GENERAL PURPOSE STANDING COMMITTEE No. 2

Tuesday 7 November 2006

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 12.00 p.m.

MEMBERS

The Hon. R. M. Parker (Chair)

The Hon. A. Chesterfield-Evans
The Hon. D. J. Gay
Ms S. P. Hale
The Hon. C. M. Robertson
The Hon. P. G. Sharpe
The Hon. H. S. Tsang

PRESENT

Department of Health
Ms R. Kruk, *Director General*
Mr K. Barker, *Chief Financial Officer*
Dr R. Matthews, *Deputy Director General, Strategic Development*
Professor K. McGrath, *Deputy Director General, Health System Performance*
Mr R. McGregor, *Deputy Director General, Health System Support*
Dr D. Robinson, *Deputy Director General, Population Health and Chief Health Officer*

CHAIR: I declare this supplementary hearing of the inquiry into budget estimates open to the public and welcome witnesses. The Committee will examine the proposed expenditure for the portfolio of health. I will first make some comments about procedural matters. In accordance with Legislative Council guidelines for the broadcast of proceedings, only Committee members and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In recording the proceedings of this Committee the media must take responsibility for what they publish and for the interpretation placed on anything said before this Committee. Copies of the guidelines are available from the table by the door. Any messages should be channelled through the Chamber attendant or through the committee clerks. Witnesses are reminded that they are permitted to pass notes, unlike happens at school, and advisers may address comments or pass notes directly to witnesses in their advisory capacity. I ask that all mobile phones be turned off.

The Committee has a return date for questions on notice. Because the Committee's report will need to be tabled before the rising of Parliament, I advise that the Committee has resolved to request that answers to questions on notice be provided by 5.00 p.m. on 22 November. That deadline is necessary because the reporting date is 23 November. Bearing in mind that short time frame I ask that witnesses answer as many questions as possible during the hearing rather than take questions on notice. Do you anticipate that that will pose any difficulties?

Ms KRUK: Chair, we will genuinely endeavour to do so, as we always have. We were, frankly, flooded with the 600-odd questions we had on the last occasion. We have sworn in deputies for this particular hearing in an attempt to take as many questions on the day as we can. Regrettably, that is not always possible, but we will certainly try.

CHAIR: Thank you. The Committee appreciated the return of most of those questions on notice, although I believe a couple remain outstanding. Do you know when we might receive those answers?

Ms KRUK: I would hope very soon. From memory, approximately three-quarters have bee sent forward it to the Committee.

CHAIR: Thank you. I remind each of you that you are giving evidence on your former oath or affirmation. I declare the proposed expenditure for the health portfolio open for examination. Do any of the witnesses which to make a brief opening statement?

Ms KRUK: No, thank you.

CHAIR: Do Government members have any questions?

The Hon. CHRISTINE ROBERTSON: Not at this time, thank you. We would appreciate it if we could have our chance a bit later.

CHAIR: Certainly.

The Hon. DUNCAN GAY: My question is directed to you, Ms Kruk, or to whomever you indicate should answer it: On 28 August I asked the Minister a question regarding bullying and harassment in the Greater Western Area Health Service and the fact that the chief executive officer [CEO] had called in an external management expert to address allegations. Has a report been prepared? If so, could the results of that report be made public?

Ms KRUK: I will commence but I may ask Mr McGregor to add to my answer. I note that I believe it was very good action on the part of the CEO, Dr Claire Blizzard, to seek some outside assistance. It has been a major task, bringing about the amalgamation of that area health service. You know its size; it is country you are more than familiar with.

The Hon. DUNCAN GAY: It is too big.

Ms KRUK: Mr Gay, I think you understand some of the savings targets that both governments understandably seem to expect of health. The issue is actually meeting those savings targets, but also to look at the health services that are provided. Dr Blizzard elected to bring in a Mr

Vern Dalton in response to some concerns that had been raised by staff. That area health service, can I say, has a very good employee assistance facility in place—it is certainly one I am familiar with, and staff have commented very positively on it. Mr Dalton undertook a number of meetings with staff across the area health service to ascertain what the problem was and my understanding is that Mr Dalton subsequently held briefings with all of the staff who participated, but also more broadly staff in the area health service. I will ask Mr McGregor to make some further comments.

Mr McGREGOR: With the review that was undertaken by Mr Dalton, he spent three days talking to a whole range of staff. He made some recommendations to the area health service and those recommendations were provided to the staff and have been discussed. I understand those recommendations have been implemented and Mr Dalton will be returning in two or three months time to have some further discussions with the staff to ensure that his recommendations have been sustained.

The Hon. DUNCAN GAY: Could you provide the Committee with those recommendations?

Mr McGREGOR: I do not have them with me, but we will certainly make them available to the Committee.

The Hon. DUNCAN GAY: Will you take that question on notice?

Mr McGREGOR: Yes, that is fine.

The Hon. DUNCAN GAY: Do you consider that the new hospital in Lithgow is in good working order? Are there any outstanding building and maintenance issues with the Lithgow District Hospital?

Mr McGREGOR: I will just check on that. Nothing major has been brought to the notice of the department of recent time. The maintenance of the public hospital system is a matter for planning by each of the chief executives of the area health services and, if there are issues, we would expect that they would have been raised with them. Bear in mind the Lithgow hospital is both a public and a private hospital. It has a private wing, so there may be issues there. If there are concerns, we would like to hear about them.

Ms KRUK: Do you have concerns, Mr Gay?

The Hon. DUNCAN GAY: I certainly do.

Ms KRUK: I am hoping you will share them with us.

The Hon. DUNCAN GAY: I am more than willing to do so. Given those comments, you will be surprised to know that during rainy weather—in fact as late as yesterday—buckets are required in the rooms and in the corridors of the hospital to catch leaking water and prevent occupational health and safety incidents. In fact, there are buckets permanently in the ceiling and the occupational health and safety committee apparently has received a quote of $700,000 to fix the roof on what is a relatively new hospital that has been received into the department within the last couple of years.

Ms KRUK: I will ask Mr McGregor to respond to that.

Mr McGREGOR: The only information I have at the moment is that there is some knowledge about some leaking. We are told that it is minor, but if you say buckets are being used permanently we will certainly investigate it and give you some further information about that.

The Hon. DUNCAN GAY: So that you are unaware of the quote of $700,000?

Mr McGREGOR: I am not aware of that, no. As I said, the management and maintenance of the hospital is a matter for the area chief executive. But we will make inquiries about that.

The Hon. DUNCAN GAY: Would you be concerned that entire rooms in that new hospital have been closed due to water leaking from the roof?

Mr McGREGOR: We certainly would be concerned about that. As I said, we will make inquiries into that and see what the solution is.

The Hon. DUNCAN GAY: And you will get back to the Committee with that information?

Mr McGREGOR: Most certainly.

The Hon. DUNCAN GAY: Is there maintenance staff within the hospital, or is the maintenance done from outside?

Mr McGREGOR: I cannot answer that question. A lot of the maintenance work is done by a regional team in that part of the area. But we will certainly get an answer to that specifically as well.

The Hon. DUNCAN GAY: Are all hospitals in New South Wales categorised by obstetric levels that range from one to six? If so—and I think they are—please list all New South Wales hospitals that contain a functioning obstetric unit according to their obstetric levels? I am happy for that question to be taken on notice. I do not pretend that anyone would have that information at his or her fingertips.

Ms KRUK: I might get Richard to speak to that. Is it useful, Mr Gay, that you run through the range of your questions in relation to this aspect so that Richard can answer them?

The Hon. DUNCAN GAY: I am happy to list all of them so that you know where I am going. There is not a trick in this one. What are the basic staffing requirements for each level? How many doctors, including specialists, and allied health professionals are needed for an obstetric unit to operate according to each level? Will you provide a breakdown by occupation and level of unit? How much per year does it cost to run an obstetrics unit—the answer could be by level of the unit? And, most important, how many obstetric units have closed in New South Wales since 1995 and what were the dates of those closures?

Ms KRUK: Chair, on question of this type and of this length, we will endeavour to give you what is publicly available. Obviously, the category and the role delineations of the hospitals is not a difficulty, in terms of providing you with that. With regard to a detailed breakdown of staffing and the more comprehensive questions that followed, I think it is very unlikely we will be able to provide that in the time frame you ask. We will make best endeavours, Mr Gay, as we normally do. Richard, do you have anything to add?

Dr MATTHEWS: well, you are correct. There is a role delineation—not all hospitals have maternity services, obviously. There are different models of obstetric care ranging from the very big teaching hospitals in Sydney that offer very high-level services for significantly at risk births to some models that involve midwives only for instance, which deal only in low-risk births and doctors are provided as backup. They occur both in country and metropolitan settings. The endeavour is to match the individual birth to the level of care it is anticipated will be required, with a system that enables rapid transfer to a higher level of care on those few occasions when the birth becomes at risk because of unforeseen circumstances. Many births occur in the private setting—I think it is about 55,000 in public hospitals and about 30,000 in the private sector—and, of course, many births occur at home with various arrangements made.

We can certainly provide the role delineation information. We can talk about the types of staff that would be required for each model—the types of ancillary support, such as neonatal intensive care cots, neo-natologists, x-ray imaging et cetera to support different levels of care. That is all available in our role delineation documentation.

The Hon. DUNCAN GAY: It is a detailed question that I am happy to leave on notice.

Dr MATTHEWS: We can tell you that there are more than 80 maternity units in public hospitals. Of these, about 50 are based in regional and rural hospitals. They are all networked to ensure the appropriate management of maternal, foetal and newborn clinical needs. There is a framework for maternity services report, which sets out the broad framework to provide, essentially,

the appropriate level of care for each birth. We can certainly provide you with that. The framework outlines the range and the clinical staffing profiles that give women a choice of where and how they want to have their baby. The appropriate advice as to where to have it is also important. We will provide that for you.

The Hon. DUNCAN GAY: Thank you. Are you aware that the head of psychotherapy at Lourdes Hospital, Dubbo says that patients are missing out on what they need for recovery because there is no hydrotherapy pool available? What is the department doing to overcome the fact that all patients do not have access to a hydrotherapy pool?

Dr MATTHEWS: The director of psychotherapy?

CHAIR: Physiotherapy.

Ms KRUK: I was a bit concerned about models of care.

The Hon. DUNCAN GAY: It is a new leap.

Ms KRUK: Yes, a new model of care. Can we, if necessary, come back to that question and see whether there are notes on that issue? I know that the issue of hydrotherapy has been a vexed one and there have been a number of discussions between the area health service and some of the local providers. Chair, please remind me to return to this issue later.

The Hon. DUNCAN GAY: Is there a permanent VMO at Lightning Ridge? If not, is there a locum who flies in and out?

Mr McGREGOR: I think we have some comments on that. The information we have from the area health service is that in September the VMO at Lightning Reached advised the area health service that he had decided to retire and was leaving Lightning Ridge. The chief executive officer has advised that they have taken some action to ensure that, firstly, as an interim measure locum doctor services are being provided, and that is occurring; and, secondly, the area health service is about to advertise a tender for the provision of total medical services to the Lightning Ridge service. I think that is all we have.

The Hon. DUNCAN GAY: It is my understanding that two local GPs have already applied for the position. Can you tell us what may be holding up the appointment of one of those GPs? Why has a contract not been offered?

Ms KRUK: It is a tender process. My understanding in relation to it—should there be further information—is that the decision was actually to go to a tender process. Obviously, if two GPs have expressed an interest they will no doubt be part of that tender process. I am not aware of the terms upon which they have offered their services. I think the important thing is that Dr Blizard has made a very strong commitment to having ongoing services there, has a locum in place and wants to get the best deal for her health services as possible. I do not know the terms and conditions under which the GPs you mentioned have offered their services.

The Hon. DUNCAN GAY: Can you come back to us with an answer?

Ms KRUK: If there is something additional on that, we will do so. But I think the issue is that the decision to go to a tender is very acceptable and sensible practice.

The Hon. DUNCAN GAY: And a timetable?

Ms KRUK: If that is available, yes.

The Hon. DUNCAN GAY: Thank you. How many genital mutilations have been treated in New South Wales hospitals and notified to NSW Police?

Dr MATTHEWS: I cannot answer the question of how many. I am not certain. They may in fact be coded under different diagnostic groups depending on the type of injury inflicted. But I think

we would have to take the question of how many on notice and come back to you with what we can provide.

The Hon. DUNCAN GAY: I expected that you would. Turning to the Isolated Patients Travel and Accommodation Assistance Scheme [IPTAAS], what was the actual expenditure on IPTAAS in 2005-06? What is the estimated expenditure on IPTAAS for 2006-07?

Dr MATTHEWS: The total funding for the total transport for health programs, which is all non-emergency health-related transport, is $15.9 million in 2006-07—an increase of $2.6 million on last year's budget. In addition, the area health services spend an estimated additional $10 million on other types of transport assistance. This combined funding provides about 60,000 passenger trips per year for patients across the State. On 17 March the Premier announced the integration of five separate health-related transport schemes into a single program under the revised Transport for Health policy. That change commenced on 1 July this year. The schemes being integrated under the new transport for health program are IPTAAS; Statewide Infants Screening and Hearing [SISH] travel—which specifically supports babies who are required to attend for audiology for severe hearing loss identified by SISH—the health-related transport program, which principally funds community transport organisations; the inter-facility transport schemes; and the former transport for health program. The types of assistance provided under the new transport for health program will include subsidies to assist eligible patients who need to travel long distances for specialist medical treatment not available locally.

The Hon. DUNCAN GAY: Dr Matthews, it was a discrete question about the actual expenditure and the estimated expenditure on IPTAAS. Are you able, even on notice, to extract those figures from the group travel figures?

Dr MATTHEWS: I will have to take the breakdown of the specific IPTAAS component on notice and let you know. But I need to advise that all those things have been amalgamated.

The Hon. DUNCAN GAY: I understand that the egg has been blended.

Dr MATTHEWS: Hopefully to make a better omelette.

Ms KRUK: Mr Gay, it is a serious matter. I was at Dubbo two weeks ago—

The Hon. DUNCAN GAY: I would not have asked the question if it was not a serious matter.

Ms KRUK: You come from the country; I come from the country. Transport is one of the most critical things. I was pleased to see in Far West that Dr Blizard has actually combined transport co-ordination functions with the patient flow unit. The feedback I have had from a good number of practitioners in Far West is that that has made a huge difference to the co-ordination of transport across the area health service. It is not just assistance in terms of financial components—which we discussed at the last estimates committee—but also sensitivity in terms of the time of the bookings and support provided to the families after the discharge of the patient. I think all those components are important in patient transport.

The Hon. DUNCAN GAY: Are any staff allocated to an IPTAAS office at Broken Hill? If so, what is the staff EFT, number of staff, at that office?

Mr McGREGOR: We will have to take that question on notice. We do not have the specifics of the breakdown of the distribution of administrative staff in relation to that at the moment. Bear in mind what Dr Matthews said: It is being integrated into a cohesive program.

The Hon. DUNCAN GAY: How many other staff are allocated to IPTAAS and where are they located?

Dr MATTHEWS: We will have to take that question on notice as well.

Ms KRUK: Is it Far West? I am concerned, Chair, that these are incredibly detailed questions and I go back to my commitment in terms of the time frames.

The Hon. DUNCAN GAY: I challenge that. The number of staff working for IPTAAS is hardly rocket science.

Ms KRUK: The issue is having access to this information in the time that it is being sought. NSW Health has, at every parliamentary inquiry, made every endeavour to provide the information that is available. That needs to be acknowledged.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And answer.

Ms KRUK: No, the information that is available. The issue is that the time frames are very short here and, in a climate where we have tabled two sets of papers in the last two weeks for standing orders, I am indicating that we will do our best possible in the time frames.

The Hon. DUNCAN GAY: These are not impossible questions and they are important questions.

Ms KRUK: I have a limited resource, Mr Gay; that is the point I am making.

The Hon. DUNCAN GAY: And so have the people in regional New South Wales who are receiving that resource.

Ms KRUK: Mr Gay, the point I was making in relation to IPTAAS is that it is actually a far more detailed issue than the number of staff. The work that has actually progressed in relation to patient transportation has been successful because of co-ordination with ministries such as Transport, some of the non-government providers, and making the best use of the ambulance service and non-patient transport. Patient transport is a far broader program than IPTAAS.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Kruk, what do you do to retain public hospital doctors, particularly consultants and VMOs?

Mr McGREGOR: Is there a supplementary question that might assist us?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you ever thanked any public hospital doctors?

Ms KRUK: To the contrary, Dr Chesterfield-Evans, most recently emergency physicians. I have said it in every forum, and will continue to do so: The quality of the health system is dependent on the individuals we have and the ones we are able to attract. There is a range. I am not clear about your question: is it an issue with the award or an issue in relation to various incentives?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a problem in rotating VMOs? Is the VMO population ageing severely?

Ms KRUK: I think there is a problem in relation to, as you would know, the health workforce, per se. We are currently looking at that and are in negotiation with VMO award. The issue is to get the best indication of various incentives or other allowances. They are quite significant, recognising that we compete in an international market.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give figures on the age distribution of the VMOs? Are they ageing severely?

Ms KRUK: I have seen data specifically in relation to the surgical work force. We will give you whatever information we have regarding the demographic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By specialty?

Ms KRUK: I will give you the information that we have. It depends, because we work with other States and Territories in relation to getting a breakdown of all health professionals. Some of that is better developed than in other areas. I have seen it for surgeons, but I have not seen it for all specialities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You drew my attention to obstetricians some time ago but that was generic, including both the private and public work force. I believe these things will be worse in the public work force, would they not?

Ms KRUK: I have seen quite detailed breakdowns in relation to radiologists. What tends to happen is, in relation to the Commonwealth-State discussions, we target a number of areas to do quite detailed analysis. It is a major data gathering exercise, made somewhat more complex probably by the fact that each State codes that information differently. It has been done for particular specialities. Most recently we have done it for dentists. Mr McGregor may be able to tell you what other areas have done in quite detailed analysis.

Mr McGREGOR: Certainly overall in terms of nursing numbers, not just doctors, as the director general said, there is a shortage of dental staff. Nursing staff is short in a number of particular groupings, and you would be familiar with those: intensive care, mental health, are particular challenges for us, and continue to be so. There is an issue that we are attempting to address, and this goes back to your question about the ageing of the VMO population, particularly in relation to general practice proceduralists in rural communities. That population has been ageing. Sometimes they have difficulty in maintaining their skills, given the nature of the work. We have invested in recurrent funding of about $3.5 million to run with them a general practice procedural training program to do two things: first, to skill GPs who want to do procedural work, and, second, to assist those who wish to continue doing what they have been doing and to maintain and develop their skills. We certainly accept that there are issues in rural areas about that.

In addition to that, in terms of remuneration of visiting medical practitioners, there are different and more rewarding arrangements for VMOs who work in rural hospitals under what is called the Rural Doctors Package, where they are paid under a different regime to VMOs who work as a specialist, say in regional hospitals and metropolitan hospitals. Presently we are in discussion with the Rural Doctors Association and the Rural Doctors Network about what more can be done to assist them. We are also reviewing the currency of the package; at the moment we are in negotiations with them about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are any steps being taken for the metropolitan hospitals? Are they having difficulty in retaining staff?

Mr McGREGOR: In some places, yes. We are having discussions with the Australian Medical Association at the moment around the VMO packages in metropolitan areas. We are addressing both issues at the same time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you ever thank people? Is there any recognition in non-financial terms of VMOs for their work and their service records?

Ms KRUK: Probably one of the best examples, if you look at our recent quality and safety awards, the Baxter awards, where literally the best practice across the State is acknowledged, in most instances they are rolled out through all the facilities. In nearly all those categories the VMOs were part of teams that brought about quite major changes in quality of care. Having met most recently, Friday last week, with the rural health priority task force, which has a number of medical clinicians on it, it was obviously quite keen to look at what incentives could be provided to rural doctors and rural nurses and rural allied health, which would give them an ability to compete against some of the metropolitan hospitals. As Mr McGregor said, this is an issue at the moment in which people have a range of different views. We are looking at some ability to recognise the scarcity of resources west of the sandstone curtain, but acknowledging that there are probably some areas of shortage in some of the growth areas, and in the metropolitan area as well. That is a difficult negotiation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have asked the Minister in the House, without success, whether there is any limit to the number of patients that VMOs get in terms of

their workloads. What guidelines are there to prevent one doctor, as the rosters get tighter, getting endless numbers of patients?

Ms KRUK: Professor McGrath has just reminded me that the Premier and the Minister held a session at Westmead Hospital a few months ago to publicly thank the surgeons who had worked on the predictable surgery program. That is one occasion that I am familiar with. What was your second question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The workload. What limits are there on the workload, or the work hours, of VMOs?

Mr McGREGOR: The VMOs are expected to have a contract for service with the respective area health service. They are expected to negotiate and agree on the service level that they will provide. In terms of funding, some areas use the episode of care funding arrangement and negotiate both the level of service to be provided, and that is negotiated with all of the visiting medical practitioners and visiting dental practitioners where they have them, and also in many instances the quantum of funds that will be targeted towards that particular service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are regulated and remunerated in terms of hours. What about in terms of the number of patients? Presumably if the roster withers or the number of people on the roster withers and they are covering someone else for a temporary arrangement that become semipermanent, or they have so many patients that their time per patient could not possibly fit in with what they are doing, they either have to see the patient in a very perfunctory fashion or they have to work a lot of free hours. When they are given those rosters, is there a ceiling on the number of patients? If not, why not?

Professor McGRATH: I will comment on that. We are looking at the whole issue of quality and safety and the question goes to the heart of that. One of the important thing is that we are introducing this year is that every clinician will have a meeting with their direct line manager to have a discussion about the issues that affect them in their performance within the system. We want to establish a system where there is regular dialogue between clinicians and their managers. In relation to the surgery field we are very much trying to load the balance between surgeons to get a predictable access to surgery for patients within a reasonable time frame and to make sure that surgeons, particularly those who have very long waiting lists, share that load with colleagues who do not have waiting lists that are anywhere near so long.

You do get into some quite complex issues, because clinicians feel very attached to their patients, if you like a personal responsibility. It is often difficult to suggest that they do load balance. We certainly encourage managers to have a look at service delivery and waiting times and making sure that clinicians in that process are not burning out and getting stressed. That is one of the reasons why we do promote a reasonable downtime at Christmas—taking the pressure off staff, giving them a chance to have a break and a chance to refresh and recoup. A range of initiatives is undertaken in terms of the workload; it is an ongoing dialogue between the clinicians and the health service delivery unit and their manager. It is a very constant dialogue, from my previous experience as a CEO. Clinicians are not prepared to man very onerous on-call arrangements and so those onerous arrangements lead to a dialogue and increased resources going into busy units on a daily operational management sense.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you have not answered my question regarding numbers. Is it correct that you do not have a ceiling on numbers?

Professor McGRATH: There is not a set patient load that is considered safe or unsafe, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should there be one?

Professor McGRATH: I am not aware of anywhere in the world that does that. I am not aware of any precedence.

Mr McGREGOR: We are in dialogue with the AMA and the areas are in dialogue with their visiting practitioners and staff specialists at a hospital level and area level around safe working hours.

We have already introduced reasonable workloads for nursing staff and we are now working with the medical profession on their issues. On the issue of education and training—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I want you to come back to numbers.

Mr McGREGOR: I cannot give you specific numbers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not have any programs about numbers?

Mr McGREGOR: Not at the departmental level. Dr Matthews may indicate how he, as the chief executive of Justice Health, negotiates his arrangements with his visiting practitioners and how that dialogue ends up in the form of a contract.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There may be many prisoners who are not sick. I am talking about patients in beds, or visits.

Mr McGREGOR: That is the same issue that we have answered. This is a matter for each visiting practitioner to negotiate in terms of the workload and their availability for any given number of sessions. If it is for a surgeon, it is an issue about the number of sessions that they will have, and the allocation of theatre time. They are all negotiated at the local level, where it must be negotiated.

Dr MATTHEWS: The norm is to consider the hours of work. Looking at numbers of patients is quite difficult, because patients vary a lot in complexity and degree of difficulty. The issues we face in facilities that we run are really no different from the issues that doctors face in their rooms and in private facilities. We look to hours of work as being the best measures of what a human being ought to do as opposed to the actual number of people they can see. I have worked in a lot of settings where I have seen 100 patients, and that has been easier than seeing 20 patients in another setting. It is not really a valid measure.

Ms SYLVIA HALE: Unfortunately, I only caught the tail-end of the question asked by the Hon. Duncan Gay about Lightning Ridge. When I was at lightning Ridge about three or four months ago, I met a man with a broken leg who had walked three kilometres into the town, and faced the prospect of walking three kilometres back to the camp, outside the town. I am sure that you are aware that in Lightning Ridge there are camps with no water, no sewerage and no electricity, unless there are generators. What sort of outreach health services are available to people living in camps in Lightning Ridge?

Dr MATTHEWS: The first and obvious one is that the ambulance service is an outreach health service; where appropriate it goes to just about anywhere in New South Wales. It assesses and triages patients and when necessary conveys them to the nearest treatment facility. That is not just road transport; because with serious injuries transport can be by helicopter or fixed-wing aircraft. Community health services in both metropolitan and rural settings travel by motor vehicle into people's homes in order to provide a range of health care. Primary care in the community as delivered by general practice used to have home visits as a normal part of that care, when I was a boy. In a city that is almost non-existent, and in rural areas it is disappearing. To some extent we are picking up a level of activity that was previously provided by home visits by GPs.

Ms SYLVIA HALE: You would appreciate that in Lightning Ridge there are instances of many people who cannot get into the town. When I was there the one taxi service had broken down and was off the road. A woman, who had three children, had no means of getting her children into the town. Rather than calling for an ambulance—which people may be reluctant to do, particularly if they do not have a telephone and obviously many do not—what regular health service can be offered to people?

Dr MATTHEWS: Under that integrated transport for health policy that we spoke of, there are increasing and ongoing attempts to co-ordinate the non-emergency transport systems to meet patient needs. It used to be the case that the ambulance service provided a lot of non-urgent transport. It is our view that it is appropriate for that to be provided in other ways, and that integrated transport

policy is an attempt to provide transport for a range of people who need it both on a regular basis, such as renal dialysis, and on an RPOC appointment-based basis. Are there extraordinary and considerable challenges in implementing that in a place like Lightning Ridge? Yes, of course there are, and the more remote you become and the greater the distances, the more difficult it is to do. Nevertheless, there are services there being implemented.

Ms SYLVIA HALE: Earlier you referred to the appointment of a permanent visiting medical officer being put out to tender. Have you encountered any problems or resistance to the contracts that are being offered? I understand that there are two local general practitioners. Is there any resistance to the contracts being offered to those GPs?

Dr MATTHEWS: Not that we are aware of. The advice we have is that there is a locum GP in place and that the area health service is tendering for those GP services. We will have to get further advice on that.

Ms SYLVIA HALE: Do you have any idea of when you expect that position to be filled?

Mr McGREGOR: The Hon. Duncan Gay asked us to obtain details and a timeline for that. We have undertaken to provide that.

Ms SYLVIA HALE: Has there been an increase in involuntary treatment orders, both inpatient and community, that have been issued over the past, say, three to four years?

Dr MATTHEWS: Yes there has.

Ms SYLVIA HALE: What is the result of this increase in the number of orders that are being issued? Is it putting more pressure on the Mental Health Review Tribunal?

Dr MATTHEWS: Certainly, the number of hearings that the Mental Health Review Tribunal has had to hold to fulfil its statutory obligations has increased, and that increase is documented in its annual report. I cannot tell you the exact figures off the top of my head but there has certainly been an increase.

Ms SYLVIA HALE: To what do you attribute that increase?

Dr MATTHEWS: I think there are a considerable number of factors. Firstly, as I have said before and repeatedly, the increase in the use of stimulant drugs, which is well documented by independent researchers, is a factor. It means that people who have mental illness have more frequent, more severe and more treatment-resistant exacerbations of their illness. That is not in dispute. Whether those stimulant drugs actually cause mental illness in people who do not have a predisposition is a subject of intense research and, indeed, debate. Most researchers will tell you in their heart of hearts that they think the answer will be yes, but at this stage it cannot be said for certain. Another reason that there are more people being treated is because we have far more clinicians. The number of clinical FTEs in community mental health over the past 10 years has increased from 1,400 to 2,400. So it is a consequence of having more resources, more doctors and more nurses that you will treat more patients, you will pick up more illness and you will have more people on such orders.

Ms SYLVIA HALE: You said that the Mental Health Review Tribunal was being required to conduct more hearings. Have the tribunals been given added resources to cope with this further increase in demands?

Dr MATTHEWS: Indeed they have. The situation that I have in having responsibility for supporting the tribunal—bearing in mind that it is ministerial; I support them—is that their function is set out in the statute. They must comply with that statute, and I have to give them a level of funding to hold those hearings. So each year as the number of patients and the number of hearings increase, I have little argument about not supplementing Mr James' budget as required.

Ms SYLVIA HALE: I understand there is a proposal under consideration to extend community treatment orders from six months to 12 months. Is that correct?

Dr MATTHEWS: That is to extend the period of review, not necessarily the orders themselves. That is one of the proposals that is being considered in the draft exposure bill of the Mental Health Act, which has been out for very extensive consultation. There is an argument that the very considerable strictures that are placed around involuntary treatment—which is, after all, the removal of a human right—were set in place at a time when things were very different. It may be argued that people were being kept in hospital for too long. You might want to make a contrary argument now. What needs to be carefully debated in the community is the appropriate auditing and strictures to be placed around clinicians who are treating someone against their will and how frequently that should be checked and audited. I do not believe that in New South Wales today we have terribly many clinicians acting inappropriately in that way, but the frequency with which the checks are carried out by the tribunal is and should be a matter for public and parliamentary debate, and will be.

Ms SYLVIA HALE: Give what you have just said, which talks about how serious these orders are, surely we should be looking at reducing the period for review of an order from six months to three months, rather than extending it from six months to 12 months. If it proceeds, what is the justification for the extension from six months to 12 months? What is hoped to be achieved by that?

Dr MATTHEWS: One justification is that if you look at the current reviews, 93 per cent make no recommendation or change in the recommendation of the clinicians. Where you carefully analyse the other 7 per cent, it is almost always a problem of paperwork and not a problem of disagreeing with what is said. The vast majority of those hearings of community treatment orders are reviews of longstanding treatment orders where there is no change. So you can mount an argument that the present level is more than is necessary. Clearly, you can mount a contrary argument, and doubtless people will.

The Hon. PENNY SHARPE: Dr Matthews, can you outline to the Committee what is happening in relation to health outcomes for Aboriginal mothers?

Dr MATTHEWS: The New South Wales Government is committed to the support of Aboriginal mothers in the provision of appropriate and safe care. The New South Wales Aboriginal maternal and infant health strategy was funded by NSW Health in December 2000 and commenced in 2001. The goal of this maternal and infant health strategy is to improve the health of Aboriginal women during pregnancy and to decrease perinatal mortality and morbidity by providing culturally appropriate and accessible maternity care programs. The strategy consists of teams of midwives and Aboriginal health workers working together to provide community-based culturally appropriate antenatal and postnatal care in New South Wales in collaboration with existing medical, midwifery, paediatric, child and health staff. There are seven sites across Greater Western, Hunter-New England, and North Coast area health services, representing 20 local government areas.

Importantly, this strategy has been carefully evaluated, and the first three-year evaluation was released in August this year. We can report that it has successfully led to a significant decrease in prematurity rates from 20 per cent to 11 per cent, which is almost a halving, which is an outstanding achievement. There has been a 13 per cent increase in the number of Aboriginal women accessing antenatal care before 20 weeks, which is another one of our KPIs, enabling successful early intervention to maximise the health of the baby at birth. The evaluation also demonstrates that breastfeeding rates are gradually rising in the program. Breastfeeding rates at six weeks have risen to 62 per cent, compared to 59 per cent in 2003. These rates are still below the non-indigenous population but there is a slow and steady increase. There is also some indication that the perinatal mortality rate in the program areas is decreasing. Although not yet statistically significant, the trend is encouraging.

The training of the support program component of the strategy provides a high level of support to the midwives and Aboriginal health workers in the program sites. It is clearly an excellent mechanism to support and engage clinicians who are undertaking difficult and challenging work. It is a good example that if we are to be successful in this difficult area we have to train appropriately indigenous staff to carry out these tasks in a culturally appropriate way. It is the key to success. So with regard to education of those health workers, 18 Aboriginal health workers and Aboriginal health officers have now graduated from a one-year maternal and infant course at Yooroang Garang, and

more than a third of these are planning further education in the future. Indeed, seven of them are currently enrolled in the Bachelor of Midwifery program at University of Technology, Sydney. Getting those folk through that undergraduate course will be a very strong outcome, as well as the outcomes we have had for the mums and bubs.

The Hon. PENNY SHARPE: Professor McGrath, what is the current position with regard to improved performance in emergency departments?

Professor McGRATH: As you know, there has been a lot of focus in the past 12 months on improving performance. Over the past two years we have seen increasing performance year on year in terms of all the parameters that we measure, including off-stretcher time, access block, triage. Triage one and two have been hitting their targets for some time and triage three and four have also been improving. In the latest figures that we have internally, which are hot off the press, I am pleased to be able to report that on both access block, triage 1, 2, 3, 4 and 5 we were hitting the benchmarks across metropolitan Sydney. The rural areas have been doing that for some time but this is probably the first time in quite a number of years that there has been an achievement of those benchmarks across the metropolitan area, and that includes substantially improved performance in most of the major hospitals as well as the district hospitals. It has been a huge effort of many staff involved in that process. We believe that access for patients has improved remarkably over the past 12 months.

The Hon. CHRISTINE ROBERTSON: Dr Matthews, what is happening with the mental health needs of New South Wales rural communities during the drought? Although it rained this weekend, it is still in the middle of drought out there.

Mr McGREGOR: Unfortunately I do not think it was quite enough.

Dr MATTHEWS: I was in the bush myself on the weekend; it persistently drizzled but it did not really rain. As the rain shortfalls persist, and we are now confronting what is arguably the worst drought in over a century, that is not only affecting the economic health of the communities but it is also having a significant impact on the mental health and wellbeing of people in rural communities. That is not just farmers; it is all the people in those communities because in the end everyone pretty well is dependent on rain. There has been some targeted support announced by the Premier recently, including funding for six additional mental health workers to be based at key sites in each rural area mental health service and who will work closely with drought support workers, rural financial counsellors and divisions of general practice. Those sites have been determined in consultation with the rural area mental health services, and each worker will have mobile outreach responsibilities across rural areas in partnership with other agencies. The recommended sites that is outreach work will be in the Greater Western Area Health Service, Walgett and Parkes-Forbes; in Greater Southern, Wagga Wagga and Queanbeyan; in the North Coast, Kyogle and Casino; and in the Hunter-New England, Tamworth.

Additional targeted support will include 15 mental health workshops in rural areas, involving 15 local communities, which will assist in building personal and community resilience as well as creating linkages between farming communities and mental health services, simply working out where the services are. There will be 50 mental health first aid training sessions, which will be run for front-line service providers across the State to confidently identify and refer a person in crisis to appropriate support. That is about teaching other front-line workers in the bush awareness of mental health problems.

A mental health resource package will be developed for front-line health and agricultural support workers to better integrate services. These will be included as resource materials in all training interventions and farmers workshops. NSW Health is also going to work in partnership with Beyond Blue, which is a nationwide initiative around depression, which is supported by the Commonwealth and every State jurisdiction, to ensure that country families under pressure have access to services addressing depression/anxiety.

The Centre for Rural and Remote Mental Health, which is based at Orange, will oversee and provide leadership in the implementation of these drought mental health assistance package measures, in collaboration with the area mental health services, the Centre for Mental Health and a range of other agencies. Close links will be maintained with the New South Wales Farmers Association,

through the Centre for Rural and Remote Mental Health's role within the New South Wales farmers mental health network. This targeted and specific response to the intense and prolonged drought sits within a broader framework for action addressing the mental health and wellbeing of people in the rural sector.

We already know that male farm owners, managers and workers commit suicide at around twice the national average. We also know that even if it rains buckets fairly soon the pressures on farmers and rural communities will continue for quite some time. Heavy rain alone is not going to solve the problem. That is why NSW Health has been active in providing support for initiatives that promote the mental health and wellbeing of people in farming communities—so that is promotion as well as dealing with problems when they arise—and we have provided funding to the New South Wales Farmers Association for the provision of mental health first aid training to farming communities. This strategy sits within the blueprint for improving the mental health and wellbeing of people New South Wales farms in developed by the association's mental health rural network. NSW Health is represented on that network by the Centre for Rural and Remote Mental Health.

Since November 2004 we have also funded the Rural Mental Health Support Line 24 hours a day, seven days a week, put in place by NSW Health for farmers and other rural people to allow people in rural communities the opportunity to speak with a trained mental health professional about themselves, a family member, friend or colleague they are concerned about. The line can provide on-the-spot help in an immediate crisis and help with referral to local specialist services. This telephone line continues to be widely promoted to communities affected by drought, and data from the line suggests that it is being used increasingly by the target population.

The Centre for Rural and Remote Mental Health has been the leading longer-term project co-ordinator, in collaboration with the areas, to develop strategies to foster service networks and cross-agency partnerships. The centre was itself established in 2001 as a partnership between the Centre for Mental Health and the University of Newcastle to support mental health services in the bush, and it has a particular mission to train clinicians who will remain and work in the bush.

The New South Wales Government is renewing its funding agreement, and will provide $895,000 per annum from 2006 to 2010, with enhancement funding of $465,000 between 2006 and 2008. Other projects are a lead role in the New South Wales Farmers Association mental health network, cross-agency partnerships with the Department of Primary Industry, rural financial counsellors and rural lands protection board, research critically examining effects of drought on rural and remote communities, and presentations to front-line human service workers in the agricultural support sector, representing mental health services on the Premier's Department Drought Welfare Co-ordinating Committee and the other networks.

The Hon. CHRISTINE ROBERTSON: Mr McGregor, I understand that redevelopment of the Orange Base Hospital will be delivered through a public-private partnership. I would be very interested to hear what this project actually involves and what it will deliver in the long run.

Mr McGREGOR: I thank you very much for the question. The development of a public-private partnership for the Orange Base Hospital follows the successful development of two PPP programs in other places, one at Justice Health with the Long Bay facility, and one with the Mater Hospital in Newcastle for the redevelopment of that hospital. The development at Orange health campus at Bloomfield is about a $200 million investment by the Government to improve health services in that region. It is in fact the biggest capital investment in health infrastructure outside the Sydney metropolitan area at the present time. In the metropolitan area of course the major development is that at the Royal North Shore Hospital, to be commenced shortly.

The redevelopment of the Orange campus will encompass improved services, including a range of ambulatory and community health services. The redevelopment will comprise 175 general acute hospital beds. It will obviously have an emergency department, full emergency services, renal chairs, chemotherapy, dental chairs and the like, and importantly 156 mental health beds. There will be 90 additional tertiary mental health beds, 20 forensic beds, 10 child and adolescent mental health beds, including ambulatory care, intensive care beds, and specialist beds for older people.

The services at the hospital will include the sorts of services expected at a major regional facility: intensive care, cardiovascular, medicine, rehabilitation, paediatric, obstetrics and other support services. A 20-bed medium security forensic unit is part of the suite of specialist units being developed on the site. Support services to be considered to be delivered by the private partner are generally ground maintenance, cleaning, catering distribution, linen distribution, utility management security.

It is important to make the point, as we have with the Mater in Newcastle, that the responsibility for the provision of clinical services shall remain with the Department of Health and the area health services. That will not be contracted out. Detailed tender proposals have been requested from three construction groups selected from a call for expressions of interest in the private sector. The underlying principles of the PPP project, as with the other two projects, are value for money, public interest protection and protection of employees. The advantages and benefits achieved with PPPs include optimal risk transfer to the private sector, value for money, and integrated whole of life asset management. Site preparation works are expected to commence early next year, and full construction is scheduled to commence in early 2008, for completion in early 2011.

The Hon. PENNY SHARPE: I have a question for Dr Robinson. There has been a lot of discussion about the recent increases in obesity, particularly childhood obesity. Could you give an overview of what NSW Health is doing in relation to this?

Dr ROBINSON: I think we have all recognised that there is a significant issue in overweight and obesity for the New South Wales population. For the child population, the major issue is actually children being stigmatised by their peers, being made to feel different and being left out of a lot of the normal activities that they might otherwise extend themselves to. For adults, of course, it involves physical disability and premature death with associated cardiovascular disease, diabetes and some cancers.

Our figures are not at all encouraging at the present time. Approximately 67 per cent of men and 52 per cent of women over the age of 25 years are considered to be either overweight or obese. As far as children are concerned, almost one-quarter of those fall into that same category. This is a rise from 11 per cent in 1985, to 20 per cent in 1997 and 25 per cent in 2004. Interestingly, it is accelerating even more in boys than it is in girls. We recognise that, particularly in childhood, if no action is taken there can be a longer-term effect and that a large number of the children, 25 to 50 per cent, would progress to adult obesity.

We have a large number of initiatives currently in place, outlined primarily in the Prevention of Obesity in Children and Young People, the Government action plan for 2003 to 2007, and also as part of the general chronic care program that is being run within NSW Health to educate the community more about the benefits of healthy nutrition, adequate physical activity, good practices in alcohol consumption, and overall improving our level of exposure to risk factors. There is a particular program, which is being run in the Hunter New England Area Health Services over the next four years, with a substantial investment of money, some $8.5 million being put into the community there, with the particular purpose of looking at this issue of obesity in children in the ages 0 to 15 and providing us with appropriate policy development and evidence of good practice, so that this will be able to be rolled out in other parts of the New South Wales system. It is not focussing entirely on health; it is actually looking at our partnerships with other agencies and other groups, and particularly looking at the school communities, the child care community and working with local government and other community organisations to ensure that we extend our reach to the extent that that is possible.

We have also had a particular initiative, which you may have heard about, the New South Wales Healthy Schools Canteen policy, with the traffic light system in operation. It has been mandated for all government schools that there be adherence to this policy. I am advised that about 89 or 90 per cent of school canteens have now moved down the path of taking up that traffic light system. Also, more recently, we have been working with the Catholic Schools and Independent Schools associations in having the same program rolled out for them. We are coupling this with a lot of information to parents and to the children on healthy behaviours. A web site that has been established will help us to relay this information in an attractive way to the children and to their parents.

As part of the Australian Better Health initiative, we will be rolling out across New South Wales an education program, Go for 2 and 5, a program that has operated out of Western Australia and has shown a significant increase in the uptake of healthy fruit and vegetables. We have worked constructively with our area health services to develop a target to stabilise overweight and obesity rates within the New South Wales population. If we do not do anything, if we are not successful, we will find that approximately a 1 per cent increase is occurring each year, and our intent is to stabilise the rate and to stop this increase that we have at the present time, and then progressively endeavour to bring it down. So we will be setting ourselves some internal targets in terms of our work with the area health services.

The Hon. HENRY TSANG: I am interested in innovations that the health system might provide. What progress has been made to date in terms of health services reforms, and what benefits have been realised through those reforms?

CHAIR: Is this a lengthy response?

Mr McGREGOR: Yes, it is.

CHAIR: Perhaps you could table the response.

The Hon. HENRY TSANG: I would like to hear a summary.

Mr McGREGOR: I will give you a thumbnail sketch. As you know, in July 2004 the Government announced reforms to improve health administration and frontline delivery of service. Targets were set for both numbers of administrative positions to be saved as a result of that restructure, and the investment of those funds into a range of services. I am pleased to report that, in terms of those targets, both in reduced numbers of employees and improved services, that those targets have been achieved. I am happy to give some further information about that.

The Hon. HENRY TSANG: What are the numbers?

Mr McGREGOR: Over a thousand positions were deleted from the administrative ranks of the health system in areas, and the money from those savings has been directed progressively into frontline clinical services. There have been benefits form the amalgamations that arise from the administrative savings, for example, better networking of medical services. We know, for example, historically that employment of medical practitioners in the Illawarra area has been extremely difficult. However, with the networking of clinical services between what was South East Sydney and now Illawarra, some 30-odd positions for medical practitioners in the Illawarra have been established, have been funded, and have been filled. So that is a by-product of the reforms, by having chief executives and clinicians take responsibility for services across a wider area of the State. It is accepted that some of those areas are very large, but we hope that with new technology we can cope with the issues around that.

The Hon. DUNCAN GAY: What is the current status of the report about the death of Jehan Nassif?

Ms KRUK: I think members of the inquiry team would be aware that the Coroner has indicated that the hearing dates have been set for the coronial investigation, from memory—but I am happy to be corrected—for the middle of November, with the intention to have the hearing in December. I do not have the exact dates, I am sorry. As I think I indicated at a press conference a few weeks ago, we have provided all of our background material to the Coroner. So we await the hearing.

The Hon. DUNCAN GAY: Can you indicate whether the ambulance officers were interviewed?

Ms KRUK: The independent team interviewed all of the parties that made themselves available, including the ambulance officers.

The Hon. DUNCAN GAY: Were the family's legal representatives able to be present during your investigation?

Ms KRUK: As I think honourable members would be aware, the family indicated that they did not feel able to work with the inquiry team at that time. I think the family's solicitor may have approached the inquiry team and asked to have parties involved in those meetings, and the inquiry team did not consider that appropriate.

The Hon. DUNCAN GAY: Is it a fact that the inquiry team informed the family's legal officer that was because it would take too much time?

Ms KRUK: I am not aware of the discussions between the solicitor and the inquiry team. I recall that the family solicitor was very keen to have the matter considered by the Coroner. We are certainly pleased to see that the Coroner has made an early decision for that to take place

The Hon. DUNCAN GAY: Did the family indicate why it did not want to participate in the department's investigations?

Ms KRUK: I spoke with the family, as did the Minister, on a number of occasions. I extended my deepest condolences for the loss of their daughter. Initially they did not feel emotionally able to be involved in the inquiry. As a secondary point—and I should never ascribe reasons—but I understand that they preferred to await the Coroner's investigation. I stress again that I should not read reasons into their decision making; that is not fair.

The Hon. DUNCAN GAY: Has the department taken any action against any officers involved in this matter?

Ms KRUK: My understanding from the announcement made by the chief executive of the Ambulance Service was that he had directed the matter to his professional conduct unit. I think he was also very clear in saying that at the time he had the benefit of only one viewpoint and what was also important was what was going to come out of the coronial investigation.

The Hon. DUNCAN GAY: So it is an ongoing matter.

Ms KRUK: He has already commenced the review, as he should. However, you are testing my memory. I think at the press conference he indicated that obviously, because the family did not put their issues on the table before the investigation team, it was rather a one-sided argument. Therefore, I think his approach is appropriate. I have received advice from the Ambulance Service and from the public health officials involved in the exercise that we have implemented recommendations from the inquiry team. That is right?

Dr ROBINSON: That is correct.

The Hon. DUNCAN GAY: What is the current estimated cost of the Royal North Shore development and how much money do you expect to receive from the sale of land at the hospital?

Mr McGREGOR: As I indicated when speaking briefly about the Orange Hospital redevelopment, the redevelopment is the major and most significant redevelopment of a major tertiary hospital in metropolitan Sydney. It is estimated that the redevelopment will cost in the order of $702 million. It will consolidate facilities for acute, subacute, serious burns unit, community health services and support services, recognising that paediatrics and emergency care have already been redeveloped by this Government as part of the Douglas Building. This extends on that.

The redevelopment includes a new main hospital building with operating theatres, procedure rooms, emergency department, day-stay and ward areas. Work on the new building is expected to be completed by 2012. There will be no disruption of services during construction. Other features in the longer term will include onsite accommodation for staff, a new childcare centre, underground car parking and same-grade access to nearby St Leonards railway station.

The Hon. DUNCAN GAY: My question was a discrete question; it was not about what was being provided. I simply asked about the cost.

Mr McGREGOR: I thought it was important to give the context of what we are paying for and what services will be provided in that region. It is intended that the project will be another private-public partnership [PPP] at this time. The concept plan has identified areas required for the hospital and some surplus land has also been identified for disposal, recognising that a small proportion of the site has already been disposed of some years ago for office accommodation development almost on the Pacific Highway. The land we have now identified as surplus is simply not required for health care purposes and will be divested to enable affordable accommodation for staff, students, carers, mixed residential and conversion development to be built. It will contribute to meeting the cost of the total redevelopment.

The Hon. DUNCAN GAY: How much do you expect to receive for that land?

Mr McGREGOR: I am not inclined line respond to that at this stage.

The Hon. DUNCAN GAY: Why not?

Mr McGREGOR: That is commercial information and valuations that we have had.

The Hon. HENRY TSANG: It is a PPP.

The Hon. DUNCAN GAY: The land is not a PPP.

Mr McGREGOR: I would not want to put a figure on it that might influence the marketplace. I have to be very cautious about that.

The Hon. DUNCAN GAY: Sorry?

Mr McGREGOR: I would have to be cautious about that because it may influence the marketplace. By giving what we consider to be a reasonable price it might set the market to bid around those sorts of numbers, and I am not prepared to do that.

The Hon. CHRISTINE ROBERTSON: They may get more.

Mr McGREGOR: Yes, we may get more. Obviously it will be disposed of at a commercially acceptable rate.

The Hon. DUNCAN GAY: Do you expect to get more than the cost of the redevelopment?

Mr McGREGOR: No, not by a long shot.

The Hon. DUNCAN GAY: So you expect to get less than the $700 million.

Mr McGREGOR: Absolutely; considerably less.

The Hon. DUNCAN GAY: But this is a PPP.

Mr McGREGOR: Indeed.

The Hon. DUNCAN GAY: So the money is coming from outside.

Mr McGREGOR: Yes, but there is no such thing as free money. We all know that if you have a mortgage you have to pay it back. We have to pay that money back to the private sector over time.

The Hon. DUNCAN GAY: Are you saying that the money from the sale of the land will go straight to the private sector?

Mr McGREGOR: No, I am not saying that.

The Hon. DUNCAN GAY: It was what you said.

Mr McGREGOR: No, I am saying that the total project will cost $700 million. We will seek expressions of interest from the private sector to do it as a PPP. As I said earlier in relation to the response about the Orange Hospital, it has to be value for money. If that cannot be demonstrated then the Government will look to an alternative method of securing it; that is, funding it itself. However, if it does offer value for money and if it has appropriate risk transfer to the private sector then it may be a viable project and the Government will proceed. That is yet to be done.

The Hon. DUNCAN GAY: Where does the money from the sale of the land go? Does it go to this infrastructure?

Mr McGREGOR: The money from the sale of the land will go towards the contribution the Government will have to make towards the redevelopment of this facility.

The Hon. DUNCAN GAY: Consolidated revenue?

Mr McGREGOR: As I indicated, it will go towards the overall cost to the Government of this redevelopment.

The Hon. DUNCAN GAY: Does it go to your department or into consolidated revenue?

Mr McGREGOR: Under the guidelines the Government has in terms of health, where we are able to dispose of an asset, the money is retained by the department for use for its capital works program. In this instance, the funds will go towards the total cost of the redevelopment of the Royal North Shore Hospital.

The Hon. DUNCAN GAY: How much money does St Vincent's Hospital expect to receive for the redevelopment of the two properties referred by New South Wales Health as Caritas and O'Brien?

Mr McGREGOR: That matter is still the subject of consideration in terms of planning approvals. The extent of the redevelopment will determine the income that St Vincent's Hospital may secure for that. Again, I do not wish a canvass or bandy around projected figures that we think they might get. We certainly do not intend to influence the private sector's thinking about that.

Dr MATTHEWS: As a point of clarification: It is Caritas, not O'Brien. The O'Brien Building is on the campus of St Vincent's Hospital and is the building to be demolished to make way for the new building. It is not being disposed of except in a physical sense.

Ms KRUK: The Government's contribution is $23 million.

The Hon. DUNCAN GAY: Would New South Wales Health, given the limited amount of land owned by St Vincent's Hospital and New South Wales Health in the surrounding area, prefer to keep the land for future development?

Dr MATTHEWS: The land known as Caritas, or which has the Caritas facility on it, is virtually an entire block in Darlinghurst bounded by Bourke Street, Burton Street and Forbes Street. It is a triangular block. The majority of the buildings on the site are very large sandstone heritage buildings. The acute unit, which faces Burton Street, was built in the 1960s and it has no heritage significance. However, it is a site which, because of its position, its distance from the hospital and heritage issues around the redevelopment, does not offer very good value for money in terms of redevelopment for health purposes. That option was carefully considered, but the amount of that land that can be built on because of the sandstone buildings is quite small.

The option of demolishing the O'Brien Building and building on that site is better for two reasons. First, demolishing the building will create a greenfield site and, secondly, it collocates the mental services with the acute services in St Vincent's Hospital. It also brings the drug and alcohol services, which are currently located in an old building called Rankin Court in Victoria Street, onto the same site and thereby brings mental health, drug and alcohol services together. It also gives enormous benefits in terms of service delivery by having all those things on the one site.

The Hon. DUNCAN GAY: Why did St Vincent's Hospital apply to have this listed as a state-significant development?

Ms KRUK: I think that is a matter for St Vincent's Hospital. Given the significance of mental health services, it is not one that we would oppose. It is obviously a matter that St Vincent's Hospital took up with the Minister for Planning.

The Hon. DUNCAN GAY: I would have thought that, given the importance of such a matter, you would not have needed to go to state significant.

Ms KRUK: As you know, the granting of state-significant status offers some benefit. No doubt the proponents at St Vincent's Hospital were of similar thinking.

The Hon. DUNCAN GAY: When do you expect the Minister to make the decision on whether it will be a state-significant development? Is there a timeline?

Mr McGREGOR: I think that is a matter for the Minister for Planning.

The Hon. DUNCAN GAY: Is there a current valuation on the land occupied by St Vincent's Hospital?

Mr McGREGOR: Do you mean in terms of the total site?

The Hon. DUNCAN GAY: Yes.

Mr McGREGOR: I am not aware of the existence of one, but we can make some inquiries.

Mr BARKER: Under Australian Accounting Standards they are controlled by the Australian Securities and Investments Commission. Therefore, if they are complying with Australian Accounting Standards, recognising that they are not a controlled entity of New South Wales Health, you would expect their financial statements to contain valuations. The answer would be yes. However, with regard to when they did it, you would have to ask them.

Ms KRUK: Whether they give it to us is another issue.

The Hon. DUNCAN GAY: When we look at that, would we expect there would be a valuation for land occupied by them and for land not occupied by them?

Mr BARKER: Under Australian accounting standards any land they own should be valued on a regular basis. How they interpret that and how they do that you would have to ask them and their parent company.

The Hon. DUNCAN GAY: The Prince of Wales Hospital: Has NSW Health received any proposal to dispose of land at Prince of Wales Hospital?

Mr McGREGOR: I am advised that we have not recently received any proposals—at the department that is.

The Hon. DUNCAN GAY: You use the word "recently"?

Mr McGREGOR: I do not recall whether there were proposals 10 or 15 years ago, but certainly I have not seen any proposals in recent times.

The Hon. DUNCAN GAY: So, nothing for 15 years?

Mr McGREGOR: I do not think I have ever seen any real proposals. There are no proposals.

The Hon. DUNCAN GAY: Are there plans to sell off any more health land beyond the Royal North Shore Hospital?

Mr McGREGOR: The department always looks at its assets when it is undertaking redevelopment to see whether some of that land is required on a continual basis and, if not, we are happy to dispose of that so we can expand our contribution to our capital works program.

The Hon. DUNCAN GAY: Could you list those?

Mr McGREGOR: I do not have a listing with me at the moment, I am sorry. I will take it on notice.

CHAIR: I have a couple of questions in relation to some comments Professor McGrath made before about the emergency department statistics. You spoke in glowing terms of emergency departments and triage times, but my understanding is there is a 30 per cent failure rate in major teaching hospitals in treating patients within time and reaching targets. Can you tell me whether the fast track zones have improved your statistics?

Professor McGRATH: Yes. I think it is worth noting that in the past 12 months we have had a substantial rise in demand across emergency departments to the point where there is over 28,000 more patients presenting to emergency departments in this financial year compared to the same time for the past financial year. Where you are quoting a figure of 30 per cent shortfall in performance, I think that is a three or four-year-old figure.

Ms KRUK: Is your concern in relation to the triage targets or is it in relation to the access related targets?

CHAIR: Access related would probably be the better one in treating patients.

Professor McGRATH: In access block, the target we have across the State is 80 per cent of the patients admitted within an eight-hour period. Over the past 12 months, and indeed over the past couple of years, we have been moving closer and closer to that target and across metropolitan Sydney, which we monitor frequently because that is where the greatest demand is, virtually all the hospitals are meeting that target and certainly the rolled up target across the metropolitan area, particularly for the month of October, we have been meeting that target. About three or four years ago there was a substantial shortfall in meeting that target, particularly in the peak demand period of winter and at times, back in 2002-03 and 2003-04, it would have been substantially below that target. But over the past two years there has been a gradual improvement in performance in the number of patients admitted within that eight-hour time frame and most hospitals are moving forward, sometimes six steps forward and four steps back, but a significant improvement. If I can look at these figures here, it depends on which hospital you are talking about, but there has been year-on-year an improvement of about 10 percentage points in access across the system.

In relation to fast track zones, this was an initiative that came out of the clinical services redesign and has been gradually growing in its implementation across the major hospitals in New South Wales. Most, if not all, are putting those into place and, as a consequence of that, there has been a substantial improvement in both triage 3 and triage 4. Triage 4 performance, again across the metropolitan area and rolled up across all the major hospitals, has met the target for the past couple of months and, as I referred earlier, in the past couple of weeks the triage 3 has been virtually on target.

Ms KRUK: Can I just add, because it is important and I think this is what the Hon. Dr Arthur Chesterfield-Evans was referring to, Professor Rod Bishop, who is head of emergency at Nepean, was the one who in effect pulled this initiative together and has worked with emergency department heads across the State to look at the feasibility of rolling out a model of that type. To pick up Katherine's point, one of the benefits of the redesigned clinical process is your front-line people working out where your blockages are. We have a system this year that is 8 per cent busier than the previous year, which was a number of percentage points busier than the year before that. The performance is remarkable but we also do not rest on our laurels. Unless we bring about some of those changes in models of care such as the fast track zones we would have significant difficulties and we have to continue redesigning patient flow through the system.

CHAIR: Before I go to the Hon. Dr Arthur Chesterfield-Evans, could I just get clarification. I think it was either Mr McGregor or Mr Matthews, about the Prince of Wales Hospital and proposals for disposal of land. Have investigations been done? I know you said there were not any proposals but have any investigations been done?

Mr McGREGOR: I think there were a series of reviews over time. The area health service has looked at it and, as I said, it has not resulted in any firm proposals coming forward. Can I just take a few moments to respond further? We have further information about Lithgow. The area health service advises it is aware of that issue. There are design issues there. There has been consultation with the department. Tender documents are now being prepared with a view to issuing before the end of the year so design solutions can be implemented.

The Hon. HENRY TSANG: Chair, may I make a one-sentence statement please? In terms of emergency services, I wonder whether the director general—

CHAIR: You will have time to make a statement when it is the Government's time for questions.

Ms SYLVIA HALE: Mr McGregor, when talking about the Royal North Shore Hospital you said this might be another PPP but that would be dependant upon the appropriate risk transfer to the private sector. What sort of risk can you transfer to the private sector when you are providing a hospital?

Mr McGREGOR: Well, for example, risk transfer, we transfer some of the risk associated with the back of house services that are provided. As we have with the Mater hospital we have a labour services agreement that protects the employment rights of the individuals and we would transfer some of that responsibility and some of the risk associated with that to the private sector. The overarching guidelines are public and they are called Working with Government guidelines issued by the Government some time ago, and they direct how we shall proceed with PPPs. It is about improving public service delivery through private sector provision of infrastructure, and you will find that the Working with Government guidelines go into some detail about risk management and risk transfer, and that is available on the Department of Commerce or Premier's web site.

Ms SYLVIA HALE: Surely the experience of Port Macquarie Base Hospital shows that reliance upon the private sector to provide public hospital services is not without its problems? What measures are you putting in place to prevent a recurrence of that scenario?

Mr McGREGOR: The Port Macquarie arrangement is not a PPP under the Working with Government guidelines. As the Auditor-General reported, the contract negotiations around that led to a scenario where at the end of the day to have that asset secured over a longer time the Government had to pay for it three times. The PPP negotiations we have completed with the Mater hospital and the private sector there include no such arrangements. At the end of the contract period the assets are returned to public ownership automatically. I think Port Macquarie is not a very good example of involvement and working with the private sector and would not be permitted to recur under the Working with Government guidelines.

Ms SYLVIA HALE: Could you explain to me precisely what sorts of services you would expect the private sector to provide in relation to Royal North Shore Hospital?

Dr MATTHEWS: The principal distinction is that under the current PPP or arrangement all clinical services are provided by NSW Health by NSW Health employees or contractors. It is so-called corporate services or back of house services, which include food, the provision of linen, maintenance of buildings and grounds maintenance, that are provided by the consortium but, importantly, not clinical services.

Ms SYLVIA HALE: But you would be conscious, no doubt, of British experience where similar private contracts are entered into and great dissatisfaction has been expressed with, for example, cleaning services and the role of volunteers within hospitals? How do you overcome those sorts of problems?

Mr McGREGOR: Under the labour services agreement the employees in New South Wales under the PPPs will remain employees with their employment rights protected. They will be managed by the private sector. This agreement has been entered into willingly with the private sector with the knowledge of the unions so we do not have a scenario where our employees, when they become part of a PPP, are transferred to the control or management of the private sector under awards or lack of awards, as is the case in the NHS and its PPP arrangements. Our PPP arrangements are quite different and I believe we have learned—as has the NHS—from its very early experiences with PPPs.

Ms SYLVIA HALE: But surely private contracts are dependent upon the specific description of the jobs that are to be done and it is very difficult, up front, to stipulate exactly what is to be performed under that contract?

Mr McGREGOR: I am going to ask Dr Matthews to answer this, because in his role in Justice Health he has had to deal with the nuances of all of that.

Dr MATTHEWS: We have been involved in a very detailed process for determining those contracts. I can give you some clear examples of how it works and how I think it is going to benefit us. Under those contracts, every single piece of maintenance is determined and there is a 24-hour help desk. So, if a nurse unit manager in a ward reports that a lightbulb or a fluorescent strip is out of action that goes to a help desk and is logged onto a computer and under the terms of the contract that contract has a KPI to replace the bad lightbulb or, indeed, to unblock a blocked toilet or any other piece of maintenance. A monthly or weekly computer-generated report shows exactly the time each problem was logged and exactly the time when the problem was remedied. That report comes to us and there is a mechanism within the contract that if the consortium has not met those KPIs it reduces the monthly payment made to them to comply with the contract.

Ms SYLVIA HALE: My concern is that it is almost humanly impossible to envisage beforehand every instance that will require the performance of some form of maintenance; and that, in fact, the history from the United Kingdom—and also if we look at the detention centres that the Federal Government has operated—would suggest that the private sector will look for every loophole and will exploit that loophole accordingly.

Dr MATTHEWS: I understand that that is an argument that might be put. I can assure you that the contract documentation that we have has a level of detail that literally boggles the mind. The other thing I would put to you is that there is considerable competition in the private sector around the building and management of these contracts and poor performance—or, as you put it, the seeking of loopholes—is not the way to get more business. If you look at some of the experience closer to home, in Victoria, and I would urge you to visit the Casey Hospital, as I have done, the level of partnership and co-operation between the clinical staff, the non-clinical staff and the consortium is extremely high, and there is a partnership developed that effectively says, "This is our building. We want it to be in the same condition in 30 years as it is now and we are going to work together to ensure that it is." That can be done.

Ms SYLVIA HALE: But would you not agree that, in the case of detention centres, they are now reverting to government control because of poor service, poor management and an emphasis on cost cutting? If the Federal Government has experienced that do you think that you are in a position to sort of exercise the wisdom of Solomon, as it were?

Dr MATTHEWS: I think I would take umbrage at being compared with detention centres—

Ms SYLVIA HALE: Well, Long Bay is equivalent, is it not?

Dr MATTHEWS: We would argue that the people held at Long Bay had a real legal basis to be there, but I am confident that with the contractual arrangements we have we will be able to manage these buildings and that at the end of 30 years they will be in similar condition to the condition they were in when handed over.

Ms SYLVIA HALE: Will those contractual arrangements be made public so that the public can see whether in fact the performance is meeting the expectation?

Dr MATTHEWS: The contractual arrangements will not be made public but the proof of the pudding is in the eating and I would be happy to invite anybody to come out there and tour the facility when it is opened. I would be happy to invite you to the opening because I am very proud of it. Indeed, I would be happy to invite to all back after one year, two years and five years to inspect the buildings and to see that we have kept up our responsibility as contract managers. I am happy to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I refer you to some of the answers that have been provided. I must say I am very disappointed in them. Number 558 refers first to the answer to 558 and then to 568, which answer refers to 563, which refers to budget estimates transcript page 42. You are talking goose chases, at least. Number 561 refers to 466, which refers to the Government stabled response of 29 September 2006; 500 to 502 refer to funerals and says to refer to *Hansard* of 7 September 2006. A lot of these responses are fob offs that simply refer us somewhere else. What use is that?

Ms KRUK: The Minister indicated when he appeared before the Estimates Committee that if the information is publicly available elsewhere he would refer the inquirer to the information publicly available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Simply being referred to a web site does not make it very easy to find.

Ms KRUK: Your concerns are noted. I can only restate the Minister's comment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Many of the answers are not at all specific, and specific things that were requested have not been answered. For example, could you give us some more information on when the Gosford mental health unit will be completed? All the answer 378 says is that there is going to be a consultation process. The announcement was made in 2001. You could also look at Coffs Harbour, which is No. 413.

Ms KRUK: Dr Matthews, do you want to add anything to your answer?

Dr MATTHEWS: The current mental health unit at Gosford Hospital, as you know, is the Mandala Unit, which has 25 beds. As part of North Sydney Central Coast Area Health Service overall planning that unit is to be replaced, on a separate part of the hospital site, by a new unit, which will include, from memory, an additional four or six child and adolescent health beds. There are a number of master planning issues to be taken into account on that site. The new site involves the demolition of a building, which in turn means that services are going to be moved. It is actually a very complex planning issue on site. It is part of the forward program but the exact commencement date has yet to be determined.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Nothing is happening. Funding was promised in 2001 and in 2006 you cannot give us any sort of guidelines at all. Is that what you are saying? It is no good simply saying five years later that it is a complex planning issue. You would presumably give me the same answer in a decade.

Dr MATTHEWS: I guess what I can respond is that during that period we have continually enhanced the number of child and adolescent beds across this State and we are currently building a number of units, and have opened a number of units. There are specific issues about that site that need to be resolved. But you are correct; I cannot tell you today when the building will commence.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell me anything about Coffs Harbour?

Dr MATTHEWS: Yes. Are you referring to the 20-bed subacute unit?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The one in 413. You have given no specific details there. The question was: When was the new rehabilitation unit at Coffs Harbour first announced by the Government? What proportion of the $3.8 million to be spent in New South Wales

for inpatient clinical mental health rehabilitation program announced in the budget will be spent on actual mental health professionals? There are two questions there. One is about rehabilitation at Coffs Harbour and the other is about how much is spent on professionals rather than generic mental health workers. The answer is, "It is all on the public record," with no fact. What do we do? Do we have to read everything that has ever been written?

Dr MATTHEWS: I can tell you that the unit was announced by the Government in May 2005 and the money is available in the forward program. We are currently resolving an issue in relation to the koala corridor.

The Hon. DUNCAN GAY: Why was that not the answer?

Ms KRUK: I say again, and members are aware of this, these are the Minister's answers to those questions that I do not think that we should second-guess to the content of those. If Richard has further information to add to the question, he will do so but these other Minister's answers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us not get too precious here. Surely you produced the draft answers?

Ms KRUK: I am not being precious, Dr Chesterfield-Evans, these are the Minister's answers to the questions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that you may have produced different answers and that the Minister adapted them?

Ms KRUK: I am saying these other Minister's answers to the questions.

The Hon. HENRY TSANG: Madam Chair, the director general has currently provided additional information and the honourable member should be appreciative of the information provided rather than giving the director general a hard time by trying to get the answer he wants.

Dr MATTHEWS: I can advise you that the 20-bed non-acute unit at Coffs Harbour will, at a total cost of $7.8 million, be completed in March 2008 with a projected official opening date of April 2008.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Thank you very much, Dr Matthews. I note in questions 374, 377 and 417 but the number of hospital assault do not distinguish between private and public hospitals. Surely if you are trying to improve public hospitals you would need to have that problem remedied? Are there any plans to look at the number of assaults in public hospitals?

Ms KRUK: Sorry, which questions?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Questions 374 to 377 and 417.Well, 417 only refers to 377 and 374, so you can go back to those other two. It relates to assaults on people within mental hospitals.

Ms KRUK: And you are concerned with the limitation of the data that was collected, is that right?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr MATTHEWS: Have you actually looked up the data?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I have not had time. I only got these things this morning. It is very difficult dealing with government agencies.

Dr MATTHEWS: This does not suggest that there is any discrimination between the two. Well, there is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you lump the figures together you do not know how many of them were in private hospitals and how many in public hospitals, which means it is difficult to ask you about public hospitals. I do not know about the figures

Dr MATTHEWS: This information, we understand, has been prepared by the Bureau of Crime Statistics and Research and is available on the web site that has been given to you in the answer. Perhaps it might be useful to refer to the web site first to see if that sort of dissection is there. I suspect that it is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I know. You have actually said that in your answer and it is useful, but it does not distinguish between public and private facilities. Is that your way of saying that you do not know how many assaults there are in public facilities because some of them might have been private facilities?

Dr MATTHEWS: But the question itself does not distinguish, either. It refers to mental health facilities and, as you know, there are some private mental health facilities in New South Wales.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, there are, but it would be nice to know how many are under your direct administrative control. The questions about dental interns seems to be very vexed, questions 382 to 385 and 458 to 463. There appears to be money for 10 overseas-trained graduates but it is quite vague about whether there is or is not a program for new graduates in Australia undertaking higher degrees. Can you clarify whether there will or will not be such a program and, if so, what is the nature of it?

Dr ROBINSON: We are actually in a very fortunate position with respect to dentists inasmuch as the registration process within New South Wales gives us the ability to attract some overseas-trained dentists from certain countries without having them go through an AMC-type process. They can come and be registered and start to work. With some of the other countries, particularly Malaysia, Singapore and Hong Kong, we are not in the same position. We have to have a period of supervised training, which you would be familiar with, under the AMC-like process. What is proposed here is that we will recruit an additional 10 positions. We will place them within existing dental hospitals, where they will be mentored and supervised for a period of 12 months. That is the internship that is referred to there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is no program for higher training for Australian graduates, is that correct?

The Hon. HENRY TSANG: Madam Chair, I would like to make a statement.

CHAIR: Just a moment.

Dr ROBINSON: If we were to move to a program for Australian graduates we would need to do so on a cross-jurisdictional basis, have all the States move at the same time and also do it prospectively. So, no, we cannot do it alone at this point in time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So we are not going to do it. Is that the bottom line?

Dr ROBINSON: We have to ensure that there is a nationally consistent approach otherwise the dentists that we train will simply move across the borders and they will be able to work without any internship in other jurisdictions. So it is critical that we actually have a national approach on this.

CHAIR: Thank you. Our time is almost up. However, before I allow the Hon. Henry Tsang to make the statement that he is desperate to make, Ms Kruk, you asked me to remind you about hydrotherapy pools.

Ms KRUK: I do not think we have been able to get any additional information so I will have to take the question on notice. Thank you for reminding me.

The Hon. HENRY TSANG: The statement I desperately want to make is in regard to the triage issue that was raised earlier. I ask the Director General to extend my family's appreciative thanks to Westmead Hospital. My mother was sent to the Westmead Hospital emergency department. She received attention and the triage was done within three minutes. Within one hour I received a call from the doctor to say, "You're mother is critical." She subsequently died within 24 hours. During that period the doctors gave wonderful professional service. Even after my mother passed away, the hospital staff and doctors were wonderfully courteous to my family. I noted that a large number of emergency services personnel, doctors, nurses and even cleaners had been recruited from overseas. They were migrants, who work very hard. Director General, I ask you to extend my family's appreciation to the staff, who do a very difficult job every day.

Ms KRUK: Thank you for that. I offer my condolences on the loss of your mother. I honestly think the staff will be incredibly pleased to hear your comments. I think it goes back to Dr Arthur Chesterfield-Evans's comments: All too often people forget to acknowledge the very good work that is done. I respect the fact that you have raised that issue after you have lost your mum. I will convey your comments to the clinicians at Westmead. Thank you.

CHAIR: Thank you. That concludes today's hearing. Ms Kruk, we look forward to receiving answers to the questions that have been taken on notice today.

Ms KRUK: We will try. Thank you.

CHAIR: Thank you.

(The witnesses withdrew)

The Committee proceeded to deliberate.