The thing that drives the indicator means that if you can better the indicator you are probably doing the patient a better good.

Mr CLOUT: It does.

CHAIR: It might drive you to have a lot of sicker people being admitted for day of surgery who perhaps could have been admitted the night before.

Mr CLOUT: That is one of the significant reasons why we have to ensure in dealing with any of these quality indicators, that we have from the beginning right through to the end, the involvement of all of the clinical staff and that we have access to clinical staff advice to our board.

The Hon. HENRY TSANG: I do not understand. Same day surgery means that people go in and get out the same day?

Mr CLOUT: Correct.

The Hon. HENRY TSANG: Day of surgery admission, what does that mean?

Mr CLOUT: It means that they have the actual operation in the theatre performed on the day they enter hospital, so they come in, in the morning, they have the surgery during that day. It does not necessarily mean that they are discharged on the same day. They may well have an overnight stay, but they are having the operation performed on the day they come into the hospital.

The Hon. HENRY TSANG: The day they arrive. It is efficient. You are efficient. They go in and you do the surgery on the same day.

Mr CLOUT: It is more efficient provided it is clinically appropriate.

CHAIR: Does it mean that if there are 100 patients having an operation, 94 per cent will be admitted on the day they are having the surgery?

The Hon. HENRY TSANG: MBH is only 76, so that hospital might not be as efficient.

CHAIR: I am trying to clarify what the figure means. If there are 100 people having surgery in your hospital in a month, 94 of them will be admitted on the day of surgery. 57 of them will be in and out in a day.

Mr CLOUT: That is correct, for elective procedures.

CHAIR: Of course. This is all for elective surgery.

Mr CLOUT: Yes, it is.

CHAIR: Does it mean also that there are 100 patients having surgery where they stay for more than a day, 94 per cent of them are admitted on the day of surgery?

Mr CLOUT: Not necessarily.

CHAIR: Is the same day surgery included in the day of surgery admissions?

Mr CLOUT: No, they are separate figures.

CHAIR: In other words, if there are 100 patients having surgery who are going to stay more than a day, 94 per cent of those people are admitted on the same day?

Mr CLOUT: Correct.

CHAIR: But a separate group of people, there might be 30,000 in the bottom group and in the top group there are 2,000 people.

Mr CLOUT: That is correct.

CHAIR: It does not tell you how many of the people who should be same day surgery, are actually done same day surgery, does it?

Mr CLOUT: Yes, it does. The same day surgery is a distinct figure.

CHAIR: I know that. That is why it is very important to understand these numbers. Say, for example, Coffs Harbour Base Hospital has 5,000 people done same day.

Mr CLOUT: Yes.

CHAIR: And there are another 25,000 elective surgical cases.

Mr CLOUT: Yes.

CHAIR: All up that is 31,000 elective surgical cases for Coffs Harbour Hospital.

Mr CLOUT: Yes.

CHAIR: Of the 25,000 day of surgery admissions, of the people who are day of surgery admissions, 94 per cent, 21,000, come in on the day of surgery.

Mr CLOUT: Yes.

CHAIR: And stay a day or so.

Mr CLOUT: Correct.

CHAIR: It does not mean of that 21,000 some of those could not have been done day surgery, does it? In other words, it could be.

Mr CLOUT: They could be, that is correct.

CHAIR: In other words there is a shifting number of sands here. What do you bring in same day, in and out in a day, and what stays overnight?

Mr CLOUT: That is right.

CHAIR: That depends on how you plan it in the first place. If, for example, you had a same day surgical patient who stays overnight that would be, if you like, a bit of a failure of selection, or a failure of the process?

Mr CLOUT: It could be seen that way, but it may well be that for the quality of care of the patient, the clinical judgment overrides that.

CHAIR: If it was planned to be the same day and they have to stay overnight, that is the one per cent of failure?

Mr CLOUT: That is right.

CHAIR: There is an indicator for that in terms of selection and doing the stuff and whatever. If you have a

same day case that turns into an admission, then one or two per cent is the figure normally acceptable for that. They have too much pain, or they bleed, or they get too sick to go home.

Mr CLOUT: Correct.

CHAIR: That is an indicator of your acceptability of how you do it and your indications?

Mr CLOUT: Yes.

CHAIR: Are they completely separate? That 57.5, is that 57.5 of all the cases that are done electively, are done same day?

Mr CLOUT: Yes, that is correct.

CHAIR: That is why I wanted to get the figure right. Does the 94 then only go for the other 43 per cent? I want to get this clarified because it is important.

Mr CLOUT: Day of surgery admission applies to those who are also same day surgery.

CHAIR: In other words if there are 100 patients being operated on, 94 per cent of them come in day of surgery.

Mr CLOUT: Correct, and of the same 100 -

CHAIR: Of the same 100, 57.

Mr CLOUT: Correct.

CHAIR: If you take 57 out of the 94, you get a percentage of those cases who are going to stay overnight, which might be 80 per cent. I am sorry to take that time but it is important to understand.

The Hon. RON DYER: There might be good clinical reasons why they would stay.

Mr CLOUT: That is right.

The Hon. HENRY TSANG: Can I therefore deduce from that figure that Manning Base Hospital is in fact more efficient because 76 per cent were admitted for day surgery and 71.2 per cent actually got it done and left, whereas Coffs Harbour you have 94 per cent supposed to come for the day but only 57 per cent that actually were done on the day, so you use that figure.

Mr CLOUT: I do not think it is quite that black and white. I think what you can say is against the State benchmark both of them are operating very well compared to the benchmark. They would both be considered as appropriate and effective and efficient if you used these measures and these alone.

CHAIR: That was an important thing to clear up for every one of the presentations.

Mr CLOUT: I think I have covered the main areas of quality that I would like to.

CHAIR: The other parts of your presentation, if you could hand that to us we will get that analysed by the Committee, the other slides you had prepared.

Is that agreed, the answer we got, is that agreed to by the other two chief executives?

Dr BEARHAM: Yes, it is. In my presentation I am going to give you a profile of the Mid Western Area Health Service. I am going to talk about the organisational structure of the quality framework. I am going talk about some of the phase one indicator projects that we are going to be undertaking in the current year. I am going to talk a little bit about Orange Base and give three clinical examples of quality.

The Mid Western Area Health Service was formed in March 1996 from three previous districts. We have about 170,000 residents. We cover 13 local government areas. We have a diverse geographic area that goes from Lithgow out to Lake Cargelligo, 59,000 square kilometres and 3.4 per cent of the population identify themselves as Aboriginal and Torres Strait Islander.

The area has 22 public hospitals and one referral psychiatric hospital, Bloomfield, based in Orange. We have 37 community health sites. The budget this current financial year is $162 million.

CHAIR: How close is that to the RDF?

Dr BEARHAM: We are nearly on RDF.

CHAIR: Mid North Coast, how close are you to the RDF?

Mr CLOUT: By 30 June 2003, which is the end of the current three year budget cycle --

CHAIR: When the budget comes out in 2002 for the 2002-03 year, where will you be?

Mr CLOUT: We will be within two per cent.

CHAIR: By the spending year 2002-2003, in other words, the RDF will be complete for you in 2002-03?

Mr CLOUT: It will be close.

CHAIR: Plus or minus two per cent.

Mr CLOUT: Yes.

Dr BEARHAM: On this slide you can get an indication of the consumer and community participation within the mid west. We have had 12 health councils operating since about 1998 and two health councils/multipurpose centre advisory committees. The councils report through the health service and quality committee, which is a subcommittee of the board.

A number of program advisory groups also have consumer representation and an example of a program advisory group that would be in aged care, and they have undertaken an active role in health planning.

CHAIR: You are mirroring almost exactly what was presented before?

Dr BEARHAM: Yes. On this slide you can see the governance model in terms of organisational structure for accountability and responsibility in the mid west. You see at the top the area health service board to which the health service and quality committee report, and to that committee the area quality council, actually chaired by the chairman of the board and representation on that committee of all the facilities and services.

CHAIR: The provision of general practice feeds into the area quality council?

Dr BEARHAM: Yes.

CHAIR: Does that happen in other areas?

Mr SCHNEIDER: Through individual membership.

CHAIR: But not from the division itself?

Mr SCHNEIDER: No.

Mr CLOUT: We have representatives of the divisions of general practice on our quality committee.

CHAIR: Separate from the medical staff councils?

Mr CLOUT: Yes.

Dr BEARHAM: On the next slide you can see a number of phase one indicators that my colleague has been talking about and that we have been looking at. When Paul Tridgell and Professor Gibberd came out there were a number of clinical indicators, phase one so-called, that were being looked at, at a State-wide level. We have undertaken to look in detail at three of those over the next financial year.

We are going to be looking at chronic obstructive pulmonary disease because it has a higher admission rate and a longer length of stay than perhaps our peers.

CHAIR: Are they corrected for incidence?

Dr BEARHAM: It is my understanding they are corrected for age, sex, all of the kinds of things you would expect them to be corrected for.

CHAIR: Incidence as well?

Dr BEARHAM: Incidence as well.

CHAIR: In other words, some populations might have a lot more asthma than others.

Dr BEARHAM: They are not corrected for incidence. Maybe at the end of the day we have a high percentage of smokers in the area which is leading on to chronic obstructive airways disease, or something like that, because that will be something that we will need to look at.

Looking at diabetes we have a higher admission rate and looking at endoscopies there are variations in the admission rate across the area, so we are also going to be looking at those

CHAIR: Is the diabetes admission rate just for diabetes, or does that include admissions for, say for example, renal dialysis where diabetes is one of the co-existing conditions?

Dr BEARHAM: I do not believe so. I believe that the primary diagnosis is diabetes. On the next slide you will see why we have chosen those three topics to look at. All three of them can be addressed in our current organisational structure so COPD will be addressed through chronic care advisory committee, which was established under GAP.

The Hon. RON DYER: Have these been chosen for study internally so far as the health service is concerned?

Dr BEARHAM: Yes.

CHAIR: These are your own indicators, not part of the phase one roll-out?

Dr BEARHAM: These are part of the phase one roll-out and each of the area health services was asked to look at three of those and to undertake more work in those. We have chosen those three to look at.

CHAIR: These are State-wide indicators, so the department can get a better feel across the system?

Dr BEARHAM: Yes. Again the diabetes issues can be discussed and processed through the diabetes program advisory group and it is worth pointing out that those first two in fact have had consumer representatives on them as well. Endoscopies will be addressed with the area surgical services steering committee.

CHAIR: What are you looking at there in endoscopies?

Dr BEARHAM: There are variations in endoscopy rates across the area health service.

CHAIR: It is the rate?

Dr BEARHAM: Yes.

CHAIR: Fine, thank you.

Dr BEARHAM: This is a bit of information about Orange Base Hospital. It is a 164 bed major non-metropolitan hospital. It has a broad range of specialist services, oncology, palliative care, pediatric and renal services, and has a catchment population of about 80,000.

CHAIR: You do not have radiotherapy?

Dr BEARHAM: No, no radiotherapy and no interventional cardiology. The next slide shows a summary of activity, and compares 1995-96 with 2000-01. You can see there has been an increase of admissions to approximately 14,728. You can see there has been significant reduction in length of stay to 3.4 days. The number of non-admitted patients is about the same, 170,000. The emergency department presentations have increased to 22,000. You can see that our day of surgery admission rate is about 73.8 per cent for Orange. Unfortunately we do not have any data for 1995-96. You can also see that our day surgery rate is 51.7 per cent.

CHAIR: Why do you not have the results for 1995-96?

Dr BEARHAM: I am not sure, Mr Chairman.

CHAIR: The issue was to start off at 40 per cent, then the bar was raised to 50 per cent, then to 60 per cent. I remember being in Government at the time, and we insisted on 40 per cent, and it took ages for it to get to 40 per cent. It has exploded since then, but figures were being collected in 1995-96.

The other question I have is NAPOOS, non-admitted patient occasions of service. Is that more like the NAPOOS collected in Coffs Harbour, or the NAPOOS collected at Port Macquarie?

Dr BEARHAM: I think not Port Macquarie. I think our non-admitted patient occasions of service would be your classical attendances in emergency department without being admitted, attendances in our outpatient department.

CHAIR: From a Committee point of view, we are going to need the collections a la Port Macquarie. Because we are wanting to look at Port Macquarie in particular at the end of the day, we have got to be a bit more comparable with Port Macquarie, in other words, deleting nurse home visits and some of the primary care stuff, which is separately provided in Port Macquarie by Northern Rivers Area Health Service or by Mid North Coast. You would put some of this stuff against Orange Base Hospital, for example, because it is continual?

Dr BEARHAM: Yes.

CHAIR: So that Orange would look like 107,000 or whatever the figure is, and that would look much more like the 230,000 at Coffs Harbour?

Dr BEARHAM: Yes.

CHAIR: We really need to dissect some of those figures out if we can, to reflect only the services that Coffs Harbour is providing under the contract.

The Hon. RON DYER: The incidence of day surgery in the year 2000-2001 appears to disclose there 51.7 per cent. I think it is true to say that the benchmark Statewide is set at 60 per cent. Is there any reason why it would be fairly significantly below?

Dr BEARHAM: Not that I am aware of. I guess it is one of those things, that with this data being prepared, we go back, talk to our clinicians, work through their working party, and look at the issues. There might

be good clinical reasons. I guess that is something where we work with our clinicians to see whether we can improve on that figure.

The Hon. RON DYER: I just notice that it is a lower rate than applicable to any of those three base hospitals in the Mid North Coast area.

CHAIR: How many hospitals do you do that same day surgery in, 29?

Dr BEARHAM: We have six surgical hospitals in the Mid West, and I believe that they all do day surgery.

CHAIR: Have any of them got specific day surgery suites except Bathurst?

Dr BEARHAM: Lithgow has. It is a brand new facility so it would have a proper established pre-operative service and day surgery.

CHAIR: But Orange being older and in need of refurbishment, does not?

Dr BEARHAM: Correct.

CHAIR: So that is a physical constraint.

Dr BEARHAM: Yes.

CHAIR: Does that seriously impact on it though?

Dr BEARHAM: I have not really been there long enough to tell. I have undertaken a tour of Orange Base Hospital on a couple of occasions, and the day surgery suite is separate from the main theatre suite. So in that sense they are geographically separate. Coming from my previous position, I think it would be more efficient if it was all together.

CHAIR: I sort of disagree, but what we really would like is why you have failed to meet State-wide benchmark. Perfectly good reasons may be available, but we are only interested in Orange Base.

Dr BEARHAM: Okay, I will provide that, Mr Chairman. On the next slide you can see the committee structure for quality within Orange Base Hospital, and you can see how it reports to the Area Quality Council, and if you look at the way Orange Base Hospital decided to structure their committee, it is along the lines of the functions within the Australian Council of Health Care Services, the way they actually accredit facilities.

So you can see there are committees on improving performance, continuing care which is basically the Clinical Committee, and you can see that there is a Human Resources section, a management section, an IM&T, and then safe practice and the environment.

CHAIR: I notice that division for general practice is not there. They are represented in the continuing of care, are they?

Dr BEARHAM: I believe so, Mr Chairman, yes. They would have been put into the clinical side of things.

CHAIR: The reason is that not all the general practitioners would be a visiting medical officer and therefore be on the medical staff council of Orange Base Hospital, but they almost certainly would all be part of the division of general practice. Not all, but most.

Dr BEARHAM: Yes. On this slide you can see that over the last couple of years about 260 quality activities have been done by Orange Base Hospital, and I guess with the emphasis on clinical outcomes and doing good quality projects, what we have attempted to do on this slide is demonstrate what happened to the outcome of the quality activities in 1998, 1999 and 2000.

You can see that there is a steady trend from perhaps no measurable outcomes, in terms of maybe it was an

educational pamphlet so you could not directly measure the output onto the patient, to in the year 2000 approximately 35 per cent we would be able to say actually had a quantitative outcome that we were able to measure.

CHAIR: 66 per cent.

Dr BEARHAM: 35 per cent?

CHAIR: No, that was no measurable outcome achievable, 33 per cent. So 70 per cent of them had a measurable outcome.

Dr BEARHAM: Yes. On the next slide, Orange Base Hospital has had a Quality Improvement Committee.

CHAIR: So in other words, you are doing projects where you can actually measure an outcome.

Dr BEARHAM: Correct, yes.

CHAIR: You are setting them up so that you can actually look at an outcome to see whether you are being effective or not?

Dr BEARHAM: Yes.

CHAIR: Are those State-wide things or are they individual projects?

Dr BEARHAM: They are individual projects that all the departments of Orange Base Hospital have come up with.

CHAIR: Have you reported these to the Department so they can be taken up by others?

Dr BEARHAM: Not directly, Mr Chairman, but we have representatives from the area offices who sit on State-wide committees to deal with quality, and so that would provide a forum when they are looking to introduce new clinical indicators across the State. Then various people will be able to say we are doing this work in the Mid West, we are doing this thing on the Mid North Coast, and you can see where these indicators would be suitable. So I guess in that sense everybody has input into the development of future planning.

CHAIR: And are they costed, so if they do a project, "It costs this and we got these results? We looked at this problem. We said let's do this and see what happens, and we got this result"? Mind you, the outcome might be negative or positive. In other words, if you stop doing something, which is just as important as doing something, and things got worse, you would start doing it again. If you stopped doing it and no change happens, you just keep stopping doing it.

Dr BEARHAM: That is true.

CHAIR: So these are reported at what level? Every time you do one of these they do not just disappear, they go into the Department?

Dr BEARHAM: No, what actually happens is they get reported through Orange Base Hospital, and again there are representatives from Orange Base Hospital on the Area Quality Council, and we will look to see how those kind of things are reported. At the moment there are probably only global indicators that come up from each of the facilities to the area health service. So, for example, what has been going on at Orange Base Hospital will be reported to the Quality Council at the area health service.

They may say, and you will see this a bit further on my slide, that yesterday they had Quality Day. That was the second annual Quality Day; they had the first one last year. They will probably provide information to the quality council on the nature of the day, what quality activities were actually showcased and presented.

Going back to the slide, you can see the composition of the Quality Improvement Committee of Orange

Base Hospital. It has got a wide representation. On the next slide there is a summary of quality activities at Orange Base Hospital. They have accreditation with the ACHS, the Australian Council of Health Care Standards, until February 2002. They are accredited by the Post Graduate Medical Council, PGMC.

As you saw on the previous slide, about 250 quality projects have been completed or are in progress since 1998, and as I just mentioned, the second annual Quality Day was held yesterday. The kind of things that were showcased at that day yesterday included ten presentations, a stroke pathway presentation which I am going to talk about in a minute, dialysis screening, food services, family conference research, patients enquiring into dental treatment, wound management, and a nutrition supplement project.

I will now give you three clinical examples. Firstly stroke. In December 1997 New South Wales Health released a report "Stroke in New South Wales, Priorities and Strategies". That document was picked up in April 1999 by the allied health staff and the medical staff in rehabilitation. They formed a working party and they then audited 170 medical records. The audit of those medical records revealed poor referral of stroke patients to allied health and rehabilitation staff.

So one of the goals in the report that came out from New South Wales Health was to ensure access to organized in-patient care, including access to early rehabilitation. They developed a stroke pathway, and then they implemented it. In February 2001 they evaluated the outcome and found a greater percentage were referred for rehabilitation consult, and I am advised that there has been a 30 per cent to 40 per cent increase in allied health referrals, although that number is not on the slide, and approximately 20 per cent to 30 per cent referral to the physicians in rehabilitation.

There was then a timing assessment by allied health staff, and the time between referral and assessment was decreased, and significantly there was a greater percentage of patients admitted to the rehabilitation unit, and I am told that is about 40 per cent.

CHAIR: At the end of the day, what was the consumer response to that, and did the patients do any better because all the other personnel got at them?

Dr BEARHAM: I would say the answer is yes to that question, but I would have to refer back and ask the director of rehabilitation.

CHAIR: I suppose you are addressing an issue to make sure people get access, and that is the end point, is it not, you have actually improved access?

Dr BEARHAM: Yes.

CHAIR: Whether that makes any difference to the patient is a different matter. You just looked at the quality indicator the Department has of getting access.

Dr BEARHAM: Yes.

CHAIR: And that is enough, because you cannot achieve everything. But that addresses an issue which is a goal of the Department. Have you achieved the goal?

Dr BEARHAM: Yes.

CHAIR: Fine. Thank you.

The Hon. RON DYER: You have been referring, Dr Bearham, to consumer response. Have you measured that?

Dr BEARHAM: I am not sure. I will have to ask if they have done a patient satisfaction survey on that service specifically.

CHAIR: Do you do those generally in the hospital?

Dr BEARHAM: Yes.

CHAIR: On most discharge paperwork, or a sampling, or what?

Dr BEARHAM: I could not say. I would have to take that question on notice.

CHAIR: Mr Clout, does your hospital?

Mr CLOUT: We do them, but they are not done on every patient, they are done on sampling.

Mr SCHNEIDER: General and sampling.

CHAIR: So you ask everybody?

Mr SCHNEIDER: We generally do them, and if we are doing them they are by sampling.

CHAIR: Thank you.

Dr BEARHAM: The next example was that in May 2000 Orange Base Hospital established an ambulatory care unit, and since the establishment of that unit attendances per month have averaged approximately 300, and the outcomes we are seeing are a decrease in hospitalisation with the attendant associated risk for DVT and infection. We have seen a decreased length of stay, we have seen fewer unplanned admissions, and those admissions might previously have been precipitated because someone was anaemic or things like that, so being able to come to a clinic like this, have a blood transfusion or a liver biopsy, or intravenous antibiotics, has pre-empted those admissions.

CHAIR: So they have saved the same day medical admissions?

Dr BEARHAM: Exactly.

CHAIR: Excellent idea. Do you have that as well, Mr Clout?

Mr CLOUT: Yes.

CHAIR: Do you have those, Mr Schneider? Do you have a same day medical admission centre?

Mr SCHNEIDER: We do have, but it is not an indicator we are measuring at the moment. We do have same day.

Dr BEARHAM: The last example I would like to talk about is looking at Warfarin errors. A study was done recently within Orange Base looking at whether in fact patients were getting their Warfarin.

The Hon. RON DYER: Can you explain that to me?

Dr BEARHAM: Warfarin is a medication that a number of the patients need to take to thin the blood, to stop them from getting clots. It is quite important when they commence on their Warfarin or get their Warfarin dose that it is monitored, because if you have too much Warfarin you have easy bleeding and easy bruising, and if you do not have enough Warfarin then you could develop clots.

This slide demonstrates that significantly there were issues around the signing for this medication on the medication charts. Sometimes the medication might have been put by the patient's bed and it may not have been signed for. So that was part of the problem.

I have not included all the slides on this but basically a working party was put together with pharmacists, clinical nursing staff and clinical doctors. They had an education campaign within in Orange Base Hospital. You can see when the project first commenced in June last year the number of errors noted were quite high, an average of about five per month, and that was basically due to increased reporting.

The Committee may be unaware that the reporting of medication incidents is notoriously unreliable. People see it as additional work. We need to keep educating staff about the importance of medication errors.

Following the intervention we were looking at changes in policy about how medications were signed, how they were given out, who actually dispensed the medication. We have seen a significant fall in the number of Warfarin errors. This is a quality study that has some objective measures that you can look at.

Mr SCHNEIDER: New England Area Health Service is located in the northern part of New South Wales and covers an area of 98,000 square kilometres. We have 19 local Government areas and a population of 178,000 people. It is an area that is one and a half times the size of Tasmania and if you look at the map, it resembles the shape. We have 20 hospitals, 7 community health centres, 12 primary care sites and they are organised across 23 health services for administrative purposes.

CHAIR: The primary care services are included in hospitals?

Mr SCHNEIDER: Yes, but we have not got any MPSs on site. Two are due for start of construction this year. The mission of the health services is to improve the health status of the people living in the New England area, providing appropriate clinical and population health services around a continuous quality framework.

I move on to population characteristics.

CHAIR: 5.83, is that the highest percentage for an area health service for Aboriginal and Torres Strait Islanders for New South Wales?

Mr SCHNEIDER: It is. We have the highest in absolute numbers, 10,228, of all area health services in New South Wales.

CHAIR: The Hunter has a fairly high percentage.

Mr SCHNEIDER: In numbers we are the highest.

Mr CLOUT: The Mid North Coast does too, but nowhere near as high as the 5.8.

CHAIR: 10,000 is a lot of people.

Mr SCHNEIDER: It is. That can be seasonal in some instances, Mr Chairman.

CHAIR: That is more Aborigines than there are in Western Australia. Sorry, Western Australia has only 30,000, so it is a very high percentage.

Mr SCHNEIDER: The area provides a wide range of services, community health, population health, chronic care, acute care, critical care, maternity and child health, Aboriginal health and aged care, from primary care to a level of major non-metropolitan referral hospital, which is Tamworth, which we would drill down to.

Activity on an area wide basis, 45,000 is the number of admissions per year. You can appreciate from the data that is the profile.

CHAIR: That is 2000-01?

Mr SCHNEIDER: It is. The non-admitted patients occasions of service I have included there.

CHAIR: The average length of stay is longer but that is not just Tamworth Hospital, is it?

Mr SCHNEIDER: No, this is area.

The Hon. RON DYER: Which are the major hospitals in the area? Tamworth is one.

Mr SCHNEIDER: Tamworth is the major hospital for the purposes of the inquiry but we have Moree, Inverell, Gunnedah, Tamworth, Armidale.

CHAIR: Glen Innes?

Mr SCHNEIDER: It is not regarded as one of the major hospitals in the area. It is a district hospital. Our financial profile, our initial cash budget allocation for 2001-02 is $149 million, which is 10.4 per cent increase since 1994-95.

CHAIR: This is in a real terms?

Mr SCHNEIDER: Yes.

CHAIR: Where are you in terms of the RDF?

Mr SCHNEIDER: Within the period you have referred to before, within two per cent by the period you have indicated.

CHAIR: 2000-03; where are you now? You are a bit above, are you not?

Mr SCHNEIDER: It is just above.

CHAIR: Just above the line.

Mr SCHNEIDER: At this stage.

CHAIR: You were another area that benefited from the forgiveness of debts when the Minister announced the $2 billion injection into health. You and Greater Murray were the two.

Mr SCHNEIDER: Prior year debts, we have been, Mr Chairman.

CHAIR: I just make the comment. It has been an area of difficulty for budgets for a long time.

Mr SCHNEIDER: It has been.

CHAIR: Not now.

Mr SCHNEIDER: Net cost of service $400,000 unfavourable last year.

CHAIR: That is very good. It used to be minus six and seven, 13 million in the old days, I mean four years ago.

Mr SCHNEIDER: Yes. Mr Chairman you have had outlined various aspects of directions of New South Wales Health so I will move straight to, I guess, the implementation and Government action plan for health as it applies to the New England Area Health Service and I will come back, as questions require, to anything relating to our own strategic plan which we have developed and how that relates as need be.

The area health service, our board committees, the board recognises clearly its clinical focus and responsibilities in clinical governance as well as corporate governance. The board is served by committees as shown there, the same as you have appreciated other health services and their committee structures. That provides ample opportunities for full range of staff representatives and community input.

CHAIR: Do the community nurses get an input into say, for example, the surgical stream or the chronic care stream?

Mr SCHNEIDER: They do and I am coming to that on the next slide, Mr Chairman. In reference to the

clinical council that we have established, that is serviced by the five streams of surgical chronic care, maternal and child health, critical care and mental and drug and alcohol and in the chronic care stream, the chronic care conditions of cancer, cardiovascular disease and respiratory conditions which we are pursuing. We have divided New England up into three areas and we have community health councils with extensive community membership, looking at various conditions and that feeds into the chronic care stream as well.

The clinical council's role is one of planning and maintaining clinical networks, both internal to New England Area Health Service and external, setting and maintaining clinical standards within New England Area Health Service, implementation role and delineation program for individual health services within the New England Area Health Service, adoption and implementation of evidence based practice throughout the area, and reviewing clinical indications in relation to individual health services and individual clinicians.

Mr Chairman, I would note that has been well received by the clinicians for that opportunity of input into practice.

CHAIR: Certainly what New South Wales did in terms of IT has been, without doubt, one of the strongest drivers of quality, the education model, computer-based, where you can get access to the net, CIAP, clinical information access project.

Mr SCHNEIDER: Our directions in quality are governed by the framework for managing quality of health services by New South Wales Health and the dimensions within that of safety, effectiveness, appropriateness, access, consumer participation and efficiency, our own quality health plan and, as a subset of our own quality health plan, risk management features strongly in both corporate and clinical governance.

With respect to our quality plan, our aim is to establish a culture of continuous quality improvement. We have voluntarily pursued accreditation of all health services within the area accredited by the Australian Council of Health Care Standards along with other specific services. The service itself has its own accreditation and they are listed there, Mr Chairman.

CHAIR: In terms of risk management if you have an incident and you do an inquiry into that incident, as you would, do you do it through one of the section 22 committees, or do you do it in a way that is discoverable for court action?

Mr SCHNEIDER: That depends on the incident itself and the implications, whether it be negligence or otherwise, and by far the majority we do in a way that is discoverable.

CHAIR: If, for example, somebody gets a wrong blood transfusion, that would go off to the coroner. Something less than that, if somebody gets a double dose of Warfarin, they do not come to any harm, but there is a double dose, how do you investigate that matter for reporting, for example, in terms of mismanagement to the board or the clinical council?

Mr SCHNEIDER: It would be done in an open way, Mr Chairman.

CHAIR: In a totally discoverable way?

Mr SCHNEIDER: Yes.

CHAIR: A lot of the reviews of clinical things would be done through section 22 committees.

Mr SCHNEIDER: They will be.

CHAIR: The reports coming out of them are discoverable and all of the initial inputs are of course discoverable, the data is discoverable, but the machinations and discussions are not necessarily discoverable.

Mr SCHNEIDER: No, not always. I guess in this case we are not wanting to pursue a blame culture. We are wanting people to be quite relaxed in improving things.

The next slide is a philosophical sense of where we are trying to move the organisation to.

CHAIR: Can you explain the last slide?

Mr SCHNEIDER: We do not just want to have a reporting culture, and that is halfway along the continuum, nor is the aim to finish with an informed culture, but one of continuing learning.

CHAIR: Learning culture.

Mr SCHNEIDER: Whether it be from adverse events, or from professional colleges contributing to the world changes in contemporary practice.

CHAIR: You house the rural chair in rural medicines, do you not?

Mr SCHNEIDER: We have been designated.

CHAIR: Before that there was a centre for rural training at Tamworth.

Mr SCHNEIDER: We do.

CHAIR: You have as a chair a professor.

Mr SCHNEIDER: We do not.

The Hon. RON DYER: I thought that was Broken Hill.

CHAIR: There was a centre for rural training established.

Mr SCHNEIDER: That centre still exists but there is not a professorial member. This approach on the next slide has not just been around recently, it has been around for ever. That is reflecting my rurality. The Furphy water cart carries a small logo on the end "Good better best. Never let it rest until your good is better and your better best".

CHAIR: It was the water cart. It is not really a furphy though, is it?

Mr SCHNEIDER: The water cart is manufactured by the Furphy company. It is real.

CHAIR: It is not a furphy.

Mr SCHNEIDER: No, it is real. Of course, again the Government framework is giving that framework for us to pursue this culture of improvement and excellence.

Moving to the quality initiatives and I will distinguish between national, State and our own development indicators, and on the next slide nationally we have been involved in national hospitals demonstration project and that saw the setting up of a pre-admission clinic in 1998 at Tamworth. This is just for Tamworth,this particular focus. Pre-admissions for example in 1998 we were seeing 30 per month and now 120 per month.

Through day of surgery admission process in 1998 Tamworth Base Hospital had 55 per cent and has moved recently to now 86 per cent, with the benchmark being 80. The New England Area Health Service as a whole is sitting at 89.5 per cent.

Day only surgery moved from 44 per cent to 64 per cent, just above the benchmark for Tamworth Base Hospital and the New England Area Health Service is 67 per cent.

CHAIR: Looking at those figures, you have gone from a day surgery admission rate of 55 to 86, which is a difference of 30 per cent. 20 per cent is doing more day onlys and 10 per cent is for other people who are going to stay overnight.

Mr SCHNEIDER: In percentage terms, but I would have to look at the numbers.

CHAIR: That is assuming there is an equal number.

Mr SCHNEIDER: It does.

CHAIR: In other words, much less improvement in same day of admission surgery for bigger cases, or cases to stay overnight, than there has been for same day, which is not necessarily exactly the same as Coffs Harbour. Coffs Harbour has increased much more.

The Hon. RON DYER: There was a substantial increase, I noticed, in your day of surgery rate as well.

CHAIR: That was 20 per cent. Actually it was more than 20 per cent. Go back a slide. These figures we are going to have to come to grips with.

The Hon. RON DYER: I am referring to the day only surgery rate.

CHAIR: They have gone from 44 to 64, which is a 50 per cent increase. The increase in day of surgery admission has gone from 55 to 86, but a substantial amount of that has been an improvement in the day surgery. It is same day surgery, which is not necessarily what happened at Coffs Harbour.

Mr SCHNEIDER: In our quality initiatives we have included staff education and with staff attending New South Wales Health education , they have been encouraged as part of that to return to the New England area and undertake specific areas of improvement. The four areas indicated that we have just begun collecting data on are those where we have only started to initiate the program but we have information on pneumococcal vaccinations and I will spend a brief amount of time on that.

The graph there indicates the patients being admitted to one ward in the hospital, that the base line vaccination rate was 12 per cent when they came into our care, and we converted that over a period of time to being 80 per cent.

Coming into our care, the guidelines by the Commonwealth National Medical Research Council indicate that people over 65 and immuno-compromised people should all be vaccinated, but we are still finding people coming into our care being not vaccinated, and we have undertaken a program to increase that vaccination rate within the hospital.

CHAIR: But that is a community based project?

Mr SCHNEIDER: It will move to be a community based project.

CHAIR: So they come in, and if they are not immunized you immunize them in the hospital?

Mr SCHNEIDER: Yes.

The Hon. RON DYER: What sort of vaccination are we referring to here?

Mr SCHNEIDER: Against pneumonia; pneumococcus.

CHAIR: So if you get one of the chronic obstructive airways disease patients in, who should all be immunized, then you take the opportunity when they are in hospital.

Mr SCHNEIDER: Mr Chairman, you have picked the very ward in which the program was initiated, the medical wards where many of the patients did have those sorts of conditions.

CHAIR: So over time you hope to reduce your "Frequent Flyers" by actually stopping them getting pneumococcus. Has that been very successful for you? It is a different project.

Mr SCHNEIDER: Not measured as yet, Mr Chairman, but you can see the rationale, where we are heading with it. On further quality initiatives, Mr Chairman, I have moved to a further slide just before I go into those indicators, which I will come to shortly. Equipping staff to have skills to look at issues, to define appropriately what is an appropriate indicator, collect data, look at solutions and implement them and monitor them. That just does not happen without education. Within our health service we have undertaken a number of programs.

CHAIR: Did you find that the Tridgell and Gibberd roadshow picked up the interest?

Mr SCHNEIDER: It certainly did.

CHAIR: When the roadshow came, with Tridgell and Gibberd, was that a big impetus for your area to get a bit more active?

Mr SCHNEIDER: It was, and for us the timing was very good because we have undertaken the program I am about to highlight to you of giving staff skills. Then, before they had a chance to think what they were going to do with it, we were presented with the indicators I am going to go through shortly, where we deviated from the cone before. There were six that we deviated from.

Mr CLOUT: If I could just comment briefly on that, in our area health service it was very deliberately and specifically aimed at being an impetus, because one of the biggest issues is getting the clinicians involved. Their plea is, "Don't try to get us involved unless you have got the data and the information", and it was a very good way of being able to show them the data is there, it is discoverable in a form that they can easily use.

CHAIR: It is targeted at them personally.

Mr CLOUT: Absolutely.

Mr SCHNEIDER: The areas on education that staff had undertaken, and then looked to internally develop some areas to look at, were non-urgent ambulance transport, and internal patient transport ourselves. The first one was where we used New South Wales Ambulance Service to provide that service on a non-urgent basis. We sat down with the Ambulance Service to look at improving the service right around the area. Internal patient transport, clinical risk management, employee assistance program, learning and development within the organisation and group purchasing. On the latter one we have not yet started.

On the internal patient transport where people will move from one small hospital to a larger hospital for surgery and then go back, or come for appointments from very small centres where there is no health service and go to a larger centre, they have to be moved at times, and the outcome from that has been the expansion of our internal patient transport. That has resulted in improved appointment times, treating more patients in the day at diagnostic centres and pathology where we do not have late people holding up treatment. We have had a great deal of positive consumer feedback on not waiting within the health service, and getting back to their own district sooner than happened before.

CHAIR: That is where you get actual benefit. You get quality and you get more efficient use of dollars too. It is a good one.

Mr SCHNEIDER: And the public perception of this area of quality, as you have highlighted, improved considerably. We have, as well as staff training programs, encouraged staff to attend outside the Australian Council and Health Care Standard functions, risk management programs that are offered by other bodies, change management.

CHAIR: In the learning and development, how much money does your area health service spend on, for example, staff training?

Mr SCHNEIDER: I wish to take that on notice, Mr Chairman.

CHAIR: Is that hard to find, or not?

Mr SCHNEIDER: No, it is not hard to find.

CHAIR: Would it be hard to find for each of the other area health services?

Mr CLOUT: I think it is very difficult to find.

CHAIR: Because within a service there is funding people to go away, there is occupational health and safety, there is all that stuff.

Mr SCHNEIDER: Mr Chair, we will give you an answer, but it may not be comparable because, with a large number of factors to be included in it, some areas may include them or not include them. So I think it would be difficult to compare.

CHAIR: And if you are a teaching hospital, of course, that is different.

Mr SCHNEIDER: Markedly different.

CHAIR: In terms of employee assistance for learning and development, that would go to the issue of quality, would it not? A lot of the other training, for example, maintaining your staff's knowledge about occupational health and safety, is vitally important, and that would be hard to identify, because it goes on every day. Yes, it might be too hard to do that one. Is it too hard or not too hard?

Mr SCHNEIDER: You have hit on an important point there. We are aiming to add all of this into their day to day routine, and not to be exceptional events. So we could give you an answer, but I believe it is difficult to get if you wanted comparability.

CHAIR: Yes, I want comparability. Is it something you believe that we should look at as part of this inquiry?

Mr CLOUT: Mr Chairman, we do an enormous amount of training every day. Most of the training we do, and we should do, is on the job. What we could identify in terms of dollars is specific programs that people go to. I really think that if you are wanting some idea of the level of training that goes on, trying to put a cost on it I think is –

CHAIR: Too hard? What do you think?

The Hon. RON DYER: We can deliberate about that privately.

CHAIR: I do not want to put these people to an exercise which is not going to come up with something comparable and something that is meaningful, although it is vitally important.

Mr SCHNEIDER: I think Mr Chairman you could get a feel from each of the people who appear, and that would satisfy you whether there is that consciousness of building it in and doing it, or you may not get that feeling.

CHAIR: I have got the feeling that they have done it. From Miss McPeake yesterday we got that definite impression, and I think that is all part and parcel of it because she is going through a different quality management process, and that is a very important part of hers. In the Australian Council of Health Care Services I know it is a very important part because it actually gets tested by them. They actually go to people and ask whether they have trained them or not. Whether or not we look at that – we will have to deliberate on that, I think.

Mr SCHNEIDER: We also participate within New South Wales award programs, the Baxter Health Care Innovation Awards across Australia, the Premier's award, and our own internal awards, and that is very encouraging for staff, to see how they compare with other areas. They have been well worthwhile initiatives.

Moving directly to the indicator we were referring to before, these are New South Wales Health indicators. There are seventeen that we were provided data on for the New England Area Health Service, in six of which there

is significant difference to the New South Wales population, and I have three to present directly if you wish. I will identify the other three, of course, but that has actually been provided.

Moving to the three that I am providing information on, we have the cone which was referred to by Mr Clout before, and the flag that we are getting of course is Gunnedah, with more caesarian sections occurring. Tamworth was within the cone. That is high, but it is a major referral hospital so it is appropriate, as we believe it should be, and at Armidale it is low, so that is a flag we are looking at. I do not have explanations at this point. This is being used for data. We should be concentrating on using this type of information.

CHAIR: But obviously your area health service fits well within the cone?

Mr SCHNEIDER: It does, but we have had one variance outside, and there are some extremes. Of all the indicators we are looking at, and will continue to monitor, there are six where we deem we have a problem, and this is one that we do, and that is the Armidale area.

The other indicator is total hip replacement, and when we go to the cone shape, this is a frequency occurrence with the population, days observed admission. The flag for us is Armidale where it is perhaps higher than State average. For Tamworth, that is due to specialist shortage, which was rectified six months ago, and I believe the data updating this will change that significantly. So I have one explanation.

CHAIR: Maybe Armidale went ahead because people had to be accommodated in some way, and so their patients were moved up to Armidale.

Mr SCHNEIDER: It did, and we had two specialists there at the time who could cope with the workload. So we will get a cone correction, and I expect it to be within the cone next time.

The third area is with asthma, and I am pleased we spent some time earlier on using these indicators as to their appropriateness, because asthma is one where, if you look at Gunnedah and Narrabri, they service people who come from extremely isolated areas, and best practice is to keep those asthmatic type people, when they have any indication of an attack, within the hospital and not go home where they are at risk of not receiving any help within a brief timeframe.

In Yallaroi Shire, on the extreme right hand side of the slide, is the community up at Warialda which is on the Queensland border, and again with such an isolated population you are at risk in putting those people back into the community after an asthma emergency, so the likelihood is for admission to ensure closeness.

That is the early explanation that we are receiving. However, as we talk to the doctors and they are involved, that will be modified, with more preventative programs on asthma management and education, and particularly on farming properties, how to prepare your day and what to take with you on the day.

So I stress it is very early and I have not got definitive outcomes on how to change that, but it is valuable information for us to give to staff attending, and the specialists recognise it as valid data to work with.

The other three that I have not included by which we do deviate is tonsillectomy over fifteen years, the diabetes primary diagnosis, and with our high incidence of Aboriginal population, that is one of the explanations that will be provided, but there may well be others.

To finish on this set of indicators, the chronic obstructive pulmonary disease again is higher, but this has a number of conditions and our low incidence of immunisation would be an explanation for that as well.

We have developed indicators internally, to finish on the presentation. We have just started these, and the dimensions on the left hand side are from the Government Action Plan for health under the quality program. The indicators are purely our own, and whether they are valid, and whether they are successful, will be decided over the next eighteen months as the professionals work with them and collect data on the use of them.

CHAIR: But the falls indicator is one of the State-wide collections, is it not?

Mr SCHNEIDER: Yes. A number are, but we wanted to focus on this before we got some data given to us, and you can see some caesarian section work as well that coincides. That has been good to get that data. I stress this is very early and I cannot give you outcomes and details as yet.

CHAIR: I think it is true to say that there is a quiet excitement out there.

Mr SCHNEIDER: There are two other internal indicators we have chosen. Radiology is one, to improve the turnaround time when reports are available and the other one is our dialysis unit, Mr Chairman, and on that particular slide we have used a number of indicators to improve our dialysis effectiveness and efficiency and patient outcomes.

CHAIR: That would probably drive your cost efficiency too.

Mr CLOUT: I have realised that, in answer to a question, I have given you incorrect information and I would like an opportunity to correct that. It is an issue which is considerably important. On reflection it is clear to me that day only surgery is not only included in the day of surgery.

CHAIR: That is why I went through that quite deliberately, because it has been confusing. What does the 57 per cent reflect?

Mr CLOUT: They are quite differently defined and they are separate.

CHAIR: We will get a briefing paper for the Committee about that.

Mr CLOUT: Please accept my apologies.

CHAIR: I accept that. That is why I went through it carefully because it has been confusing to me for some time. Can I ask you about self-sufficiency? We received an answer from Ms McPeake yesterday that she is 88 per cent self-sufficient if she includes Wodonga within her area health service. What percentage of self-sufficiency would you have in the New England?

Mr SCHNEIDER: We are 86 per cent.

CHAIR: And for you?

Dr BEARHAM: I believe it is 85.

Mr CLOUT: And 90.

CHAIR: That is very good. Is there a special definition for this, or do you say that you are 90 per cent self-sufficient for those services that you provide, or you are 97 per cent self-sufficient for all services?

Mr SCHNEIDER: 86 per cent, the response I am getting, is for self-sufficiency for public inpatient separations.

CHAIR: How would you count somebody from Tamworth who ended up in Sydney and had their gall bladder out?

Mr SCHNEIDER: That would be in the 14 per cent that we were not providing that particular service to that patient, if they were admitted as a public patient somewhere else in New South Wales.

CHAIR: Are you losing much to Sydney for the bone and joint at Camperdown, given your shortage of orthopods?

Mr SCHNEIDER: I would like to take that on notice in that period where Tamworth was down, just what there was.

CHAIR: You might see a great change in that.

Dr BEARHAM: Not that I am aware of.

Mr CLOUT: There are three ways we measure self-sufficiency. One is by raw separations, one is by case weighted separations and the other is by dollars. Certainly one of our outflows of significance is orthopaedics.

CHAIR: To?

Mr CLOUT: A variety of places including Central Sydney.

CHAIR: In terms of patient consultation and complaint handling, do any of you have a patient advocate in your hospitals?

Mr CLOUT: Mr Chairman, we have at Coffs Harbour a patient liaison officer and at an area level we have established a community liaison officer and a patient complaints officer and they both work in my office. They are very new positions and ones that we believe are important in terms of servicing those areas.

CHAIR: So your patient support person, if somebody wants to complain, is there anybody they can go to, to help them overcome what is perceived to be a problem?

The Hon. RON DYER: Mr Clout said that there is a patient complaints officer.

CHAIR: That is a new one. That might just be somebody who receives complaints. Do they actually work with a complainant to make their complaint?

Mr CLOUT: The community liaison officer facilitates working with other people within the hospitals or services, so, yes, they do. Hospitals have for a long time had mechanisms and individuals who work with patients, or their carers, who raise complaints or concerns in relation to the services that are provided. They do it differently from place to place and it is done variably well.

CHAIR: Tamworth would have an Aboriginal liaison officer.

Mr SCHNEIDER: We do.

Dr BEARHAM: And so does the Mid West.

CHAIR: There is always an Aboriginal liaison officer. All of the hospitals have that. Does the Health Care Complaints Commission provide you with what they call their patient support officer, a PSO?

Mr CLOUT: We have two across our area.

CHAIR: Are they funded by the Health Care Complaints Commission?

Mr CLOUT: I am not sure where they are funded from.

Mr SCHNEIDER: We do not have one.

CHAIR: I know you do not have. I do thank you for those presentations. We have a letter saying that these were not all quality indicators. We know that. That is all we have. That is all there is available for the public to make comment upon. We are thinking of going out and getting a consultant to see what we should measure and there is some disagreement on the Committee. The tenders we received were at huge variance. I think I can say that publicly. The matter is now in the melting pot about whether we are going to do that again, to try to find out whether the indicators which are being used are world's best practice, or whether there could be others, but if you could please give us the answers as were circulated to us in writing, as well as your presentations, I would really appreciate it because we do intend, as I said privately before, to produce a discussion paper which would have the information for the community to see and let them then come forward to us with submissions about quality of service and value for money, because without the department's view and your own presentations, we do not believe that we can get informed submissions.

(The witnesses withdrew)

(Short adjournment)

CHRISTOPHER JOHN CRAWFORD, Chief Executive Officer, Northern Rivers Area Health Service, 67 Alston Avenue, Alstonville, New South Wales, and

DEBRA THOMS, Chief Executive Officer, Macquarie Area Health Service, 23 Hawthorn Street, Dubbo, sworn and examined:

ACTING CHAIR (The Hon. Dr ARTHUR CHESTERFIELD-EVANS): Are you conversant with the terms of this inquiry?

Mr CRAWFORD: Yes.

Ms THOMS: Yes.

ACTING CHAIR: If you should consider at any stage during your evidence that any certain evidence or documents you wish to present should be heard or seen only by the Committee, the Committee may be willing to accede to your request. Do you wish to make an opening statement?

Mr CRAWFORD: I wish to give a presentation to address some of the terms of reference of the Committee. I am going to present on the Northern Rivers Area Health Service. The presentation content will include an introduction, some material about governance, the Government action plan for health, about quality and then I will bring that together in a conclusion.

Just to give the Committee an idea of what makes up the geographic area of the Northern Rivers Area Health Service, I have a slide there. It is basically the top north eastern corner of the State, stretching from just below Grafton to the border and west to the dividing range.

The main hospitals, as you can see there, are Tweed Heads in the north, Lismore Base in the middle and Grafton Base in the south. The only one which is pertinent to the terms of reference of the inquiry, which is a non-metropolitan major hospital, is Lismore Base and we will focus on that as well as on the Area itself.

A little bit of information about the area; we have a population of about a quarter of a million that we serve; a needs index of 103.7, which means we are slightly more needy than the average; a 2.5 per cent Aboriginal and Torres Strait Islander population; 16 per cent, and this is important, projected to go to 21 per cent by 2016, aged over 65 years which are the bigger consumers of health services, and the population is expected to increase in the same time by 1.7 per cent or about 72,000 people.

ACTING CHAIR: Sorry 72,000?

Mr CRAWFORD: People, so it will go to about 250,000.

ACTING CHAIR: That is not 1.7 per cent of 250,000 though. It is probably 17 per cent.

Mr CRAWFORD: It is 1.7 per cent per annum, so that is over a 16 year period. Admissions: the area has about 59,000 admissions and Lismore Base just under 20,000. Lismore Base's complexity is 1.09, which is at the higher end of the range of hospitals you are considering.

The Area has emergency department attendances of 142,000 and that Lismore Base figure is the wrong way around. That should be 23,000 not 32,000 so 23,000 attendances there; 142,000 in the Area.

Occasions of service: the Area has 772,000 and Lismore Base has 256,000. For those who were here earlier, that is more similar to Coffs Harbour in the way we count it than to Port Macquarie.

There is a major concentration by the Area board on its governance responsibilities divided into the two forms of governance. Firstly, the corporate governance, and most of the corporate governance, the actual detailed work, is done through the board committee structure where we have a quality council which we will focus on a little later, health service and ethics, medical advisory, finance and resources and audit committee. That corporate governance

responsibility particularly focuses on the importance of planning, budget control, delegations and by-laws, and we have compliance reviews regularly conducted and also a board evaluation, self-evaluation usually with a facilitator, which is conducted annually.

If I can then move on to clinical governance, we have just outlined there in a slide the clinical governance structure for the Area and that cascades down from the Area Board, through the quality council, the Area quality improvement committee, which is below the Board level, into the quality committees at Lismore Base, of which the peak one is the service improvement committee. We will come back to that under the quality section.

If I can now move to the Government plan of action for health which is the major driving force of reform at this point in time, firstly, there are three year budgets that have now been set out for the Areas and this gives us greater certainty. It also enhances our planning and increases the RDF share of the Area. This will give in real dollars an extra $29.5 million over three years to the Northern Rivers, taking it up to a target eventually of 4.3 per cent of the health budget, its share previously being in 1998-99 3.9 per cent.

The initial cash budget for 2001-02 will be $218.6 million and this represents an increase of 65 per cent since 1994-95.

A key focus of the Government plan of action is episode funding and this addresses one of the value aspects of the committee's work. Lismore Base Hospital is slightly over its cost per weighted separation by about $20 as against the benchmark of 2,450 and strategies are being put in place by the hospital over this year and next year, as it was given three years to bring itself back to the benchmark. We are closely monitoring its expenditure.

We need to say that for Lismore Base episode funding will apply to ICU and other emergency department funding models. This year it is going to be on a shadow basis, but with a view to introducing it real time in future years. Lismore Base is working hard, making sure that it has those as well as the acute services episodic budget which was in last year, the ICU and ED budgets on an episodic basis as well.

Another important part of the Government plan of action is consumer and community participation. We have three health councils in the Northern Rivers to give that focal point for that input. Firstly, an Aboriginal health council, which provides feedback from our Aboriginal and Torres Strait Islander communities; a mental health council, made up of a wide range of representatives; and a hospital and community health council.

We also have local consultative committees that are set up on an as needs basis to help us plan and deal with particular issues or projects. I just refer to a couple of them there. The Byron Shire consultative committee is helping us work on producing a new central hospital for the Byron Shire and Kyogle and Nimbin multipurpose service planning committees, to help us set up multipurpose services in those two towns.

Other parts of the consumer and community consultation include the Board itself which holds its board meetings in a rotational fashion around the area so that 12 meetings are held in 12 different towns, so that it is accessible and before each Board meeting it meets with the community in that town for an hour, to take feedback on any issues of health relevance, particularly focussing on its delivery of hospital and community health services.

The Board subcommittees have a wide range of community and consumer representation, particularly on two, the area quality council and the health service and ethics committee, so that we get that directly at the board subcommittee level, that consumer and community input.

Moving on now to the acute services at Lithgow Base Hospital, there was a focus earlier in the hearing on the day of surgery admissions and day surgery. This is Lismore Base Hospital against the benchmark there on day of surgery admissions, and it is well above the 80 per cent benchmark. It has in fact gone from 82 per cent up to about 91 per cent over the last twelve months, which is a good result and shows that it is pursuing that strategy of the Government Action Plan Acute Committee State-wide that asked to move those rates up, for all the quality advantages that they bring.

The Hon. RON DYER: Are you saying that the incidence of day surgery at Lismore Base Hospital has gone as high as 91 per cent?

Mr CRAWFORD: No, this is day of surgery admissions, and that purple line is the benchmark. So you can see even before this year it was doing well, because it was above the benchmark at 82 per cent, and it has gone up now to 91 per cent. So it was already doing well and now you would have to say it is doing very well.

The Hon. JANELLE SAFFIN: Are you giving us a copy of these?

Mr CRAWFORD: Yes, we can certainly do that. On the day surgery it is doing well, but not as well as that. As you can see, it has just edged along below the benchmark there, pushing occasionally above, and quite a bit of work is going into beating the 60 per cent benchmark, which was exceeded on two occasions in the last four or five months. But it has been just under on other occasions, and certainly they are working hard on pushing that above the 60 per cent so that they stay above it. Overall the Area, in three out of the last four months, has been above that 60 per cent, but Lismore Base Hospital being the biggest hospital and doing some of the more complex work, is just edging below that at this stage.

If we move on to the critical care services, there have been some important changes there recently. As part of the enhancement of services an additional intensive care bed has been opened at Lismore Base Hospital. That is on an annual basis, and for the winter period another additional one was opened. So Lismore Base Hospital was operating with two additional intensive care beds over the busy winter period, and then has one on an ongoing annual basis.

With the emergency department there has been considerable enhancement. An additional staff specialist has been funded, additional nursing staff have been funded, the facility has been expanded to give more spaces and better functionality, and a mental health clinical nurse consultant has been put in to improve liaison with the mental health services and dealing with mentally ill clients who go to the emergency department.

Budget holding has been introduced as part of a government plan of action, and this is very significant for the Northern Rivers Area Health Service because we are so close to Queensland and particularly the Gold Coast and Brisbane hospitals. As you can see there, in 1998-99 $20.4 million, or 8,600 weighted separations, sought health care in Queensland. As I say, $20.4 million was paid by New South Wales for those.

Coming into the Northern Rivers, particularly to the Tweed Shire where we have a hospital right on the border, 4,700 weighted separations at a cost of $11.8 million. This means that New South Wales pays out to Queensland the difference there, being $8.6 million. Under the budget holding proposal that has been introduced there is the opportunity for Northern Rivers to invest in its own services, reverse those flows or reduce them, and therefore have that money invested in New South Wales rather than having to be paid out to Queensland.

I have been involved in six or seven meetings with the Queenslanders, supported by the New South Wales Department of Health, and we are very close to an agreement with them to reflect some of the changes that have been made, which I will refer to in this next slide.

The Hon. JANELLE SAFFIN: Are you able to provide everything in Tweed that is currently done over the border?

Mr CRAWFORD: No, we are not able to do everything, but if I can take a couple of examples, we cannot now and we do not think on the advice we are getting for our clinical services plan on things such as neuro-surgery operations or cardiac bypass operations, they are still best provided in a principal referral hospital. However, of those cross border flows going to Queensland, $2 million is routine orthopaedics that we could do if we had been set up properly for doing orthopaedic work of the amount that is being demanded. So in other words, if we were able to invest in our own orthopaedic services and expand them, people could be treated locally rather than having to go to Queensland.

ACTING CHAIR: Are these not happening at cost? When you say "reverse the flows and get the money back", is the cross border charging not at cost?

Mr CRAWFORD: No.

ACTING CHAIR: Do you make a profit? If you do something and someone comes over the border do you make a profit, and do you make a loss if they go to Queensland, or are you both charging roughly what costs are, in which case it does not matter which hospital it goes to except for convenience for the patient?

Mr CRAWFORD: No. Certainly convenience is one important part, because people would much prefer to be treated locally, but the second part is firstly that average cost is applied rather than marginal cost, so if our patients go to Queensland they will charge the average cost, but if we treated them in New South Wales at our own hospitals we could treat them at a marginal cost.

Secondly, it is the national average cost which is used, not the State average cost. So Queensland, being a low cost State, is actually charging the average rather than the marginal price, and is charging the national average price rather than the Queensland average price.

If I can use an example to show what that all means, just to take a practical pull-down illustration, renal dialysis. We were having our renal dialysis for patients in Tweed treated at Queensland hospitals. We found in fact we could let a contract after tender to the John Flynn Private Hospital on the border, and even after they had paid taxes and having to make a profit as part of Mayne Health, we were able to reduce the cost by about $300,000.

It costs us a bit over $850,00 for Queensland Health to treat those patients, and about $550,000 to have them treated at John Flynn Private Hospital. So we are paying top dollar for patients to be treated in Queensland. That is fine if they are neuro-surgery or cardiac that we cannot provide, but if they are orthopaedics, it would be much better if we spent that money in our own hospitals and treated more patients. That is what we are aiming to do through this budget holding policy and the negotiations we are now carrying out with Queensland.

ACTING CHAIR: If you are paying the national average to Queensland, is New South Wales cheaper than the national average? If you were above the national average you might still come out ahead.

Mr CRAWFORD: New South Wales prices are generally above the national average, as I understand it.

ACTING CHAIR: It is costs rather than prices.

Mr CRAWFORD: Well it is cost, yes, that is right. But we only reimburse the national average cost. So in some senses, on averages, we are not doing as well as we might otherwise. But I think what we are trying to do in these negotiations is get away from averages and concentrate on actual cost, and while the negotiations are not complete, one of the things we are trying to look at is actually paying Queensland more like what it actually costs to treat patients, and having them pay us what it actually costs to treat the patients, rather than using artificial figures that do not bear any relationship to the actual costs in each State.

ACTING CHAIR: If they are below the national average and you are above average, Queensland will probably take a dim view of that.

Mr CRAWFORD: Well, that is why the negotiations have been going on for about six months. It may be that after all is said and done it might be like the Australian Capital Territory in that we might have to go to an arbitration, because that is what happened ultimately between New South Wales and the Australian Capital Territory, but we are hoping we can reach some sort of agreement with them because we feel that that would be easier.

The Hon. RON DYER: We were told yesterday by the Greater Murray Health Service that women having babies in Albury had them at Wodonga Hospital almost without variation. You have referred to renal dialysis, if I understood you correctly a moment ago. Are there any other specialties or areas where cross border flows are systematised so to speak, and certain classes of patients sent across the border, either way?

Mr CRAWFORD: We will send from Tweed up to Queensland any of the patients which are of a higher level of complexity, that we do not do basically. Otherwise, if patients come to Tweed and that is the level of treatment that the hospital can cater for to the level of complexity, then it will treat those patients. So there is nothing I think that provides as good a parallel as renal dialysis, but I see what you are getting at.

Another good example might be chemotherapy. We do not do chemotherapy at this stage at Tweed Heads Hospital and therefore we have quite a big outflow for that to two Brisbane hospitals. But as part of the Tweed Valley strategy which is expanding the services we provide at Tweed Heads Hospital, that service is going to be introduced. So that would be a clear example of something where the flow would change very dramatically once that service is introduced. So that is another example like renal dialysis.

There is an agreement in Greater Murray for these births to occur at Wodonga, I am told.

Ms THOMS: Yes, they do not do obstetrics at Albury. They actually have an agreement to do them in Wodonga.

ACTING CHAIR: So in a sense you are doing the same as that with dialysis, are you not?

Mr CRAWFORD: We did.

The Hon. RON DYER: Was that as a result of a formal agreement, or is that just something that happens?

Mr CRAWFORD: It is as a result of a formal agreement, our formal contract with John Flynn Private Hospital. There are no other examples at this stage of formal contracts, not cross border. We might say that in Lismore, which is where we are focusing, we do have some contracts with St Vincents Lismore where we have our ophthalmology and our palliative care carried out at St Vincents on a contract basis.

Some of that is historical, because St Vincents was originally a third schedule hospital but then became a private hospital, and that has been ongoing on a contract basis.

ACTING CHAIR: In that you are able to save a lot of money sending your dialysis to John Flynn Private Hospital rather than to Queensland, are you sure that the quality that you are getting –

The Hon. RON DYER: John Flynn Private Hospital is in Queensland.

The Hon. JANELLE SAFFIN: You are differentiating between private and public.

ACTING CHAIR: You are saying you have changed your contract. It does not matter which side of the border it is on.

Mr CRAWFORD: We have got quality indicators in the contract, and actually I am told that the clinician who oversees the dialysis program at Gold Coast hospital is also the one who oversees it in John Flynn Private Hospital, with doctors who work across the private sector and the public sector.

ACTING CHAIR: Have you surveyed the consumers?

Mr CRAWFORD: I do not think we have surveyed the consumers.

The Hon. JANELLE SAFFIN: The expertise happens to be at John Flynn Private Hospital, that is the reality.

Mr CRAWFORD: We have not done that survey, but we should do that.

ACTING CHAIR: If you are saving a lot of money by going to a different provider, then at an administrative level that is obviously good, but the question is are they doing it quicker or whatever.

Mr CRAWFORD: No, I think the example really just shows what an inflated price you are paying when you are paying national average costs. That is what I wanted to illustrate. I would certainly not say what we are paying at John Flynn Private Hospital was anywhere near the cheapest you could do renal dialysis for.

ACTING CHAIR: But it is a step in the right direction.

Mr CRAWFORD: No, we still should survey. I think that is a good point, one we will take on board. If I can move on then to give you a couple of other examples where we are particularly wanting to decrease flows, we have focused very much on our intensive care and high dependency services, because we should be able to provide those services locally, particularly at Lismore Base Hospital. You heard what I said about increasing the intensive care beds, and that is so that patients of the complexity which we can treat at Lismore Base Hospital, which is up to level 5, can be treated there locally without having to go to Queensland. So that will decrease outflows.

We are increasing orthopaedic services, as I said, to decrease outflows, and what we are doing in neuro-surgical services is looking to have a preferred provider arrangement with one of the Queensland hospitals, so that the neuro-surgeon will come down to places like Lismore and give clinics there. So although people will have to have their neuro-surgery in Queensland, they do not have to travel two or three hours for perhaps a twenty minute appointment.

So that surgeon might come down once every two weeks or once a month, and do all the neuro-surgery outpatients and people who are now having to travel, and that will come out of, once again, the budget holding and cross border preferred provider arrangements.

If I could move on to chronic and complex care, I know it has been covered in more detail, but just to say that in the Northern Rivers we are putting $2.1 million into that over three years. We have established something rather unique in the way that the Area is going about it, in that we have gone into a partnership with our local Division of General Practice, our Northern Rivers Division.

We are running the program basically together, and it is using the opportunity to put its More Allied Health Funding, MAHS funding, which it gets from the Commonwealth, into the pool of funds available, to extend the pool and therefore drive the program further, rather than us both essentially doing the same thing in parallel. We are very happy with this partnership model and it seems to be going well after the first year.

It particularly focuses on heart failure, on the cardiac side, on cancer and the PEAK program for respiratory, which is Patient Empowerment for Exercise Activities of Daily Living and Knowledge.

If I can refer to the Sinclair Report and say that we are implementing that. We are doing a number of things, but in particular we are looking at those multi-purpose centres at Nimbin and Kyogle, a major move in terms of telehealth, and they are outlined there, and also some work in expanding our patient transport.

The Hon. RON DYER: How would you assess the success to date of the telehealth initiatives?

Mr CRAWFORD: They have been quite successful, the ones that are in place. These are relatively new, but we are getting very positive feedback. It has targeted more isolated communities, particularly out in the west of the area and they feel better supported than previously.

Ms THOMS: We found telehealth has been very well received and we are keen to continue to look to expand telehealth services. We use it quite extensively for mental health and it certainly saves patients having to travel and they can actually have a consultation in their own town.

Mr CRAWFORD: Just before I move on to quality. I have skipped over self-sufficiency, which I knew was of particular interest to the Committee. If I could say over all of the Area self-sufficiency is 88 per cent. Tertiary, for high cost complex cases, self-sufficiency is 22 per cent. For non-tertiary overnight cases, 90 per cent and day only cases 86 per cent.

If I can move on to quality, a lot of work is going into our quality of services, to continually improve those and we see quality as doing the right thing the first time in the right way at the right time. We see a key part of driving quality further and making it central to our routine business is cultural change, so that people do not think it is something extra that they need to do, but something that is absolutely at the core of the way we deliver our services.

If I could firstly talk about our quality structure, we reviewed this in 2000 and introduced a new structure that sat very well with the New South Wales quality framework and the six dimensions of quality and also related and built on the work of the Australian Council on Safety and Quality in Health Care and the New South Wales Council on Quality

in Health Care. As part of it the strategies were to consider national and State strategic directions in both safety and quality.

We firstly developed a local framework called Progressing Quality in the Northern Rivers Area Health Service and then we moved through a systematic approach to implement that through continuous quality improvement.

Just a little bit about that structure. We set up for the first time an Area quality council, as I said earlier, as a board subcommittee. It was established in April 2001. It is chaired by a board member and has three board members on the committee, but it also has a range of other participants, including visiting medical officer representatives, representatives from our divisions of general practice, from consumers, clinicians and managers, about 22 in all.

ACTING CHAIR: I notice you have a surgical audit committee.

Mr CRAWFORD: Yes.

ACTING CHAIR: Do you have any other audit committees, medical, intensive care, mental health, community based? Everyone looks at surgery because it is more easily quantifiable. Do you have other quality committees?

Mr CRAWFORD: We do. Each entity that we have has a peak quality committee that feeds into our quality improvement committee. I think I have a slide in a second that comes to some of those, so if you could give me a minute and I will get to that.

At Lismore Base we have got a service improvement committee. That is the peak committee and as part of the change to our structure, we asked every senior manager of the facility, in other words whoever is the top manager in the entity, be it a hospital, be it a cluster for our primary and community services, to chair that quality committee.

Previously I found that they were all chairing the finance committee but the quality committee seemed to be delegated a fair way down. I said, let's have the top person chairing the quality committee, because that sends an important message. It is chaired by the executive officer and reports to the Area quality improvement committee.

I might move to that slide, and we see there that we have got the Area quality improvement committee, which is a management level committee that feeds into the Area quality council, which the Lismore Base committee reports to, and as you say, we have the surgical audit committee, but we have other QIP functional teams which cover other areas of quality, and that is the way Lismore Base has set up its committees and it also has a continuum of care committee.

Some of the other areas that you refer to like medicine, obstetrics, will come under some of those broader committees. The reason for the separate surgical audit committee is because it is a section 22 committee with the privilege which we will come to in a second.

Now, to support quality, to walk the talk, we have got an Area quality unit and we make it very clear that that is a facilitation exercise, not a unit to do quality but help and support those who are doing it and similarly the Area quality improvement committee also plays that facilitation role.

We have a clinical effectiveness unit as part of our Southern Cross Institute of Health Research and it looks at a lot of more detailed projects and provides advice and information about those.

We have an Area quality manager and coordinator and her role is part of implementation of structures to support quality improvement activities, and as CEO, as part of getting linkages involved, I have been appointed as the rural CEO rep on the New South Wales Council on Quality and Health Care and can provide direct feedback to the Area on State-wide initiatives and trends from that committee.

Also an important part of the whole quality clinical mix is the Area clinical council. We have set up a council of 27 clinicians that provides advice to the Area executive and board on all clinical matters and it plays a key role in advising on quality as well as planning and financing of health care in the Area.

Just continuing on support for quality there, as part of the Government action plan for health, some best

practice funding has been made available by the Minister for Health and the Department of Health and we are looking at using that very specifically to improve quality.

Firstly, we are looking at making the initiatives that it undertakes consistent with the initiatives of the New South Wales Institute of Clinical Excellence and these are to go into the Human Factors in Medicine course which is the Aeromed, where human factors can cause error and how you avoid that and we have taken up some of the research from airline pilots and simulations there as to how human error has been found to cause errors in airline situations and how that can be used in the medical situation and the clinical environment. That is a major course and we will be the first rural Area to undertake putting a major number of our clinicians through that.

The Brent James Clinical Practice Improvement Program, we are funding a number of our clinicians to go through that program with Dr Brent James from America. That has been mentioned previously, the leading work he has been doing in terms of advancing quality and value for money in health care.

We are also going to use that funding to appoint a data manager to undertake data analysis and presentation for clinicians who are involved in clinical practice improvement. One of the problems that the clinicians have raised in the past is that the data often is not good enough or presented in the appropriate way for them to make best use of it to drive change and this data manager is going to make sure that more and appropriate data is available to assist clinicians to use it to change quality, because the old saying that if you cannot measure it, it is very difficult to change and improve it, is very true, so that will be a key part of advancing quality.

Further support for quality comes through education and training that we are putting in. As we say, we have had 11 participants through the clinical practice improvement program in the last three years. Better information management to support decision making and data analysis and Area support for accreditation and I need to indicate that the Lismore Base Hospital has been accredited by the ACHS as a hospital functioning consistent with their EQUIP framework.

Future directions, I think I might have pretty much gone over these. I think the only one to pull out there is to say that we are going to have a comprehensive clinical risk management program in place. That is a key priority for 2002 and also a major quality forum will be held early in the first quarter of 2002.

The Hon. RON DYER: Is that referring to the Area or Lismore Base Hospital?

Mr CRAWFORD: Both, referring to the Area with Lismore obviously being a key part of that.

Now, the performance frame, a steering committee was established to look at indicators which could address quality and help us measure and monitor it and in particular we were looking at those six dimensions of quality, and out of that came a reporting frame which went to the quality council and it is still being refined. It does rely to a great extent on those phase one indicators that are State-wide, but we have also looked at indicators that may be helpful, particularly to the Northern Rivers Area clinicians. Some examples are safety measures, such as medication errors, pressure areas, falls.

Quality data: we had Dr Tridgell and Professor Gibberd came to the Area, as they did to other Areas, and with Ms Maureen Robinson, director of the quality branch, to do a major workshop in July 2001 and they presented a lot of data and I think it went very well. There was a lot of discussion and feedback. In fact, the Committee Chair of this Committee attended that meeting and I think he provided some feedback to this Committee on it.

Arising from that, we determined that three projects should be pursued in detail at a local level, firstly looking at diabetes separation rates, then looking at AMI separation rates for PTCAs, and you probably want those spelt out, acute myocardial infarcts and cardiac angioplasties, I think is probably the best way of putting it.

What happened there is our separation rates for AMIs were on the high side but our PTCA separation rates were on the low side and we needed to investigate to see why that was. One of the thoughts was we do not have cardiac angioplasty in the Area and people have to go to Brisbane to access it and maybe that is causing people to access it less than would be desirable.

Some of our immunisation rates were on the low side and we had to investigate that and part of the issue in the

Northern Rivers, particularly in the Byron Shire, there is conscientious objection to immunisation, in a way which is disproportionate to other parts of the State, so we believe, but we have really to confirm that that is the case.

The Hon. RON DYER: Are you referring to immunisation of infants?

Mr CRAWFORD: Immunisation generally. Another part of the quality performance improvement arsenal is the clinicians' tool kit and we are very pleased with that. That has been developed by the New South Wales Department of Health to assist clinicians and we are going to embark on a major education program on that in early 2002.

I mentioned already the appointment of the Data Manager, particularly to look at variation and support of our clinical quality activities.

Next, qualified privilege. We have three committees in the Northern Rivers Area Health Service which have qualified legal privilege, one at Lismore Base Hospital being the Surgical Audit Committee, and that is why that committee has to stand alone, because it has that privilege and it descends only on that particular committee, with specified terms of reference.

Monitoring compliance: we monitor unplanned re-admission rates, clinical incident reporting processes, strategies to improve reporting, health care, complaints commission investigations. We monitor those on a regular basis. Lismore Base Hospital, in the last available figures, had a re-admission rate of 4 per cent compared to its chapter or round table which it uses for benchmarking with other like hospitals, which was an average of 6 per cent. So compared to similar hospitals it seems to be doing quite well there, and it certainly gives a fair focus on that.

The Hon. JANELLE SAFFIN: For what period was that measured, over what time frame?

Mr CRAWFORD: That was over the 1998-1999 and 1999-2000 years. The data that Paul Tridgell presented generated a lot of enthusiasm amongst clinicians to further investigate variations in practice. There was also a more consistent structured approach needed for utilisation of local data, and he stimulated thoughts about how we could better do that, and that came up with the idea of having a Data Manager with some of our Best Practice funding.

Amongst other things that have been done, we are introducing progressively clinical pathways at Lismore Base Hospital, and also new discharge planning policies, and having as much clinical involvement, both clinical, nursing and allied health clinicians, as we can in those processes.

In particular we have got various projects under way, and I have got a list of those. I think for the sake of brevity I won't go through all of them, but just to say the human error in medicine course and the clinical council, which I have referred to, are important. We have our own annual quality awards so that we can highlight and recognise good quality projects that people have done in the last year, and also we contribute to the annual Baxter Better Health Awards for quality achievement State-wide, and in that way try and recognise the special efforts that those who are involved in quality put in.

There are some examples there of current quality projects, particularly paediatric, respiratory, length of stay, magistrate's referral project, development of a peritoneal dialysis home training program, ophthalmology waiting list audit. They are just some examples of the many quality projects that have been undertaken in the last year.

Just in conclusion, we see active pursuit of quality and value for money as our highest priorities, and just a quote from Dr Brent James that sums up our belief. "The old belief that quality means spare no expense just turned out not to be a good model. A better model is to do it right the first time." And that is something we are stressing in pushing value for money advancement and quality improvement moving in tandem.

ACTING CHAIR: Thank you. I think we should hear from Deborah, and then ask questions together. Please go ahead.

Ms THOMS: Thank you, Mr Chairman. Similarly I will do a presentation covering a number of areas, giving an overview of the area health service and including some specific examples related to Dubbo Base Hospital,

which is the hospital included in this review, and talking about some of the quality activities that are occurring in the area and at Dubbo Base Hospital.

Macquarie Area Health Service covers roughly 116,000 square kilometres of the State of New South Wales, which is about 15 per cent of the State. It provides public hospital and community based health services for more than 102,000 residents in eleven local government areas covering Bogan, Cobar, Coola, Coonabarabran, Coonamble, Dubbo, Gilgandra, Mudgee, Narromine, Warren and Wellington shires. In those eleven local government areas we have sixteen facilities.

Dubbo Base is a 170 bed Level 4 facility. It is the major referral centre for Western New South Wales, servicing an estimated population of 120,000. That is the Macquarie population along with about 15,000 people who use it as their referral centre from what is known as the Upper Far West Sector, which is part of the Far West Area Health Centre, and that covers the towns of Bourke, Brewarrina, Walgett, Lightning Ridge. As you would appreciate in the geography of this State, it is a lot closer and quicker and easier for them to drive to Dubbo than to go to Broken Hill.

Dubbo Base provides general medical, surgical, obstetric, emergency and intensive care services, and it has specialty services in renal, paedeatrics, urology, orthopaedics, ophthalmology and psychiatry. On a typical day at Dubbo Base, 40 patients are admitted, 17 operations are performed, 78 emergency department patients are treated, and about 115 outpatient occasions of service occur.

In the most recent period, 2000-2001, there were about 28,220 admissions across the Macquarie Area Health Service, and of these 30 per cent were same day admissions. There were 323,561 non-admitted patient occasions of service across the area, which is about 886 each day, and that figure does include emergency department presentations.

If we were just to look at emergency department presentations, there were 68,000 presentations to emergency departments throughout the area. This equates to 187 presentations each day, and 38 per cent were presentations to Dubbo Base Hospital emergency department.

There is a correction for the last dot point on that slide. It should read that almost 7 per cent more people are receiving inpatient treatment compared with six years ago. It has not gone up by 7 per cent each year.

If we look at the area's budget, the initial allocation for 2001-2002 is $98.9 million, and this represents an increase of approximately 42 per cent since 1995-1996.

Within the area, except for Dubbo Base, we budget the smaller facilities on a benchmark basis. We have internally benchmarked for all support services, so that is catering, hotel services, domestic services, and we use a three year average activity to work out staffing levels. However, we do have a number of facilities that require minimum staffing levels for safety and security of staff and patients.

The allocation of Dubbo Base is moving towards an episode funding basis in line with the Government Action Plan, and Dubbo Base Hospital has had significant growth over the last five years, with its budget increasing by 40 per cent since 1996-1996.

I would like to move to patient flows, and this information is our most recent information, which relates to 1999-2000. As you can see from the slide, the major outflows from Macquarie to metropolitan areas are to Central Sydney, South Eastern Sydney, and to a lesser extent Northern Sydney. The majority of these flows are for what would be called tertiary outflows. These are procedures that we would not envisage being able to do in Dubbo in the main, and we would not be intending to attempt to do those procedures at this point in time. They mainly relate to things, as it explains there, such as interventional cardiology, cardio-thoracic surgery, and major renal disease. There is a smaller component which are of a nature that we can provide in Dubbo, but they are a small percentage of that amount.

We also have a number of flows to other rural areas, mainly to the Mid West Area Health Service which we border with, and the New England Area Health Service which we also border with. The major outflows are for acute psychiatry, ear, nose and throat surgery, and urology. Some of these flows will be addressed in the next two

years in the area of psychiatry, in that we are currently in the early stages of planning to build an inpatient mental health unit on the Dubbo Base Hospital campus. That will be a 16 to 18 bed facility, and it should decrease the necessity for people having to go to Bloomfield in Orange for acute mental health treatment. So we should see a reduction in the outflows for acute psychiatry from Macquarie to Mid West.

The area is currently seeking, and has been since the retirement of the ear nose and throat surgeon in 1999, a replacement We currently have what is called a fly-in fly-out service, which I think has been referred to previously in the Committee. So we are providing a level of service in ear, nose and throat, but we are hoping to improve that by the recruitment of a permanent surgeon to the area. We are also attempting and have been working to bring a full time urologist, and again at the moment this service is provided on a fly-in fly-out basis by specialists from Sydney.

Many of the outflows to New England are for obstetrics, gynaecology, and to some extent orthopaedic services, and we would see these as mainly what we would call natural flows. They are mainly from towns that are close to the border between the areas, and often it is easier or more convenient for people to move to towns in the New England area.

The establishment of the Dubbo Clinical School by the University of Sydney should assist us in recruiting to some of the specialties that we have had problems with to date. We are working closely with the university in what academics they want and how they can address some of our clinical services issues as well.

The inflows, patients coming into Macquarie from other areas, are, as I have already mentioned, mainly from the Far West Area Health Service, particularly that upper sector, and to a lesser extent from Mid Western. Again, many of those flows from Mid Western are from towns that are nearby to Macquarie, particularly around the Mudgee area, and also people from places like Peak Hill, Tottenham, Tomingley, who come across. They are much closer to Dubbo than they are to Orange. As it says there on the slide, Dubbo Base Hospital is the closest major referral hospital for that upper part of the Far West.

I would like to move to consumer and community participation. Various areas across the State have taken different approaches to the establishment of health councils. In Macquarie there was an extensive period of community consultation to come up with the model that they wanted to use, and that was that they would have sixteen community based Health Councils. So each town where we have a health facility has its own health council.

These were established in 1998, and the membership of the health council attempts to be representative of the mix of people who live in that community. So we always try to have someone from an Aboriginal or Torres Strait Islander background because in our area health service, based on the last census, 8.5 per cent of the population was of Aboriginal and Torres Strait Islander background.

ACTING CHAIR: Are they all consumers?

Ms THOMS: All consumers, yes.

ACTING CHAIR: They are not variants of varying service deliverers?

Ms THOMS: No, they are all consumers.

ACTING CHAIR: Are they consumer representatives or just consumers in isolation? Do they have NGO or other structural backgrounds?

Ms THOMS: There is one NGO in the whole of Macquarie Area Health Service that is health related. Most of them are people who have an interest in health. We advertise in local papers and call for nominations. You may find some who have a link with some sort of health related organisation but the majority do not.

ACTING CHAIR: You do not give preference to people in some structures who would have an input other than their own opinion?

Ms THOMS: Most of these towns do not have much in the way of other structures. They are fairly small

towns and they do not have a lot of other things. For example, you can say in Coonamble there is a project called TUFF, I think someone associated with that is on the health council, but I cannot be sure.

ACTING CHAIR: We are not familiar with TUFF.

Ms THOMS: It is Together for the Under Fives program.

ACTING CHAIR: And families.

Ms THOMS: They are pretty much your average person on the health councils. They undertake a number of activities. We also use health councils as mechanisms for identifying consumers who would be interested in being involved on some of the health services, other committees, and these have included our clinical services planning.

A number of representatives from health councils have participated in consultations that New South Wales Health has run. They have done a number of men's health initiatives. A number of them have run health improvement projects on farm safety, community awareness and education on AIDS, mental health, road safety and heart health. They tend to look at things that are of interest to their community and they feel are important to their community, and get involved in health improvement type activities.

There are also a number of other community consultation processes. I will give a couple of examples. There are mental health consumer groups in Mudgee, Coonabarabran, Coonamble and Dubbo. The methadone maintenance program was recently commended during its ACHS accreditation under the equip program, for its regular surveys of client satisfaction and its proactive approach in addressing consumer concerns.

We also, of course, have a number of MPS steering committees. We already have three MPSs. We have another three coming on line and they have a high level of involvement of community members in the design and planning for those MPSs.

I would like to deal a bit with the work force issues. On average the area is recruiting to 10 nursing positions on a monthly basis. Dubbo Base Hospital is actively recruiting to roughly five nursing positions. The average overtime has increased, compared to 1999-00, and we see that to some extent is reflective of some of the difficulties that are occurring in recruiting nurses to specialty positions.

Dubbo Base is experiencing, and the area is experiencing some difficulty recruiting midwives and theatre nurses and this increases some of the workload for the existing staff. This is comparable to the State-wide or the national, international-wide shortage of nurses that is currently existing.

There are a number of strategies that are being used in an attempt to improve this situation. Dubbo Base Hospital participates in the midwifery training program conducted through Charles Sturt University at Wagga. They take student midwives at Dubbo and they are also encouraging a number of staff to pursue post graduate midwifery and theatre nursing and they are attempting to provide flexibility through their rostering systems to encourage retention of staff as well.

I have mentioned before that we have a number of what are generally termed fly-in fly-out specialist services. These, as I have alluded to generally, occur due to recruitment difficulties or gaps due to recruiting for certain specialists. We are working with the clinical school and we feel that this should be a positive enhancement in terms of helping us with our recruitment issues for specialists into Dubbo.

Allied health: currently Dubbo Base Hospital has all its allied health positions filled except for pharmacy. They are recruiting a couple of pharmacy positions and they anticipate that they will fill those. In community health area, the child, adolescent and family health service is currently recruiting to speech pathology and occupational therapy positions. Certainly they have done some work in trying to improve the retention of these workers.

We have introduced what we call discipline advisers, which means that out of each of those disciplines they will take a lead role in putting forth the views of that discipline, in providing assistance and support to other members of that discipline. A number of these people do work in isolation.

General practitioners is a significant issue for the area health service and for Dubbo itself. There is a shortage of general practitioners in Dubbo. Many of the surgeries have closed books and there is almost no after hours general practitioner service available in Dubbo itself, and this is reflected in the triage four and five, which are the sorts of cases you would expect to present at a general practice, that present at the emergency department at Dubbo Base.

There is currently under construction a 24 hour medical service in Dubbo and we will wait to see what impact that does or does not have on the after hours.

ACTING CHAIR: That is a privately owned one, is it?

Ms THOMS: Yes,it is.

ACTING CHAIR: Mayne Health, or someone like that?

Ms THOMS: No, it is Ed Bateman. I am not sure what his company's name is. We do not know if they are going to be existing general practitioners who will move into that, or whether it is going to bring some new ones to the town. We will have to wait and see how that pans out.

We also work closely with the division of general practice and the rural doctors network. We have regular meetings with them and are working on workforce issues, particularly for general practitioners.

Macquarie has 21 areas of need positions. Area of need positions are individual positions that achieve that status due to the inability to recruit to the position. Of those, 11 are specialists and 10 are GPs. At Dubbo Base Hospital we have area of need positions which are currently vacant in ear, nose and throat surgery, urology and anaesthetics. They have five positions classified as that in internal medicine, although recently we have been able to fill two of those positions. We are still looking for another three.

I should point out that area of need is not the sole provision of specialist services. We have other specialists who do not fill area of need positions.

Accommodation is an Area that we are looking at.

ACTING CHAIR: How much of this is relevant to quality? We are going to run out of time for questions. We are getting a fair way from delivery of quality to the customers here with accommodation for the staff. I understand that there is a problem in recruiting but it is a fair way from of delivery.

Ms THOMS: It affects quality. If you cannot get adequate work force it will impact on the quality.

ACTING CHAIR: If there is a problem, but we have not actually established that there is a problem.

Ms THOMS: I can move forward.

ACTING CHAIR: That will be helpful thank you. Cut the non-essential material.

The Hon. JENNIFER GARDINER: Can I suggest that you still table the document?

Ms THOMS: I am happy to provide it.

The Hon. RON DYER: Do you have any material in this presentation dealing with day only surgery?

Ms THOMS: I do.

ACTING CHAIR: Can we whip through it?

Ms THOMS: This is particularly a quality project. The asthma management planning service is an example of what has been implemented using the chronic and complex care funding through the Government's action plan and this is a shared care approach with general practitioners, patients, asthma educators, and others as listed on the slide.

We have trialled this in Wellington and the slide there provides a graph showing that there has been a significant reduction in the presentations from when the program was introduced. 285 presentations prior to the implementation, decreased to 58 presentations after implementation, and also an improvement in separations and that program is now going across the area, including Dubbo.

The breathe up respiratory program is also a program which we have trialled in a smaller area and we will now be taking across the area and that demonstrates how by implementing a shared care and management approach, you can improve the quality provided to the patients and reduce the number of admissions that they have to hospital.

Day of surgery admissions: this is the day of surgery admission rate. This is people being admitted on the day of their surgery who are going to have an overnight stay and in the last 12 months Dubbo Base has moved from 32 per cent to 93 per cent, which is a significant improvement and that has been through the introduction of pre-admission clinics, pre-anaesthetic clinics, and a clear policy about which patients require admission prior to surgery.

The Hon. RON DYER: That is more than significant, it is almost phenomenal, is it not?

Ms THOMS: It is a significant improvement, yes, and I think it indicates that the clinicians have really got behind the program and are really making it work.

In acute care there are a number of clinical pathways being introduced. They have 23 at Dubbo Base Hospital and they cover their commonest areas. If we look at the quality structure in the area, the board has established an area quality council and each health service has their own quality committee and community health, or primary health care, also has a committee.

The various activities that are undertaken at a local level are reported up through to the quality council and thence to the board. Dubbo Base has its own quality council, which meets on a monthly basis and has a representation from across the staff.

Phase one quality indicators which Chris referred to earlier are being looked at by the area and the various facilities and the workshop has been held in April and following on from that, the three areas identified as being key for act by the group that was in attendance, which was a mix of staff, was looking at asthma, chronic obstructive pulmonary disease, and diabetes and asthma and chronic constructive pulmonary disease are being addressed by the AMPS and the Breathe-Up Respiratory Rehabilitation Program.

There is a diabetes project which has been able to demonstrate some marked improvement in the care of patients with diabetes. In particular at Dubbo Base Hospital we have seen a reduction in the rate of amputation from 23 in 1999-00 to 16 in 2000-01, following the introduction of the diabetes project.

ACTING CHAIR: Diabetes is not one of the key areas in the Government action plan?

Ms THOMS: It is not one of the ones listed, no, but it came out of the data which Paul Tridgell put together for the area. It has come up as one of the indicators that Macquarie Area Health Service is higher than the State so for us it was a significant one.

ACTING CHAIR: I was surprised it was not in the Government action plan.

Mr CRAWFORD: It is not part of the priority health care program, which is respiratory, cardiac and cancer. The Government action plan has other pillars and one of those is the quality projects and indicators that Paul Tridgell has identified, and diabetes has come out in a number of those.

ACTING CHAIR: It surprised me that it was not in with the others in the first place.

Mr CRAWFORD: They were always said to be only the starting point. A lot of people said early on that diabetes will clearly be one of the things we will move on to and pain being another.

Ms THOMS: Chris mentioned earlier the work of Brent James. We have had staff attending his workshops. One of the projects undertaken following staff members' attendance at that was what they called the merit medical early

response intervention and therapies, specifically at Dubbo Base Hospital and this enables them to recognise a deteriorating patient before they move into an arrest phase so they get appropriate medical intervention earlier, rather than deteriorating to an arrest.

If we move to monitoring compliance, and you are looking at the quality framework and the information from the workshop has established a minimum data set, which is listed on the slide, which will be the main areas of focus at this point of time. With data we have got common definitions and all the facilities will be collecting that data and forwarding that through to the quality council and thence on to the board.

Additional indicators are collected by some sites, in particular Dubbo Base Hospital, and I have just listed three there and if we move to the next slide you will see that they have very low rates, less than one per cent for each of those three for unplanned re-admissions, return to operating theatre and the day surgery return to theatre, which is very good rates, and they will be continuing to monitor those.

The Hon. GREG PEARCE: I notice that in the questions to witnesses we asked for copies of supporting documents. Did you have written answers to the questions?

Mr CRAWFORD: I think the Director-General submitted an answer, as I understand it, which was outlined earlier.

ACTING CHAIR: You mean for your health area?

Mr CRAWFORD: He submitted an all embracing answer.

Ms THOMS: Which included information on each of the area health services.

ACTING CHAIR: One of the reasons we have got you down here is we had an elaborate presentation from head office and the similarity of the data presented, indeed in the top and bottom, even in the software, would suggest that we are getting more of managerial perspective than on the ground feedback which is, of course, not the reason we asked you down here. We are keen, I think, as a Committee, to see - head office has said: This is what we are trying to do in quality - what is happening on the ground, and what is happening on the ground, as it has been presented to us, is we are doing a very good job as per head office's recipe, here we are. Yes, we have the committees we are supposed to have and we are shuffling our patients around between each other, which is all jolly, and we have numbers and structures flying everywhere, but what is happening on the ground?

No one has suggested any consumer feedback. No one has talked about the extra nursing positions they have on the ground, or home support, to support the quicker and sicker discharge rates. I understand you are managers but we are getting many managerial perspectives.

The Hon. RON DYER: Mr Chairman, that might be your interpretation.

ACTING CHAIRMAN: I was putting a point of view and asking for a comment.

The Hon. RON DYER: Could I deal with what Mr Pearce raised? The practice on the Committee, of which Mr Pearce through no fault of his own would be unaware, is that the standard questions that have been submitted to the Areas are being responded to subsequently in writing, and not orally here at these hearings yesterday and today.

The Hon. GREG PEARCE: That is what I was asking, whether I would be getting written answers from each one.

ACTING CHAIRMAN: For each one. It would be nice to have the original rather than have the whole thing done from head office. There is no point in bringing these folk down from the country if all they are going to do is give us head office regurgitated stuff.

The Hon. GREG PEARCE: Perhaps if I could ask each of the witnesses; will you please provide written answers to these seven questions within fourteen days?

Mr CRAWFORD: We would be happy to provide written answers to those.

The Hon. GREG PEARCE: Can you do it within fourteen days?

Mr CRAWFORD: Yes, we ought to be able to do that.

The Hon. GREG PEARCE: Thank you.

ACTING CHAIRMAN: Could I ask you, in a different way perhaps, in terms of do you have any evidence of quality in terms of consumer feedback data?

Ms THOMS: Certainly a number of our facilities conduct consumer and customer satisfaction surveys, and also through the Health Councils we get quite a bit of feedback from the community about issues that they are concerned about.

ACTING CHAIRMAN: Could we have some examples of that?

Ms THOMS: I could get you some samples.

ACTING CHAIRMAN: I mean of the surveys and the methodology and how you went about that. That is obviously important rather than saying there is a council there and they are all jolly fine people, which we don't doubt, of course. And have you changed the number of people on the ground in terms of delivering home services in order to support the shortened hospital stays? Obviously if you have got clinics before they come in, that saves on the input side, but what about on the discharge side?

Mr CRAWFORD: I guess there are two things there. As part of the priority health care program we have been increasing the number of people on the ground involved in delivery of respiratory, cardiac and cancer services, and that is part of trying to treat people in the community, or to have shorter lengths of stay in hospital.

Also we are investing, as part of the growth funding we are receiving, in expanding our community health services so we can better support people who have been discharged and people who are requiring non-inpatient services.

ACTING CHAIRMAN: What are the nature of those expansions of the community health services?

Mr CRAWFORD: They vary, but some of them are in community nursing, extra drug and alcohol workers. We have introduced, for example, acute community mental health teams for each of our clusters so that we can better support our mentally ill in the community rather than them having to go into the inpatient setting. Those are some of the examples.

ACTING CHAIRMAN: Have you put extra staff on, or have you redefined existing positions?

Mr CRAWFORD: No, we have put on in the mental health example an extra 11.5 FTE.

ACTING CHAIRMAN: And in other support areas?

Mr CRAWFORD: It varies between areas depending on the need, but it has involved extra staff.

Ms THOMS: The community health services have expanded in recent years to take on extra work load in terms of caring for people in the community. There have been a number of projects that they are undertaking to meet those needs, and they would be a mix of sometimes additional staff, sometimes a redefining of the work of existing staff to meet with the community needs.

ACTING CHAIRMAN: Are these projects invariably linked to your more rapid discharge policy or the increased day only rate?

Ms THOMS: It depends. They are not all directly related to that. Some of those are directed at trying to prevent people having to be admitted to hospital in the first place.

ACTING CHAIRMAN: The other thing you have said about episode funding, my understanding was that the RDF was to replace episode funding. Is that not correct?

Mr CRAWFORD: No, the two operate in tandem. The RDF is population based funding, with the aim of making sure that residents of all geographic areas eventually get an equal level of access to health service dollars. So that is about what you might call geographic equity. Episode funding is about efficiency, that each facility of a comparable nature delivers its services for the same cost, so that the value for money is implemented, with facilities of equal size and equal resources having the same outputs.

ACTING CHAIRMAN: So it is an audit of the efficiency of the RDF, more or less?

Mr CRAWFORD: No, it is the efficiency of service delivery. It is to say that if you have a volume and complexity that is the same as another facility, then you ought to be doing it at the same price.

ACTING CHAIR: When you are looking at quality care, do you look at admission and discharge policies and outcomes on the intensive care unit, because obviously it is a high cost area?

Mr CRAWFORD: Yes.

ACTING CHAIR: Can you tell me what the outcomes were of people discharged from intensive care units? For example, when I worked in intensive care units, if they left the unit alive, that was a statistic that was kept, and as post-operative people came to intensive care that statistic improved dramatically, of course, because basically the more people you put through, the better the outcome became. The fact that a lot of them spent a lot of money and then dribbled their breakfast and died in nursing homes a couple of months later was not recorded, and in a sense perhaps they should never have been admitted, to put it bluntly.

I mean, is there any auditing of the admissions and follow up of the outcomes of the discharges in those high cost areas?

Ms THOMS: I would have to take that on notice.

Mr CRAWFORD: Yes. There certainly is monitoring, but to the extent that you are asking, I think I would prefer to take that on notice.

Ms THOMS: Yes. I don't know the extent of it.

The Hon. RON DYER: Could I just ask Ms Thoms, I could be mistaken but I am aware that you showed a slide dealing with day of surgery statistics, but I didn't see anything regarding day only surgery.

Ms THOMS: It was one of the ones that was slipped over. Yes, Dubbo Base, even before the introduction of the 60 per cent target, had already been achieving 60 per cent, and has maintained that.

The Hon. RON DYER: Good.

The Hon. GREG PEARCE: Could you give me some indication of what factors make the New South Wales average costs greater than the national average costs? I would have thought New South Wales ought to be cheaper on average than other places which have greater distance problems, and I would have assumed higher wage costs and that sort of thing.

The Hon. RON DYER: Or the employees might be better remunerated in this State than elsewhere.

The Hon. GREG PEARCE: That is what I am asking.

Mr CRAWFORD: I think that is the main driver. I think the employees are better remunerated in this State. We will take that on notice and give you a more detailed answer, but I think that that is the main driver.

ACTING CHAIR: I noted, Mr Crawford, you commented that you used the Australian and the New South Wales Council on Safety and Quality as your benchmarking organisation.

Mr CRAWFORD: Not as a benchmarking organisation; as an organisation which is setting out national strategies which we are picking up on.

ACTING CHAIR: That is different from the Australian Council of Health Care Standards, is it?

Mr CRAWFORD: Yes. It is the new one which Professor Bruce Barraclough has been appointed to, to chair. It follows up the inquiry into safety and outcomes in hospitals.

ACTING CHAIR: Are all the health services using the same group, or do they use whichever one they think best, and if so what are the differences?

Mr CRAWFORD: That is the national one which I think has been set up by the Federal Government, so it seems to be the pre-eminent one at the moment, and what it does is its strategies cascade down to the States, to their pre-eminent State Quality and Safety Committees, which come down to the Areas. So I think most of us are following them.

ACTING CHAIR: And how do their benchmarks compare to Paul Tridgell's? I know he collects a number of indicators. Presumably they take a more holistic look, do they?

Mr CRAWFORD: I think because they are a national body they are dealing at a more strategic level, rather than getting right into that level of detail, as I understand it. So it is more strategies and high level policies, which then allows the States under that umbrella to do more detailed work.

ACTING CHAIR: You mean allocative efficiency rather than procedural?

Mr CRAWFORD: I am talking about more, broader ways of pursuing quality outcomes. I am told that they have not yet set standards. They are still a fairly new body. I think they have only been appointed in the last eighteen months.

Ms THOMS: Yes, and I think also Professor Barraclough is also involved in New South Wales at a State level with our own quality programs and projects, so we should hopefully see some consistency coming through.

Mr CRAWFORD: He has been nominated by the Minister as the Chair of the Institute of Clinical Excellence, so he will obviously be providing a link between his national committee and that Institute, which will be providing a fair bit of direction of quality working in New South Wales.

The Hon. GREG PEARCE: You both gave budget figures for the hospitals in question. Ms Thoms, you said there had been a 42 per cent increase since 1995-96. Do you know what those figures are in real terms?

Ms THOMS: I would have to get those for you.

Mr CRAWFORD: That figure was in the Area figure.

Ms THOMS: I gave the Area figure, but I did say Dubbo Base had increased by 42 per cent.

(The witnesses withdrew)

(The Committee adjourned at 1.30 pm)