

PORTFOLIO COMMITTEE NO. 2 – HEALTH

Wednesday 30 October 2019

Examination of proposed expenditure for the portfolio areas

HEALTH AND MEDICAL RESEARCH

CORRECTED

The Committee met at 9:30

MEMBERS

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato

Ms Cate Faehrmann

The Hon. Ben Franklin

The Hon. Courtney Houssos

The Hon. Emma Hurst (Deputy Chair)

The Hon. Natasha Maclaren-Jones

The Hon. Walt Secord

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

Corrections should be marked on a photocopy of the proof and forwarded to:

**Budget Estimates secretariat
Room 812
Parliament House
Macquarie Street
SYDNEY NSW 2000**

The CHAIR: Welcome to the budget estimates supplementary hearing for the portfolio of Health and Medical Research. Before I commence, I would like to acknowledge the Gadigal people who are the traditional custodians of this land. I would also like to pay respect to elders past and present of the Eora nation and I extend that respect to other Aboriginals present or those who may be watching on the internet. Today's hearing is open to the public and is being broadcast live via the Parliament's website.

In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. The guidelines for the broadcast of proceedings are available from the Committee secretariat. All witnesses in budget estimates have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018.

Any messages from advisers or members' staff seated in the public gallery should be delivered through the Committee secretariat. I remind witnesses and the officers accompanying you that you are free to pass notes and refer directly to your advisers seated at the table behind you. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing. I remind all witnesses, with the exception of Ms Dawson and Ms Wilcox, that you do not need to be sworn as you have already sworn an oath at an earlier budget estimates hearing of this Committee.

SUE DAWSON, Health Care Complaints Commissioner, affirmed and examined

DEBORAH WILLCOX, Chief Executive Officer, North Sydney Local Health District, affirmed and examined

ELIZABETH KOFF, Secretary, NSW Health, on former oath

KERRY CHANT, Chief Health Officer, NSW Health, on former oath

PHIL MINNS, Deputy Secretary, People, Culture and Governance, NSW Health, on former oath

The CHAIR: As there is no provision for any witness to make an opening statement, we will begin our questions. We will proceed moving from the Opposition to the crossbench in that order through the proceedings this morning. We will commence with the Opposition.

The Hon. WALT SECORD: Thank you for attending today. You would be aware of coverage last week of \$252 million in funding cuts involving NSW Health. I think this question would be directed to the secretary. Yesterday at budget estimates the head of Treasury said there was no Treasury cap and I should ask you why you were making these cuts. The Hon. Ben Franklin was there—that is what he said?

The CHAIR: Please proceed with the question.

The Hon. WALT SECORD: He said there were no cuts. Can you explain the discrepancy between the secretary of Treasury and the material that was in the public arena from Blacktown Mount Druitt Hospital involving a \$252 million cut and that this is an across-the-board Treasury cap? Can you explain?

Ms KOFF: Yes, certainly. Health did receive a budget increase. There was no reduction in the budget for NSW Health for 2019-20. As is well documented, Health received a 4.5 per cent budget increase. It is in the Treasury budget papers; it is listed there. The amount of 4.5 per cent represents about \$1 billion to the New South Wales health system. In receiving that amount of money our total budget allocation was \$24 billion. That is quite clear and we do not resile from that. The process of budget negotiation, then, with the districts and networks is a long and protracted procedure, as you can imagine.

In Health the appetite for expenditure is insatiable. I am sure we could spend the full Government budget if we put our minds to it. However, we have to operate within the budget we are allocated from Treasury. We negotiate with all districts and networks. This negotiation is not about the money, primarily—it is about the level of activity that they are undertaking; it is about the previous year's activity levels. As people are well aware, activity continues to increase in the health system. We also have conversations about population growth. Population growth will affect the level of activity that is presenting to all our hospitals. We have those discussions and then we determine how to allocate the money out to the districts and then the rest of the pillars and the health services.

As with any health system we have a responsibility to use the funds appropriately and judiciously. We would be remiss in not attempting to achieve budget efficiencies. Budget efficiencies are not a dirty word. We did not cut the budgets to any district or network. I make that very, very clear. They have not had budget reductions. What we have had the conversation about with all the districts and the networks is how they can drive productivity savings to reinvest into their health services. Hence, through that lens we have said to them, "You need to make efficiency savings." But that does not equate to a budget reduction to any district, nor does it relate to them having to save money to return to Health.

Any efficiencies that they make have to be reinvested into clinical services. Part of the efficiency targets—which are consistent with other clusters, and that is potentially where Treasury savings was interpreted incorrectly in some places—is that we need to look at back-office functions and see if we have got the right mix of back-office functions and staffing. We need to look at procurement: Are we achieving the best price for some of the consumables that we buy across these health system? We are looking at consultancy fees—and other government agencies were similarly asked to look at those. That is what we hold the districts and networks to account for.

The Hon. WALT SECORD: Thank you, Dr Koff—Ms Koff, I am sorry.

Ms KOFF: That is all right, Mr Secord. I am happy to get a promotion.

The Hon. WALT SECORD: What is the status of this document that was given to doctors at Mount Druitt hospital? If they are not told to make \$252 million in cuts then who is wrong? Is this document, produced by the local health district and given to doctors there, wrong?

Ms KOFF: I do not know the origins of that document. It has got no labels on it. It has got no identifying features on it as to the origins of it and who interpreted what was there—

The Hon. WALT SECORD: It was sent to surgeons at Mount Druitt hospital from the local health district. Have you launched an investigation into who prepared this document if it, in fact, is incorrect?

Ms KOFF: I am not going to launch an investigation into a document, Mr Secord.

The Hon. WALT SECORD: But doctors are making cuts at Mount Druitt hospital based on this document sent to them telling them to find \$252 million in cuts. Now you say it is about activity. Can you tell me—

Ms KOFF: They are not asked to make \$252 million in cuts. In our mind, as a health system, the collective health system needed to find \$252 million in efficiency savings. That does not equate to budget cuts.

The Hon. WALT SECORD: What is the difference between efficiency savings and a cut?

Ms KOFF: A budget cut is if you normally get \$10 and I give you \$8—that is a budget cut, in my mind. You have got \$2 less.

The Hon. WALT SECORD: What is an efficiency—

Ms KOFF: An efficiency saving is if I give you the \$10, as I normally would, but I would still like you to make some savings to do more work in that and set your target within that. So you still get the \$10.

The Hon. WALT SECORD: But you can only spend \$8 of it.

Ms KOFF: No, I am saying that you can still spend the \$10. You use the money across the system. If you are purchasing a wound management swab that might normally cost \$10 from a company and you can get it for \$8 and have a procurement saving of \$2 you keep the \$2 locally. You are not getting a budget cut, Mr Secord.

The Hon. WALT SECORD: You say, "Here is \$10"—

Ms KOFF: There is no budget cut. You still have the same amount of money. There is no budget cut.

The Hon. WALT SECORD: But you have to make an efficiency saving.

The Hon. BEN FRANKLIN: Getting more bang for your buck sounds good to me.

Ms KOFF: That is exactly right. Thank you.

The Hon. WALT SECORD: I am not convinced.

The Hon. BEN FRANKLIN: I am.

Ms KOFF: It ends up being \$12 that you ultimately get. We are saying if you drive up efficiencies you get the \$10 and the \$2 that you make.

The Hon. COURTNEY HOUSSOS: Let me ask you this: What happens if you cannot get the wound management system for less money? What happens if you cannot find those things for a cheaper price?

Ms KOFF: You can. Everybody can. To say that people cannot procure things efficiently or cannot look at back-office costs is incorrect. It is well documented in national evidence—the efficiency of health care. I do not resile from the fact that there are inefficiencies in health care that we need to address to maximise the investment in frontline service.

The Hon. WALT SECORD: I want to take you back to your previous answer. I cannot believe that you sat here and said that you provide \$10 to the doctors and then went on to say, "In fact, that will be \$12 if you find efficiencies."

Ms KOFF: Yes, that is right.

The Hon. WALT SECORD: That is extraordinary.

Ms KOFF: We do not give it to the doctors—number one. It goes to the health system. Mr Secord, we really drive our targets. We are not resiling from the fact that we are the best-performing health system in the country at the moment. Our acute surgery performance is on target. It is successful. It is the best performing. We do not want to reduce our efficiencies and our performance in elective surgery or anywhere else.

The Hon. WALT SECORD: The \$252 million cut in the document provided by the local health district to Blacktown and Mount Druitt doctors is actually a \$252 million increase according to your rational?

Ms KOFF: It is not a cut to Blacktown and Mount Druitt. That is not correct. If I can go to the budgets for all the districts—

The CHAIR: We may need some clarification about what you are referring to. Mr Secord, do you have a document there that you wish to present?

The Hon. WALT SECORD: Yes. It has been in the public arena and—

The CHAIR: Does Ms Koff know the document you are referring to?

The Hon. WALT SECORD: She does.

The Hon. BEN FRANKLIN: Let her answer the question.

The CHAIR: No, just to be clear—

The Hon. WALT SECORD: I seek leave to table the document. There is a small personal note on the top of the document but that is fine. Here is the document. The secretariat may want to provide it to Ms Koff. She is aware of it.

The CHAIR: It is not a case of the secretariat deciding. I just want to make sure that Ms Koff is talking about the same matter as you.

Ms KOFF: Yes. It was raised in Parliament on Tuesday of last week, as I understand it. The Western Sydney Local Health District, of which Blacktown and Mount Druitt are two facilities, received a budget of \$1.9 billion this year, which is \$88 million more than the previous year. That was a budget increase of 5 per cent. I cannot say it any clearer than that. They did not get a budget reduction.

The Hon. WALT SECORD: So why is the local health district telling doctors, nurses and allied health workers to find \$252 million?

Ms KOFF: They are incorrect. They do not have to find \$252 million in savings at Blacktown and Mount Druitt. That is incorrect.

The Hon. WALT SECORD: But why is the local health district telling them to do that? You said earlier—

The CHAIR: Order! There is a document there. That is a document that you are familiar with. Is that right? Have you seen it before?

Ms KOFF: Yes, I have.

The CHAIR: We do not know the source of the document. Is that right?

The Hon. WALT SECORD: Yes, we do. Surgeons from Mount Druitt Hospital provided it to the Opposition. That is on the public record.

The CHAIR: Who crafted the document in the first place? They have not been identified per se. But it is a document in the public domain. Ms Koff, do you know the source of that document?

Ms KOFF: It has some aspects of presentations that have been provided by the ministry. But it also has some aspects that are unknown to me. I note that there is a Treasury document in it too. I think someone has created the PowerPoint using elements of a variety of documents. I put out a media statement after this was released saying that the Treasury cap for NSW Health of \$252 million was incorrect.

The Hon. COURTNEY HOUSSOS: It is a fairly serious accusation though, Ms Koff. Would you agree?

Ms KOFF: What is a serious accusation?

The Hon. COURTNEY HOUSSOS: That \$252 million has to be found in savings. You would appreciate that that is a fairly serious thing for somebody to be going around and saying in an official document to local surgeons, doctors and health workers. Would you agree?

Ms KOFF: I am very disappointed that that misinformation was communicated. I do not know who did that. But in reality it is up to me to correct the record, which I am confident the Minister did in Parliament last

week. There is no budget reduction. If you do look at the document that you have distributed and are referring to—

The CHAIR: To be clear, that is the document that has been circulated? We understand that surgeons have received that document.

The Hon. WALT SECORD: Everyone is agreed that this is the document.

The CHAIR: There is no disagreement about that. That is the document. We do not know the source or who crafted it and put it into distribution in the first instance. But that is the document. We are trying to clear up or provide you with the opportunity to clear up beyond any doubt anything that is in there that is either correct or incorrect.

Ms KOFF: I can categorically state that the comment on the first page—and I put out a media release on the evening it was raised in Parliament—that states there is a Treasury cap of \$252 million is incorrect. It is incorrect terminology. There is no cap from Treasury of \$252 million.

The CHAIR: I want to clarify the issue of productivity savings or efficiency savings. That formed a major part of your first answer to the Hon. Walt Secord's question. Is that dealt with in that document?

Ms KOFF: Yes. The \$252 million figure is mentioned on a un-numbered page in the document entitled, "Savings allocation". As you can see, that \$252 million is broken down into districts.

The Hon. WALT SECORD: There is \$150 million. There is \$67 million for ambulance, pathology and HealthShare. There is \$35 million for Pillars and the Ministry of Health. Did you ask them to find those efficiencies?

Ms KOFF: Districts and speciality health networks have total efficiencies to find of \$150 million. It is not a budget cut. They have an efficiency target imposed by the NSW Health system. As the purchasers of activity, they have to find those efficiencies. In the scheme of things, divided between the 15 districts and the three speciality networks and with the allocation there it is a very, very small efficiency ask that they all have.

The Hon. WALT SECORD: So the \$67 million from ambulance, pathology and HealthShare is also an efficiency saving?

Ms KOFF: Yes.

The Hon. WALT SECORD: And the \$35 million from Pillars and the Ministry of Health is also an efficiency saving?

Ms KOFF: No, that is a budget cut.

The Hon. WALT SECORD: That is a cut?

Ms KOFF: When we are allocated the budget from Treasury we have discussions about how we should allocate the budget, as I said, between districts and networks. We also look at the whole totality of the health system and the services we are delivering. We made a decision in budget allocations to prioritise the funding to the frontline service delivery, so districts and networks, obviously hands-on patient treatment, we optimised the budget to those services. To the pillars and the ministry, our own department, we imposed a cost reduction on the services because we need to prioritise frontline clinical services first. None of those pillars or the Ministry of Health touch patients.

The Hon. WALT SECORD: Ms Koff, for the people who do not know the health and hospital system as intimately as you, what are the pillars?

Ms KOFF: The pillars are the agencies that support clinical care.

The Hon. WALT SECORD: Such as?

Ms KOFF: The Agency for Clinical Innovation, the Bureau for Health Information, which provides the data and information, the Clinical Excellence Commission, which supports—

The Hon. WALT SECORD: They investigate errors and things like that in Health?

Ms KOFF: They support quality and safety across the system.

Mr MINNS: HETI.

Ms KOFF: Thank you. People are prompting me and helping me at the side. The Health Education and Training Institute, the Cancer Institute and if I have left any out it is purely unintentional and the chief executives of those agencies will never forgive me if I have. But there are a number of pillars that support the health system.

The Hon. WALT SECORD: Using your language, you say efficiency savings of \$150 million for the local health districts, \$67 million efficiency savings for ambulance, pathology and HealthShare but then, using your own words, "cuts"—

Ms KOFF: Yes, that was our decision to reduce the budget.

The Hon. WALT SECORD: —of \$35 million to Clinical Excellence, which does quality and safety in the health system, HETI, which does accreditation of junior doctors, and the Cancer Institute, which runs cancer services. So a \$35 million cut. But if you add 150, 67 and 35 together you get 252. You say 35 of that is cuts and the remainder is efficiency savings.

The CHAIR: Which, to be fair, is at odds with what your statement was about the 252 as efficiency savings.

The Hon. WALT SECORD: No, she actually said that it is more. For every \$10 you get, if you put efficiency savings, that \$10 is \$12.

The CHAIR: Yes, we are trying to be reasonably forensic about this because of the significance of the document, which is out there in the public domain. You did not, as I understand the answer to the question in the first instance, acknowledge that there were cuts of that dimension. You talked about efficiency savings. So there were cuts within those efficiency savings?

Ms KOFF: Not for the districts and networks, that is what I am trying to emphasise. There were no cuts to the districts and networks.

The Hon. WALT SECORD: Do you stand by the answer provided to the Minister, which he gave in the Parliament, saying there were no cuts?

Ms KOFF: Yes. To the districts and networks there were no cuts.

The Hon. WALT SECORD: Even you concede there were cuts to Clinical Innovation, BHI, Clinical Excellence, HETI and the Cancer Institute?

Ms KOFF: Yes.

The Hon. WALT SECORD: You are not using your Sir Humphrey language. These are cuts.

Ms KOFF: We reduced their budgets to enable Health to operate within the funding envelope that it had.

The Hon. WALT SECORD: How many other local health districts or hospitals received similar PowerPoint presentations to the one received at Mount Druitt and Blacktown?

Ms KOFF: As I have had the discussion with the chief executives as late as last Friday at the Senior Executive Forum we intend to be, and will continue to be, honest and transparent with how we allocate the budget. The health system in the past operated in a very dark art of black box and nobody ever knew what funding they were getting. It was an annual cycle of budget increases and it was always felt that there were the haves and the have-nots. When we introduced activity-based funding, activity-based funding brought transparency to the funding that we gave to every single district. That activity-based funding is predicated on the volume of activity that they do, the complexity of the activity that they do and we set a State average price based on the national price.

The Hon. WALT SECORD: Ms Willcox, as chief executive officer of the Northern Sydney Local Health District, how much efficiency savings have you instructed hospitals and health services in your local health district to find?

Ms WILLCOX: Firstly, just to the Secretary's point about the transparency around the budget allocation process—

The Hon. WALT SECORD: No, my question was simple.

The Hon. BEN FRANKLIN: Just let her answer the question.

The Hon. WALT SECORD: My question was simple and direct.

The Hon. BEN FRANKLIN: Let the witness answer the question the way that she wants.

The CHAIR: You have to take a point of order.

The Hon. BEN FRANKLIN: My apologies, Chair. Point of order—

The Hon. WALT SECORD: Fair enough.

The CHAIR: Please proceed.

Ms WILLCOX: I do a presentation to the staff. I go around to all of the hospitals and the services and we do an outline of the achievements of the year, where we landed financially, what the allocations are for the new financial year and where we have to make small enhancements of the funding we got, because we did have overall growth in our budget as well as some individual enhancements to our budget for particular things—one being clock retrieval, the other being an increase in the complexity of services able to be provided in the intensive care unit in Ryde. But within that there were also some efficiencies that we had to undertake, which were split out across areas such as procurement and around the efficiency dividend that the Secretary has outlined. Mine is in the order of \$21 million.

The Hon. WALT SECORD: Of that \$21 million do you differentiate between hard budget cuts versus efficiency savings? So that \$21 million, is that a cut or an efficiency saving?

Ms WILLCOX: It is an efficiency dividend, an efficiency target, it is not a budget cut. We have had an enhancement to our budget in the order of around 4 per cent. I have an almost \$1.8 billion budget in Northern Sydney Local Health District. We are looking at savings again. The back of house component is obviously the most sensible place to go. We want to preserve frontline services. Procurement, corporate overheads, contract management, consumables, supply chain and stuff around our docks and warehousing activities.

The Hon. WALT SECORD: How did you communicate that to your staff in your local health district?

Ms WILLCOX: We had, line by line, the things that we—

The Hon. WALT SECORD: Did you do a PowerPoint presentation?

Ms WILLCOX: I did.

The Hon. WALT SECORD: Can we have a copy of that PowerPoint presentation?

Ms WILLCOX: It is on the intranet. Yes, you may. I have shared it with union officials and staff, so I have no problem with sharing that.

The Hon. WALT SECORD: When you did your presentation did you refer to it as cuts or savings? How did you refer to the \$21 million?

Ms WILLCOX: As an efficiency target with a reinvestment back into services. Again, the culture that I am trying to develop in North Sydney is, firstly, being open about what our situation is. There is incredible demand on the system, no-one is shying away from that, but we have a responsibility to be accountable and use those funds to the best of our ability. Staff are very keen to find ways they can do their job differently. They have clever ideas that I encourage staff to bring forward where they see inefficiencies and duplication.

The Hon. WALT SECORD: Give me an example. For the \$21 million did you provide examples or did they come to you?

Ms WILLCOX: They are coming to me. I am actually just about to launch Our Local Health District, Your Ideas so that staff can bring some of those things forward. But across the health system we liaise with colleagues and other local health districts with the support of the ministry to identify some headline areas where we believe that we can make some efficiencies and put some funds back into the front line.

The Hon. WALT SECORD: You have not nominated where the \$21 million will come from?

Ms WILLCOX: We are working that through now with a series of processes, with staff, with the executive team and with the ministry to work out what are the ones we are going to work on. We have started on some of those already. Again, corporate overheads, which is a big one, procurement, supply chain and pathology services are some of the headline ones that we are working through at the moment.

The Hon. WALT SECORD: Ms Koff, have you checked with the other 15 local health districts? Have they all conducted similar sessions to what Ms Willcox has conducted?

Ms KOFF: As I was proceeding to say, Mr Secord, we have an honest, open and transparent relationship with the districts and we negotiate a service level agreement every year. It is transparent what is on the service level agreement and what the expectations of each district are. It is up to them to then communicate internally. When you appreciate the number of staff who work in the health system it is very hard for me personally to communicate to every individual as to what the savings are. That is why we have a devolved governance structure. So we set the expectations with both the boards and the chief executive and we are transparent because there are quite clever ways that one can introduce efficiency savings without calling them efficiency savings. I believe—

The Hon. WALT SECORD: This is where you and I have a disagreement.

Ms KOFF: No. I could have dropped the price, Mr Secord. We pay at the average efficient price. Other jurisdictions, in attempts when you have got a smaller budget envelope, can drop the average weighted price to something less and have less funding.

The Hon. WALT SECORD: You have used the phrase "transparency" here.

Ms KOFF: Yes.

The Hon. WALT SECORD: How much is the efficiency savings that you have nominated for Westmead Hospital, Sydney Children's Hospital and the children's network?

Ms KOFF: It is in their service agreements. Everyone has it in their service agreements.

The Hon. WALT SECORD: You must know, though. So how much are they getting?

Ms KOFF: We could provide them to you, but I cannot tell you.

The Hon. WALT SECORD: The last time we had a session, you guys were very, very prompt in providing the details.

Ms KOFF: Yes.

The Hon. WALT SECORD: In fact, you were able to provide them during the session.

Ms KOFF: Yes.

The Hon. WALT SECORD: So I hope that you are able to do that for the children's network—if you can give me a commitment that you could do that to the best of your ability this morning.

Ms KOFF: Yes, certainly. We can give you that commitment.

The Hon. WALT SECORD: I would like to know—

Ms KOFF: But it is outlined in the service agreement. Schedule C, for every district and every network, is the budget allocation and the expectation of them against—

The Hon. WALT SECORD: Could I have all 15 before the end of business today, then, please?

Ms KOFF: They are on the internet. Yes, we can give you those.

The Hon. WALT SECORD: Thank you. The efficiency savings?

Ms KOFF: It is listed in the schedule C of the service agreements.

The Hon. WALT SECORD: I have one staff member. It would be nice if you could just provide it. You and I are going to differ on whether an efficiency saving is a cut, but I would love to have that.

Ms KOFF: Efficiency is not a dirty word, Mr Secord.

The Hon. WALT SECORD: It is not, but we are dealing with patients. You are dealing with patients. We are not dealing with numbers.

Ms KOFF: No reduction in frontline services and no reduction in staff. To inherently try to assume that efficiency means a reduction in frontline services is blatantly incorrect.

The Hon. WALT SECORD: But doctors feel that—

The CHAIR: Order!

Ms KOFF: I know. Doctors feel many things.

The Hon. BEN FRANKLIN: Point of order: At the beginning of this budget estimates, or relatively close to the beginning, I think what is happening is we are developing a pattern of behaviour by the honourable member where he continues to talk over the witnesses as they are trying to answer the question. It has happened now on a number of occasions.

The Hon. WALT SECORD: I will be mindful of that and I apologise.

The Hon. BEN FRANKLIN: Thank you, and you have just exhibited exactly the same behaviour to me. Mr Chair, I ask if you would rule that that is an inappropriate way to deal with eminent public servants. We have got a lot of time here today and there is a more sensible exchange of views.

The CHAIR: The way we proceed—and we know this—is a question followed by an answer, and back and forth and back and forth. I think that is the way to proceed.

The Hon. WALT SECORD: Ms Koff, you can understand why doctors at Blacktown and Mount Druitt Hospital receive this PowerPoint presentation telling them to find \$252 million—you say it is an efficiency saving; they see it as a cut. They are on the front line, dealing with patients. When they are told to find \$252 million, they think it is a cut. Have you considered using different phrases or communicating to doctors? Even myself, I feel a cut is a cut.

Ms KOFF: I am quite clear on the terminology and I do not know where they have got that impression. At no stage does Blacktown and Mount Druitt have a budget cut of \$252 million. It is incorrect. I am sorry they are interpreting it that way and I cannot say it any other way. Blacktown hospital's budget went from \$360 million in 2018-19 to \$393 million in 2019-20. Their surgery targets are all on par with what performance expectations are. I cannot say whether there is a malicious campaign, there is something going on, they want more money, they feel it is inadequate. I cannot explain the rationale there. But I reiterate: No budget cuts.

The Hon. WALT SECORD: But efficiency dividends. But you will concede that there are efficiency—

Ms KOFF: Efficiency targets for reinvestment in frontline clinical services.

Ms CATE FAEHRMANN: Ms Koff, are you aware that the Tenterfield hospital had no doctor from Thursday to Monday last weekend?

Ms KOFF: Yes.

Ms CATE FAEHRMANN: You are aware of the unfortunate death of a man early on Sunday morning as a result of, I understand, cardiac arrest?

Ms KOFF: Yes.

Ms CATE FAEHRMANN: Do you think that death may have been potentially prevented if there was a doctor at Tenterfield hospital over that weekend?

Ms KOFF: The death of the gentleman at Tenterfield hospital was a very unfortunate circumstance and we express our condolences to the family for his death.

Ms CATE FAEHRMANN: Why was there no doctor rostered on for that weekend? Tenterfield hospital, I understand, in terms of the staffing—correct me if I am wrong, but there were two nurses only. Is that correct?

Ms KOFF: If I could just in the interim refer to Mr Minns, who is the director of workforce and culture.

Mr MINNS: In the circumstances, the regular doctor at Tenterfield was on leave and the district was seeking to cover that leave with locum doctors. They had a locum doctor for the weekend, from the Thursday to the Monday, and right at the last minute on the Thursday that arrangement fell through. The locum agency said they were not able to supply the doctor. That can happen in some of our small regional facilities and in that process we rely on the framework that is in place for how nurses on staff seek support from doctors elsewhere in the network, and that occurred in this case. It is actually a reality of small regional facilities that they are able to operate with distant doctor support, which can happen quite regularly, and it did happen in this case. We cannot discuss the circumstances of the case because it will be the subject of a root cause analysis and the matter has been referred to the Coroner.

Ms CATE FAEHRMANN: The reality is, though, that there was no doctor for four or five days. I have been informed—in fact, it has been reported in *The Northern Daily Leader* as well—that the nurses on duty were unfamiliar with that hospital environment. Is that correct, Mr Minns?

Mr MINNS: My understanding is that one of the nurses was an enrolled nurse and a longstanding employee of the hospital, so I do not think it is accurate in respect to the enrolled nurse. My understanding, advised by the district, is that the registered nurse on staff on this occasion was a locum, but I cannot tell you if the person has previously provided locum services.

Ms CATE FAEHRMANN: When you say this happens quite a bit in regional hospitals and the reality is that—I think you said that staff from other districts or hospitals can assist. Could you explain what you mean by that?

Mr MINNS: There is a protocol, and I will just try and find the email that deals with it.

Ms CATE FAEHRMANN: Is this the clinical emergency response and assistance initiative, or a different one?

Mr MINNS: No, it is a different one. Nearby doctors provide support as part of the Small Town After Hours program. Emergency department staff at Tamworth and Armidale hospitals are available to provide specialist support, as they did over this weekend. It can occur that smaller facilities in regional areas find themselves without a doctor for a period of cover, and in that respect there is a process in place that nurses are well aware of.

Ms CATE FAEHRMANN: Clearly the process failed.

Mr MINNS: No, we do not know that.

Ms CATE FAEHRMANN: I am here asking you about a death at Tenterfield hospital, and you are saying there is a process in place. You said you did try and get a doctor—a locum—so you recognise that a doctor would have been ideal at Tenterfield hospital.

Mr MINNS: Yes.

Ms CATE FAEHRMANN: So it is not ideal there was not a doctor in place. And there was an unfortunate death early Sunday morning, so clearly the process of ensuring a doctor is in place at a hospital all the time failed in this instance.

Mr MINNS: My point would be that it is not uncommon in some of the smaller facilities regionally that they are without a doctor for some part of the day.

Ms CATE FAEHRMANN: Is that not a problem?

Mr MINNS: It is actually a problem driven by—

Ms CATE FAEHRMANN: From the health department's perspective, to not have a doctor in a hospital is clearly not good enough.

Mr MINNS: If your solution is that we will have a doctor in every one of them then that is not an available solution because of the way the medical workforce is distributed in the State.

Ms CATE FAEHRMANN: That is a problem, though, just recognising that in New South Wales we have hospitals without doctors.

Mr MINNS: In response to that, what we try and do is make sure that the nursing staff are capable, fully supported, can get help from outside, can utilise telehealth, and that is how we get the system to function.

Ms CATE FAEHRMANN: But nurses cannot do everything doctors can do.

Mr MINNS: But in this case I really need to say that we do not know that there is a relationship between the patient's death and the staffing that was present on the occasion. We do not know that.

Ms CATE FAEHRMANN: If a patient dies at a hospital, Mr Minns, is it not always preferable that a doctor is there? Would not a doctor being present provide the best chance of someone not dying?

Ms KOFF: Could I pass that on to the Chief Health Officer, thank you.

Ms CATE FAEHRMANN: That is the whole point of doctors, I thought—to save lives.

Ms KOFF: No, no. Nurses play a vitally important role in the provision of clinical care.

Ms CATE FAEHRMANN: Sure, of course.

The CHAIR: Dr Chant?

Dr CHANT: I think that my colleague has really described the challenges with workforce mal-distribution. I think this is a significant national problem. Other States and Territories would encounter similar issues in staffing rural facilities. Whilst we need to work cooperatively with the Commonwealth around those workforce issues and look at how we can increase the rural workforce, I think that is a shared vision we would have with our Commonwealth colleagues. I am not aware of the particular circumstances around this case but speaking generally notwithstanding we would desire the workforce situation to be fixed, our role is then to look at innovative strategies where we can work around when that workforce is not available to us. Hunter New England Health has actually put in some extensive use of telemedicine. I am aware of the way that they also have even remote monitoring in some of the smaller sites and a centralised coordination where intensive care specialists and others can provide that immediate support for rapid transit.

I think the point that Mr Minns was making is that at the moment it would be premature for us to conclude. NSW Health takes the death of any patient or any issue that requires investigation seriously. There is a root cause analysis [RCA] process. We need to make that available. Also, out of respect for the family we do need to make sure that they are the first people that are disclosed any findings from the RCA process. And the matter has been referred to the Coroner. Obviously any learnings from that will be picked up. But I do acknowledge, Ms Faehrmann, that the issue of mal-distribution of medical, and even specialist nursing and specialist allied health workforce, is a challenge for us in New South Wales as well as in other States and Territories.

Ms CATE FAEHRMANN: *The Northern Daily Leader* has also reported in relation to this unfortunate incident that a retrieval team—in terms of paramedics I understand—was on route from Tamworth more than two hours after the patient had presented when the person unfortunately was declared deceased. Mr Minns, your original response to this question was that people are brought in from other areas, but clearly that failed as well.

Mr MINNS: I am sorry, I just would not characterise it as failure because we do not know the circumstances. They are not investigated as yet. Paramedics were at the hospital assisting the nurses. Now, that is local paramedics, not the retrieval team that arrived some time after, as you point out. So there were two nurses there. I have now got information that the locum registered nurse had done five day-shifts in the lead-up to the weekend and was fully inducted into the emergency department at Tenterfield. The registered nurse [RN] in question was not on their first shift. The procedures, as we understand at this point, for getting support from a doctor in another facility were followed, and paramedics came and assisted for a period prior to the arrival of the retrieval team.

Dr CHANT: I think though we do have tried and true methods of—the Hon. Walt Secord indicated the clinical quality safety commission—we do have a process of thoroughly reviewing incidents so that we can look at these. These matters are best prosecuted by the RCA team and those findings are provided to the family, and obviously in this case will also be provided to the Coroner. Any findings we find out of the RCA will also be provided to the Coroner. We will take into account—I think it is very difficult. I am not aware of the specific details of this case, and it is probably inappropriate outside that RCA process to be commenting here. It would just be speculating.

The CHAIR: Just to clarify for *Hansard*, RCA is root cause analysis.

Dr CHANT: Root cause analysis. And that often involves multidisciplinary teams and often experts externally. Just to clarify, the medical retrieval team is actually usually medical specialists as part of a care team, and they are deployed in a particular way. So the RCA will thoroughly look at all of those issues around timeliness, opportunities for earlier intervention or escalation and any learnings and, most importantly, systems learning—so what can we learn from this case that may have relevance to any future planning policies.

Ms CATE FAEHRMANN: If, for example, one of the key findings was that a doctor should have been on duty over that weekend and been available, what will the Government need to do to ensure that doctors are able to be in our regional and rural hospitals at all times, doctors or locum doctors?

Dr CHANT: I think that takes us to a speculative point. But I have indicated that clearly where it is assessed that doctors should be present, we should take all effort to get doctors present in those—

Ms CATE FAEHRMANN: What is needed to ensure that doctors are able to staff regional and rural hospitals at any time?

Dr CHANT: I take it back to the national level working cooperatively with the Commonwealth. I think we have seen growth in medical training universities that are in rural/regional. We know if there are more opportunities for training regionally, doctors are more likely to settle regionally. We know that we have seen in some areas the ability to attract doctors where we previously have not when there is also a sufficient number of

doctors in a town. We understand some of the factors that contribute to this, but it is a piece that we have to continue to work at to improve the mal-distribution of doctors. We also have to look at innovative solutions to ensure that there is equity of access to the more high-end technology and expert advice, which will never be able to be practically provided in some of the small regional or remote towns.

Ms CATE FAEHRMANN: How common is it for rural and regional hospitals in New South Wales to not have a doctor present at any particular time?

Dr CHANT: I would have to go back to the role delineation model and provide details and take that question on notice.

Ms CATE FAEHRMANN: That would be good for every single hospital in New South Wales.

Dr CHANT: That is correct. We would be able to give you the sort of role delineation of those hospitals, because not all of our hospitals provide the full suite of services and some are more rapid assessment units with the view to rapidly get connection and move the patients that need to be moved on. It is an integrated system, so perhaps it would be better to take that on notice and provide you with it.

Ms CATE FAEHRMANN: If you could also do that and break it down, so over the last five years. I suppose I am wondering is it getting better or worse—the amount of time that our hospitals around the State do not have doctors?

Ms KOFF: As Dr Chant identified, all hospitals do not have doctors because there are varying role delineations, there are multipurpose services, there are different models of service delivery across the whole of the State. That is the first important point to understand. The second issue is the reason why we actually manage the health system according to a district geographic construct, that is so all facilities are networked within that district. Every hospital is not the same and every hospital does not do the same thing, and nor should it. So by networking with telehealth initiatives, with digital support, with other things, we can maintain their connectivity and make sure there is good clinical support at all times, no matter what the incident or the issue at the time.

Ms CATE FAEHRMANN: I suppose what is clear about this one is that it seemed to be that it was not supposed to be without a doctor, because Hunter New England Health tried to get a locum and a locum pulled out at the last minute. You are suggesting that doctors are not at some hospitals at all times. However, it appears that Tenterfield Hospital was not supposed to be without a doctor. Would that be correct?

Dr CHANT: I think the issue is that all of those matters will be thoroughly considered because, in any case, the district obviously attempted, on the basis of information provided by Mr Minns, to have a locum there. It fell through at the last minute. The question is what additional risk assessments were done or what additional steps were taken to mitigate any risks if there was genuinely no ability to get a doctor there. Those issues need to be fully considered in the root cause analysis [RCA] process, including what risk assessments were done and what additional mitigation steps were put in place.

The other aspect is to clarify my point that some services are delineated under a role delineation model. That is particularly for statewide services like maternity and neonatal intensive care units [NICUs]. In other circumstances the local health district will again take a local vision in terms of assessing the needs in those local communities, what services it needs and how those services are networked. So I think you make a valid point. I am sure that will be covered with the RCA but we can follow up with the district to make sure that those issues that you are raising are fully explored within the RCA process.

Ms CATE FAEHRMANN: With the list that you have agreed to take on notice to provide the Committee, in terms of the level—I think you said role delineation—

Dr CHANT: Role delineation or service structure. As I said the role delineation language applies largely to services that are planned on a statewide service, like NICUs and some emergency departments or trauma services. They are prescribing that certain hospitals have certain capability to do certain things and this is where we locate them. The other component is that districts themselves will determine the nature of the hospital facilities and the range of services that are required there and how the services are networked and supported.

Ms CATE FAEHRMANN: So some of that will say that these particular hospitals need to provide these particular services and therefore need, say, doctors rostered on the whole time. Is that essentially what—

Dr CHANT: What I am saying is that the role delineation applies to some services but there is a process where the local health districts will have due regard for the health facilities that they have there, and make sure they consider the staffing and the other needs within those local health district facilities. As Ms Koff has indicated, some will be more assessment centred, not staffed by permanent medical staff, and others will have medical staff.

But I note your point here that there was an intention to have a doctor there. So those issues need to be teased out in the RCA.

Ms CATE FAEHRMANN: Thank you. I appreciate that. I want to move to another issue now, which is the maternity ward at Wagga Wagga Base Hospital. In September I understand that Wagga Wagga Base Hospital maternity ward was so busy that at least three mothers and their newborn babies had to stay elsewhere in the building due to a shortage of beds and a lack of services in surrounding areas drawing other people to Wagga Wagga hospital. I am wondering what the department is doing to address what clearly seems to be a bed shortage at Wagga Wagga hospital.

Ms KOFF: I am not aware of that incident or issue so I cannot comment on it, but it is a local issue for management to manage their bed base. One would think that in maternity services it is probably a little bit hard to predict when the demand will arise for inpatient birthing. However, it is up to the local district to manage their bed base and, Wagga Wagga, with the new hospital there, has attracted a lot of extra activity, as I understand it.

Ms CATE FAEHRMANN: Have you heard from the local health district any concerns in relation to the number of beds and maternity services?

Ms KOFF: No, not at all.

The Hon. COURTNEY HOUSSOS: Ms Koff, you said that the efficiency savings will not result in cuts to frontline services. That was clearly contradicted by the public statements that were provided by Mount Druitt hospital last week. I understand that you are trying to address those, but can you guarantee that there are not other frontline cuts that are occurring across the New South Wales health system as a result of the efficiency savings?

Ms KOFF: As per the Government commitment, there was an increase of \$1 billion to the Health budget. It is the biggest Health budget that we have had on record. We have projected all districts, and we have signed service agreements with all districts, for increases in activity levels. Activity levels are the amount of emergency department attendances that will be funded, surgeries that will be conducted. All districts had an increase in activity levels as per their service level agreements. Hence to deliver those they cannot cut services because they need to deliver the critical services to their local populations.

The Hon. COURTNEY HOUSSOS: But, Ms Koff, that was clearly contradicted by the email that was provided publicly last week that surgeons at Mount Druitt hospital were being required to cut services. Can you guarantee that that is not happening anywhere else?

Ms KOFF: It is not happening and—

The Hon. COURTNEY HOUSSOS: It was happening at Mount Druitt.

Ms KOFF: The email from unknown origin, who does not have the authorisation of the Ministry of Health, is being promulgated and that is being interpreted as fact. The facts are contrary to what I keep reiterating: that there is not budget cut to Blacktown & Mount Druitt Hospital.

The Hon. COURTNEY HOUSSOS: That might be the case on your internal accounting document—

Ms KOFF: There was \$360 million in 2018-19—

The Hon. COURTNEY HOUSSOS: —but what has happening on the ground is that surgeons are being told to cut the amount of surgery that they are performing.

Ms KOFF: No.

The Hon. COURTNEY HOUSSOS: That was the direct testimony from a surgeon last week, operating within the New South Wales health system. So can you, at budget estimates, sit here and provide a guarantee to this Committee that there will be no further cuts to services in New South Wales hospitals?

Ms KOFF: There will be no further cuts because there have been no cuts to services. As I understand from Blacktown hospital, the whole genesis of the discussions around surgery around Blacktown and Mount Druitt related to the balance of elected surgery and emergency surgery. It is a very fine art in the delivery of health care that we have a finite number of operating theatres. That is the same in every facility. It is a physical footprint of the number of theatres. Blacktown hospital itself—and Mount Druitt—have a \$700 million development. There are plans to introduce a new acute surgical unit. The rationale behind an acute surgical unit—as to be expected, and what we demand—is that urgent surgery has prompt access to theatres. If there is a road trauma, if there is an

accident, if there is something that requires immediate, urgent access theatres need to be available for those acute emergencies.

The Hon. COURTNEY HOUSSOS: Of course that is the case but let me just explain—

Ms KOFF: So Blacktown Hospital is looking at what the right balance is between elective surgery and emergency surgery. I would expect any hospital to do that because elective surgery is critically important to delivering the surgery targets on time, but cannot utilise the theatres at the expense of emergency surgery. So part of the conversation with the district, as I understand it, is that Blacktown hospital is looking at the efficient use of its theatres to get the right balance between elective surgery and emergency.

The Hon. COURTNEY HOUSSOS: So an efficient use of the surgery means less elective surgery, which means longer waiting times for people in Mount Druitt.

Ms KOFF: No, no.

The Hon. COURTNEY HOUSSOS: Ms Koff, can you tell me the current waiting time on average for elective surgery at Mount Druitt hospital?

Ms KOFF: No, I cannot tell you. I will take it on notice.

The Hon. COURTNEY HOUSSOS: I can tell you that it is approximately 11 months, which is much longer than someone who is waiting on a central Sydney waiting list—which is a significantly shorter period of time. Do you say that that is an inefficiency that should be addressed?

Ms KOFF: It would depend on what category the surgery is because we categorise surgery according to one, two or three. Depending on that clinical categorisation, which the doctors themselves categorise, indicates the timeframe that is appropriate to be on the waiting list. Category three is 365 days, so the doctor is indicating that surgery should be done within 365 days.

The CHAIR: To clarify the scale for the record, what are categories two and one?

Ms KOFF: In terms of the record, 30 days for category one, which is a month. This is how it is balanced.

The CHAIR: I am just trying to get this clear.

Ms KOFF: For category two, 90 days, so every doctor categorises the patient themselves, and it is so critically important that clinicians are responsible for categorisation of whether their patient meets one, two or three.

The Hon. COURTNEY HOUSSOS: I ask you one more time: Can you guarantee that surgeons are not being told to cut elective surgeries because of efficiency savings?

Ms KOFF: Nobody has been told to cut elective surgery. As I said, Blacktown is working—

The Hon. COURTNEY HOUSSOS: That directly contradicts what a doctor was saying last week to the public.

Ms KOFF: Well, I am sorry.

The Hon. COURTNEY HOUSSOS: You cannot provide that guarantee to us. That is okay, we will move on.

Ms KOFF: No, I do not think I did not provide the guarantee. The doctor would be part of the process of the discussion of the efficient use of the theatres and how they allocate and prioritise theatre time, and I would expect all doctors to be party to that discussion of the efficient use of the theatres and the allocation of appropriate time schedules for the work that they need to do.

The Hon. WALT SECORD: Can we return to efficiency savings. You read off a list of areas that would be efficiency savings. Is procurement one of them?

Ms KOFF: Yes.

The Hon. WALT SECORD: Does the provision of linen, swabs, sterilising packets and surgical tools come under the area of procurement?

Ms KOFF: Anything that is purchased is procured.

The Hon. WALT SECORD: You are asking hospitals to find savings in the areas of procurement. Are you confident that local health districts are getting safe and secure sterilising equipment at their hospitals as part of your push for efficiency savings in the area of procurement?

Ms KOFF: Sterilising services are done locally, they are in-house services within the districts.

The Hon. WALT SECORD: They are done locally?

Ms KOFF: Yes.

The Hon. WALT SECORD: How would one find efficiencies in that area? Would that be not clean things as well?

Ms KOFF: No, Mr Secord, we never compromise on quality and safety, and it is disappointing that you would even allude to the fact that we would attempt to save money by inappropriate sterilising procedures.

The Hon. WALT SECORD: So you will guarantee that corners are not being cut involving—

Ms KOFF: They cannot be cut. There are national standards for sterilising to ensure the integrity of the equipment and the safety of the sterilisation.

The Hon. WALT SECORD: What would happen if you found that a hospital was cutting corners or not sterilising equipment properly? What would happen to that hospital?

Ms KOFF: It would be inappropriate.

The Hon. WALT SECORD: But what would happen to them?

Ms KOFF: It would be a significant breach—

The Hon. WALT SECORD: Would they get a strong letter of reprimand? What would happen to them? Dr Chant, what would happen to a hospital that is not sterilising equipment properly?

Dr CHANT: We have very professional staff in our services and there has been a lot of progress around infection control and a greater understanding in our system about the importance of infection control. As Ms Koff said, we have a number of quality standards and requirements and, through the accreditation process, infection control and compliance with infection control is a key feature of that. If staff had any concerns that there were infection control issues, that would constitute an IIMS—Incident Information Management System—or incident reporting, and all staff have access to incident reporting. We actually encourage staff to do so, and that then triggers both an investigation and a response. But I would like to support Ms Koff in the premise that our health system is staffed by very professional individuals who really understand the importance of infection control.

The Hon. WALT SECORD: Are there any investigations underway at the moment involving inadequate sterilisation such as stained surgical equipment being provided to doctors at a western Sydney hospital?

Dr CHANT: I am not aware of any investigation underway, Mr Secord, but I would not necessarily be. Some matters that are locally driven go through the process.

The Hon. WALT SECORD: Ms Dawson, I want to ask about the Health Care Complaints Commissioner. There is a report in western Sydney that doctors at Fairfield Hospital have lodged a complaint. Your office has confirmed that a complaint was lodged about stained and dirty surgical equipment being provided to doctors at Fairfield Hospital earlier this month. What is the status of that investigation?

Ms DAWSON: If that complaint has been received then it will be assessed in the normal way, Mr Secord. We take that complaint, we seek further information and we will assess that matter through the normal processes.

The Hon. WALT SECORD: Can you find out what is the status of that investigation because doctors earlier this month complained to the Health Care Complaints Commission. Your office has confirmed that it has received a complaint. Ms Koff, are you aware of this complaint?

Ms KOFF: No, I am not.

The Hon. WALT SECORD: Dr Chant, are you aware of this complaint at Fairfield Hospital involving dirty surgical equipment with stains on it?

Dr CHANT: No, but certainly I will direct my staff to make enquiries immediately because, in these circumstances, we want a rapid response to any concerns around any issues in infection control. Notwithstanding the complaint, I would also encourage people to use the normal escalation channels within their district, such as

the IIMS or reporting where there are acute incidents so that we actually get rapid response. I will take that on notice and follow it up as we speak.

The CHAIR: In terms of the matter directed to Ms Dawson, just to be perfectly clear, is there any part of that answer or any aspect that you would like to take on notice and come back to the Committee on, or have you satisfactorily answered the question? I was not quite clear whether there was anything left undone.

The Hon. WALT SECORD: I asked her to come back to me with, in fact, what is the status of that report.

Ms DAWSON: I can take that on notice too.

The Hon. WALT SECORD: Dr Chant, does dirty surgical equipment, or reports about it, occur very often in the health and hospital system in New South Wales?

Dr CHANT: That would be a matter best directed to the CEC where we could look at whether the IIMS reporting—

The Hon. WALT SECORD: Is that the clinical centre?

Dr CHANT: Clinical Excellence Commission.

The Hon. WALT SECORD: That is the one that is receiving the cut of \$35 million; is that correct?

Ms KOFF: No, it is incorrect.

Dr CHANT: No.

The Hon. WALT SECORD: What then are the efficiency savings?

Dr CHANT: Can I perhaps answer the question that you originally asked rather than go on to an issue that Ms Koff has addressed about the savings.

The Hon. WALT SECORD: Yes, I am sorry, Dr Chant.

Dr CHANT: I am not aware of any increase in notifications—that has not been brought to my general attention as Chief Health Officer—about these issues. From time to time there sometimes can be concerns—

The Hon. WALT SECORD: There was a heart machine at Prince of Wales. Do you remember that?

Dr CHANT: That was actually a different issue where there was a bacteria called mycobacterium chimaera, which was believed to have been introduced at the time of production, and because of the nature of the aerosols generated during the theatres and the fact that the bug is very hardy and resistant to disinfection processes, those machines have been replaced in the system. On our website we have information around that issue, although we have to continue to monitor patients because that disease has a very long incubation period.

The Hon. WALT SECORD: What is happening with the patients that are being monitored involving that machine? That was several years ago now.

Dr CHANT: That is correct, but regular communication occurs to remind—

The Hon. WALT SECORD: Are the patients still alive?

Dr CHANT: The group that we are interested in is patients who may have had surgery, heart surgery—

The Hon. WALT SECORD: But you are not interested in those that have passed away?

The Hon. BEN FRANKLIN: Point of order: There has literally been five times that Dr Chant has been in the middle of a sentence when the member has then spoken over the top of her.

The CHAIR: Yes, I think that is important to note.

The Hon. WALT SECORD: Okay, we will go through the questions—

The CHAIR: Hang on, please. The witness must be given a chance to answer the question, then followed by another question. That is the way this is dealt with.

The Hon. WALT SECORD: Okay, I will roll back. I would like to know the status of the patients at Prince of Wales Hospital involving the overseas machine that had bacteria in it that affected those heart patients. You said that you were concerned about a cohort of patients and I said I would like to know are there patients that have died. What is the status of those patients?

Dr CHANT: I think probably there is comprehensive information on the NSW Health website. This has been, as you have indicated, a very longstanding issue, and, I would like to highlight, an international issue. I think it is probably useful to provide you with the information from our website, which goes through the number of patients that have been impacted, including internationally. We obviously have obligations to advise the Therapeutic Goods Administration [TGA] as well when patients are diagnosed. I send my condolences to those patients that have been affected by this. But the website identifies the comprehensive response. But because of the long incubation period, there are processes in place to flag those patients in our medical records that may present to our hospitals to raise awareness but also to communicate directly to those patients.

The Hon. WALT SECORD: Then I asked a question to Ms Koff. Earlier this morning you confirmed there was \$35 million in cuts and the Clinical Excellence Commission [CEC] was one of those. Is that in charge of investigating, handling or improving sterilisation in the health and hospital system?

Ms KOFF: It is a small part of their role. They have many other functions. However that is a prioritised function for the CEC to undertake.

The Hon. WALT SECORD: Ms Dawson, I would like to return to you for some questions. Is the convicted sex offender still working in the NSW Health Care Complaints Commission [HCCC] as a lead investigator?

Ms DAWSON: I take the lead from the language that the ABC has used, which is a person convicted of flashing.

The Hon. WALT SECORD: Okay, flashing.

Ms DAWSON: That is what is in the public domain. No, that person is no longer with the Health Care Complaints Commission.

The Hon. WALT SECORD: What has happened to the two individuals who uncovered, disclosed or revealed that there was a convicted flasher—using your words—working there? What is the status of their employment—the two people who brought it to the public's attention that this person was working there?

Ms DAWSON: Those two employees resigned from the Commission more than 12 months ago.

The Hon. WALT SECORD: Is it correct that those two persons were referred to the Independent Commission against Corruption [ICAC] for revealing the flasher?

Ms DAWSON: You will be aware of the requirements of the ICAC legislation, section 11 in particular. That obliges the head of an agency to refer notifiable conduct to ICAC. When those two individuals were initially investigated for breaching the privacy and penetrating the personnel file in an unauthorised way of another employee, those employees were investigated and they were the subject of an external investigation. That investigation made certain findings. Following those findings, each of those individuals resigned from the organisation. At a later point ICAC did advise the Commission that those incidents and that conduct of those two employees should be regarded as notifiable conduct and referred to ICAC. Therefore, those two employees have been the subject of a notification to ICAC.

The Hon. WALT SECORD: Do you not think that in the public arena that it is extraordinary that the person convicted of flashing was allowed to continue to work in the organisation for a period of time, however the two individuals who revealed that he was working there were sent to the ICAC? Do you not think that in the public arena that is a major disconnect? The person who did not disclose that he had a flashing conviction worked for your agency, however the two people who were the whistleblowers were sent to ICAC for revealing the wrongdoing.

Ms DAWSON: The people to whom you refer—you have identified the two employees that breached the privacy of another employee as "the whistleblowers", so I am just trying to understand where you are coming from—those employees were appropriately subject to an external investigation. Similarly, the person with the conviction has also been subject to an external investigation and has also been notified to ICAC and is no longer with the Commission. Those are the facts. Each of these matters needs to be taken on its own terms. You cannot conflate the two. It is appropriate and necessary and indeed my statutory responsibility to make sure that when somebody's privacy is breached—no matter the reason, no matter the outcome—that I take action on that breach. That is what I have done here.

The Hon. WALT SECORD: Are you satisfied that you have handled this whole affair sensitively, appropriately and properly?

Ms DAWSON: I am.

The Hon. WALT SECORD: You are. Thank you, Ms Dawson.

The Hon. COURTNEY HOUSSOS: Ms Dawson, when did the person convicted of flashing cease employment with the HCCC?

Ms DAWSON: I will refer to my notes to get the precise time frame. It was in September 2019.

The Hon. COURTNEY HOUSSOS: So not too long ago?

Ms DAWSON: In September 2019.

The Hon. COURTNEY HOUSSOS: Can you say again when the whistleblowers left the HCCC?

Ms DAWSON: I can. Just bear with me.

The CHAIR: Was that a resignation or a termination of that individual, in September, who has been referred to as the person who flashed? Was that a termination of employment or a resignation from their employment?

Ms DAWSON: That employee chose to resign from the commission following the findings of an investigation. Back to the time frame—

The Hon. COURTNEY HOUSSOS: Mr Chair actually asked my next question. When did the whistleblowers leave?

Ms DAWSON: Those two individuals—it is a long chronology.

The CHAIR: That is okay. Take your time.

Ms DAWSON: One left in August 2018. The other left in October 2018.

The Hon. COURTNEY HOUSSOS: What whistleblower protections do you have within your organisation?

Ms DAWSON: I am happy to take that on notice and advise you of that. But, as you would know, across the sector there are well-entrenched protected disclosures that can be made. There are protocols and practices that are well established whereby individuals can raise issues with confidence that there will be no retribution, and those will be in place in the Commission, as elsewhere.

The Hon. COURTNEY HOUSSOS: Ms Koff, when exactly will the Anderson report examining hospital security be finalised?

Ms KOFF: I will refer that to Mr Minns, who is the executive responsible.

Mr MINNS: Mr Anderson has finished all of his regional visits. It was an extensive program which was a little disrupted by some issues outside of his work. But he has now completed them and is in the process of crystallising his findings and he is working with the secretariat to produce his final report. We do not at this point have a date from him. However it is a clear expectation before the end of the year that we are aiming to have it available.

The Hon. COURTNEY HOUSSOS: Ms Koff or Mr Minns, has either of you seen a copy of a draft report?

Mr MINNS: No. He is in that part of the process of collating all of his material and crystallising his findings.

The Hon. COURTNEY HOUSSOS: When did the trial commence of the additional security guards at Wyong and Gosford.

Mr MINNS: It starts on the 1 November.

The Hon. COURTNEY HOUSSOS: And how long will it go for?

Mr MINNS: I think the plan is 12 or 16 weeks. I might need to clarify that for you.

The Hon. COURTNEY HOUSSOS: Can you provide me with an update on the trial of body cameras for paramedics?

Mr MINNS: Yes. The process is quite close to being able to be commenced. The ambulance organisation is having discussions with both of its unions—the Health Services Union and the Australian Paramedics Association—around the protocol for use during the trial and some issues that have arisen about that.

The Hon. WALT SECORD: What are the issues that have arisen?

Mr MINNS: One issue relates to any kind of concern around electromagnetic fields that are associated with wearing a camera. So we will get that investigated and report it back. Other issues relate to the protocol around use: What are the circumstances in which it is used, what are the conditions for deciding to turn it off and how does that work? We are seeking at this stage to clarify the arrangements that operate in the NSW Police Force as a way of finalising what our protocol will be.

The Hon. WALT SECORD: How many paramedics will this be attached to or facilitated to?

Mr MINNS: I would have to take that on notice. It is a limited trial and I would need NSW Ambulance to provide me with that advice. They certainly know; I do not.

The Hon. WALT SECORD: Have you had discussions with the Privacy Commissioner about patients? Because patients will be in very vulnerable situations.

Mr MINNS: We did. We were required to do a privacy plan to submit for the consideration of the commissioner, which we have done. It relates to issues associated with patient privacy, other people's privacy and how those matters are addressed.

The Hon. WALT SECORD: Ms Koff, if you do not know you can direct it to someone else, but are you aware of the recent issue at Byron Central Hospital involving the embezzlement of funds?

Ms KOFF: No, I will take that on notice.

The Hon. WALT SECORD: Mr Minns, do you have any knowledge of that? It was in the public arena on the mid North Coast.

Mr MINNS: I have very limited awareness, where I know that some issues have surfaced and they have been directed for investigation. I believe the notifications were made to ICAC.

The Hon. WALT SECORD: Ms Koff, with the construction of Tweed hospital and the provision of parking at the hospital, what is the current status of parking when the hospital is completed?

Ms KOFF: I am just checking my records to see if I have the most current update on parking and if not I will have to take that on notice.

The Hon. WALT SECORD: Can I assist? During the election campaign the health Minister and the member for Tweed, Geoff Provest, said that there would be provision of free parking at the hospital. However, recently there have been different statements by the health Minister and the local MP, saying that families and patients and staff will now pay for parking at the hospital. I would like to know what the position is that you are operating on and working towards.

Ms KOFF: I will have to take that on notice. Primarily that responsibility for capital redevelopment resides with Health Infrastructure and I will seek the advice of Health Infrastructure on that issue.

The Hon. WALT SECORD: If you seek advice on that question, can you find out what the current state of play is? Will it be paid or free parking at the hospital?

Ms KOFF: Certainly.

The Hon. COURTNEY HOUSSOS: Mr Minns, have the locations for the trial of the body cameras been finalised?

Mr MINNS: I have just texted that request for information, Ms Houssos. There are three sites but I am getting the names. It will be voluntary for paramedics at those three sites.

The Hon. WALT SECORD: Ms Koff, you would be familiar with community concerns about provision of maternity services in rural and regional New South Wales?

Ms KOFF: Yes.

The Hon. WALT SECORD: Does the Government have any plans to reinstate low-risk maternity services in any regional centres?

Ms KOFF: A statement was made earlier this week about the Parkes and Forbes maternity service, with a view to introduce a midwifery-led maternity model at Parkes.

The Hon. WALT SECORD: Do you think that model is applicable to Yass District Hospital? The local mums have commissioned a midwife and there is a report that they would like to see a similar model at Yass District Hospital.

Ms KOFF: I think the important issues in determining the appropriateness of any service model around maternity services are: to consult with the local community, which I believe they did very well in Parkes and Forbes—to have that conversation; to get the expert clinical advice from both obstetricians and midwives as to what the appropriate model is; and, as mentioned earlier, to look at the networks and distances between facilities in the district to ensure that it is safe care because the paramount consideration is the safety of the mother and the bub and that should be paramount in any decision-making. I note even in media clippings I received this morning a commentary that a midwifery-led model is a highly appropriate model in the appropriate circumstances.

Dr CHANT: Mr Secord, before you go on to your next question I wanted to confirm the advice that I received that there has been an investigation into the issues at Fairfield. I can confirm that there is no indication that any of the products were not sterile. I can go into a complicated explanation of what they think caused the staining.

The Hon. WALT SECORD: Yes, I would like to know.

Dr CHANT: Perhaps it is best if we take that on notice and we can give you that report.

The Hon. WALT SECORD: No, I am very interested—take it out of my time down the track, if you do not mind. I would like to know about what caused the staining of the medical instruments at Fairfield Hospital.

Dr CHANT: I can say that this is just preliminary advice. The Clinical Excellence Commission, as I mentioned, had been in liaison with the district. They got an external consultant to review the processes but they think the staining may have been due to porous bleed back of rust mineral deposits in the line steam marks. There is no standard for the level of staining but the testing validated all compliant. They have made some changes and apparently the trays have come back clear.

The Hon. WALT SECORD: So it is rust, not blood?

Dr CHANT: It may have been a minor mineral deposit or some other issue but I think that it would be imprudent to conclude as this is preliminary advice. I think the key point to make here is that there was not an issue of sterility and the results came back as validated as compliant, in terms of sterility. I am concerned about patients taking incorrect messages from today. There is a comprehensive process for the investigation and we will be able to provide the outcomes of that investigation with a question on notice.

The Hon. WALT SECORD: Thank you.

The CHAIR: We will break for 15 minutes.

(Short adjournment)

Ms CATE FAEHRMANN: Dr Chant, does NSW Health receive any information from New South Wales police when illegal drugs are seized?

Dr CHANT: As given in testimony to, I think, the coronial investigation and also to the special commission, we are working with police to look at how we can better analyse seized products that police have to inform our understanding of the drug supply market and any emergence of new chemicals or drugs in that supply chain. An example of how we have used that data is in the methamphetamine report, which is publicly available on our website. That shows how we looked at the purity of the seized products in both tablets and capsules for methamphetamine.

We have had follow-up discussions with police around routine seizures, smaller-level seizures. So, as you are aware, mainly the seizures are tested by the forensic services when they need to go to court and they are trafficable quantities and large seizures. But we are also interested in understanding smaller quantities that police might seize and so we are currently working on a sampling framework with police so that we could glean that information from it. But we actually do share information between us and police, and we are trying to strengthen that engagement.

Ms CATE FAEHRMANN: Let's use the example that you have just given of methamphetamine. So you get information. Methamphetamine is a pretty obviously dangerous, bad substance anyway, but say if there is fentanyl or something in some seizure of meth, is there any kind of alert system?

Dr CHANT: Yes.

Ms CATE FAEHRMANN: What does that look like?

Dr CHANT: Perhaps if I take it back the other step. For instance, secondary to the work that we are doing with police about strengthening the intelligence we can have from their routine seizures in understanding the drug supply system, we have also done work with the poisons information service and our emergency departments to raise awareness if there are presentations to emergency departments where the profile is not concordant with what the patient may have presented—so if they have concerns around multiple presentations to an emergency department in a specific area purporting a particular medication or where, for instance, the patient may not be responding to naloxone and where there is concern that there is carfentanyl.

In those cases when we have detected carfentanyl, for instance, we have communicated to police and emergency services like ambulance. We have also worked with our peer support network, NUAA, to get messages out locally around the need to potentially give multiple doses of naloxone and for increased awareness of carfentanyl. There have been cases where we have detected other substances. Again, the way in which we have communicated has been on assessing the risk and figuring out who are the people we need to communicate with in order to mitigate that risk.

It is a really challenging area because sometimes you are going out and telling people that there is a purer supply of a product or something can actually cause harm. So, again, we work very closely with our partners in risk assessing what is the appropriate communication strategy. But we have the ability to send messages out to our emergency departments, for instance, if we have concerns around a particular substance or a particular presentation to alert them to that. We also have the ability to connect with our emergency services colleagues, and ambulance is within NSW Health so, again, we have the ability to send out messages through those, as well as our strong community partnerships with NUAA and other on-the-ground services.

Ms CATE FAEHRMANN: You just mentioned purer substances but of course there are potentially deadly substances. So fentanyl is not the case—

Dr CHANT: The point I would like to make, and I probably should not have said "purer", because I think one of the things we have to be careful about is the key message I would like to give you is about dose and I also want to be clear that most of the harms are not occurring through contaminants. They are occurring from the drugs that people intended to purchase and they are equally as harmful as the contaminants. Contaminants in a very low quantity do not necessarily cause harm as well. So the key message is it is about the dose that you are taking and we need to be making sure that we are not overly emphasising the role of new and emerging drugs without emphasising the role of existing drugs which are causing significant harms.

Ms CATE FAEHRMANN: Are there any barriers to NSW Health providing information to the public; for example, around, say, a batch of MDMA is seized by police and that batch of MDMA has, say, PMA in it, are there regulatory barriers right now to NSW Health issuing a public alert over social media, for example, to say, "There is this batch of pills out now that has this PMA substance. It is deadly to take"? Are there regulatory barriers?

Dr CHANT: I think it is really careful to say because we do not want to give the impression that the MDMA is okay to take. So PMA has got some characteristics that mean because of the longer onset till its effect that it can be associated with more toxicity if people take more of it because they are used to a product that brings on the effect earlier. But the toxicity profile associated with these chemicals is often linked to the dose and so we have to make sure that people potentially using these drugs know that MDMA itself can cause significant toxicity. So notwithstanding that point, the way we would generally approach it—and can I say the way we have approached it has been on a case-by-case basis, so we have become aware of, for instance, a number of different cases, for instance, some lead contamination of opium which presented as lead toxicity in a particular group of users and a particular context.

How we communicate to that individual has to be tailored—understanding how those people receive information, where they are and in what setting. For instance, in other cases where there has been a local cluster of presentations where there has been a pill that has been identified and tested, in those cases we have actually tested the pill and that has been very much to inform the doctors in the area around what is actually in that

medication because it was not what people were believing it to be, knowing how to respond to that and also sending out some awareness locally. That was a local issue so that then did not need a broadscale report.

In other cases—for instance, in an issue around carfentanyl—police were more involved in that situation because of the way in which the carfentanyl product had been accessed. So from a public health perspective the police action to mitigate that supply was part of the public health action. Our ability to respond really is on a case-by-case basis but NSW Health goes into it with the view of what information and what actions are needed in order to protect public health and safety, and that will be a variety of different strategies depending on a case-by-case basis.

Ms CATE FAEHRMANN: If, for example, the police did seize, say, a batch of what was supposed to be sold as MDMA or ecstasy that had some kind of highly toxic synthetic drug in there as well and you were made aware of that, what would your response be?

Dr CHANT: We would go through a risk assessment in terms of that and depending on the timing of when they seized it, when we had analysed the results, what the distribution of it was—was it locally distributed, what was the source of it—and an assessment of it, we would take appropriate action which may include a public warning.

Ms CATE FAEHRMANN: Has NSW Health ever issued a public warning in relation to—

Dr CHANT: Drugs?

Ms CATE FAEHRMANN: MDMA?

Dr CHANT: MDMA itself?

Ms CATE FAEHRMANN: Yes.

Dr CHANT: In terms of its being contaminated with another product?

Ms CATE FAEHRMANN: Yes. As in MDMA or ecstasy sold on the market believed to be that but containing—any public health information in relation to that alert?

Dr CHANT: Not a public alert around MDMA contaminated. We certainly have been messaging, and I think very strongly—and this is where I cannot stress this enough—MDMA itself was seen as the cause, notwithstanding the coronial—

Ms CATE FAEHRMANN: Because of the dose.

Dr CHANT: And mixing it with potentially other drugs. I think we need to understand that the Coroner is looking at these cases. The Coroner is coming down with its report on 7 November¹ and I respect the coronial process. Notwithstanding, from NSW Health's review of the toxicology and our expert review, MDMA was the major contributor to the cause of death for those individuals, at least for the ones we considered—the later cases.

Ms CATE FAEHRMANN: That was because of the quantity consumed, was it not?

Dr CHANT: It goes back to dose and what other drugs you are mixing them with.

Ms CATE FAEHRMANN: Exactly.

Dr CHANT: What I am trying to do is I acknowledge the role that emerging drugs and emerging contaminants can have issues. I gave you an example of lead contamination of opium, where the profile was that they were actually presenting with lead toxicity. That is how we picked up that cluster; they were presenting with lead toxicity in our hospitals. We have to get a balance between the messaging around MDMA itself being harmful, depending on the dose and what else you consume with it—and there is inherently a risk whenever you take any medication or any drug—but the issue of contaminants. We would take public health action that was needed on a risk assessment on a case-by-case basis.

Ms CATE FAEHRMANN: Dr Chant, is that not the point—the dose and what else you mix with it? Similar to, for example, a pharmaceutical drug that you may take. I am not going to take four of these

¹ In [correspondence](#) to the committee received 21 November 2019, the Hon. Brad Hazzard MP, Minister for Health and Medical Research requested a correction to the evidence of Dr Chant by replacing the date '7 November' with the date '8 November'.

pharmaceutical drugs and mix them with alcohol because the label says that is incredibly dangerous. Is that not the point with MDMA as well?

Dr CHANT: That is the point that we need to give young people adequate information—

Ms CATE FAEHRMANN: Information.

Dr CHANT: And what I have been clearly saying is that we are trying to, whilst acknowledging the issues associated with contaminants—and I acknowledge that, and new and emerging synthetics—we do need to continue the message that MDMA, particularly if you consume a large number of tablets or capsules—

Ms CATE FAEHRMANN: But the most dangerous thing in relation to MDMA is what else is mixed with it and the dose.

The CHAIR: That is not what Dr Chant is saying.

Dr CHANT: What I am saying is if we look at the deaths that have occurred, the major contribution has been from the MDMA.

Ms CATE FAEHRMANN: The dose?

Dr CHANT: The dose of MDMA consumed. Whilst there is individual variability, and we acknowledge there is individual variability, the key message I would say is it is around the dose. Notwithstanding the inherent risks in taking any drugs, it is largely the dose. It is potentiated by additional drugs that you take, particularly those acting in the same pathway. If you combine MDMA with other stimulants or cocaine, things that potentially contribute to increased body temperatures, or if you are on drugs that potentially block any of your ability to mitigate temperature increases, that is going to have that potentiating effect.

Ms CATE FAEHRMANN: Which is why it is so important for information regarding this.

Dr CHANT: Why it is so important that we do it. That is why I am sorry to indirectly answer your question, but it is really about getting this balance between new contaminants versus getting the messages out there about the inherent deaths we are seeing with MDMA.

Ms CATE FAEHRMANN: Thank you for your answer. Are you aware of the emerging drug network of Australia project that the Royal Perth Hospital in Western Australia is doing?

Dr CHANT: Yes I am aware of that.

Ms CATE FAEHRMANN: What is NSW Health's opinion of that project?

Dr CHANT: We are working collaboratively with some of our lead researchers, which we are collaborating with, and we ourselves are developing closer networks with our—notwithstanding that, we will cooperate and provide data and share data with that network through our academic links. But notwithstanding that, we are also strengthening our surveillance through our emergency departments and our critical care for unusual presentations or unusual clustering of presentations to inform any public messaging. At the moment we get notifications from our emergency departments or critical cares and we investigate. We are improving the timeliness of our toxicology through our forensic and analytical services so we can get more real-time information. But again, the nature of the response to that information will be tailored on a case-by-case basis.

Ms CATE FAEHRMANN: There is an issue that you are receiving information about these potentially deadly substances from patients in the emergency departments—so once they have already overdosed. Have you been provided with any recommendations around how to prevent these people overdosing in the first place and perhaps issuing recommendations before overdoses occur?

Dr CHANT: If I could take you back. I think that is a slightly different question. I will talk to you about some of the interventions that we have done. On our NSW Health website we have a website called Your Room which provides quite—it is targeted to young people. It is focused on providing details of the drugs, their interactions and the symptoms in a way that is accessible to young people. We really need to co-design with young people how they want to receive information. We are also working through our peer groups like NSW Users and Aids Association [NUAA] and we are also working on campaigns around some of the ways in which to mitigate the risk. They have been focused tested with young people.

We have surveyed a number of young people as part of the work we have been doing in music festivals and we are tailoring the messages. Some of the information that has come out of those is that young people need to know more about the signs and symptoms, about what to look out for. Sometimes the young people have reported that the symptoms that they see as indicating they are affected are much later than we would want. We

would want earlier warnings around that. From our social research, the importance of peers and their friend network in keeping people safe and making sure that they are watching over—so a key theme of our campaigns to young people is around "take care". We also need to understand that the people who are using drugs are a diffuse group and we need to tailor the messages to each of those segments and the context—

Ms CATE FAEHRMANN: Can I just check. You are saying that you are sending particular messages out through NUAA. Is NUAA basically the organisation that you are expecting to be able to disseminate the information to potential users of a particular drug if it might be more dangerous than users are expecting?

Dr CHANT: Again, I would like to say that for each drug we have a range of ways to mitigate the harm. The Coroner—

Ms CATE FAEHRMANN: I am aware of that. I can see the webpage that says "Your Room" and I can see that there is information on particular drugs generically. You know the question I am asking, which is very specific. It is in relation to if there is a particularly dangerous substance over and above, and I have heard your response on MDMA, but if there is for example—

Dr CHANT: NSW Health would put that—

Ms CATE FAEHRMANN: —PMA or this NBOMe, which is where people were hospitalised in 2016 in the intensive care unit in Western Australia, but if there is a particularly deadly substance in MDMA is there an early alert system that NSW Health engages in to prevent people taking that particular batch of drugs?

Dr CHANT: As we would for any public health risk, if we are aware of a risk and it is deemed that the risk justifies a public warning we have those messages. We can also push out through our social media channels. We can forward it to NUAA to get them to get that message out. We can forward it to ACON that also has contacts with various communities. We can use our full suite of messages in terms of getting messages out if it is assessed as that is the right way to mitigate that risk. The only point I was making was that the PMA, it would depend on the quantity, the contamination and the level in the product.

Ms CATE FAEHRMANN: When you say when it is assessed that you should issue alerts, how is that decision made?

Dr CHANT: We basically have experts and we decide on the approach we would take when we become aware of it. For instance, if it is a local issue and we have no evidence that the distribution of the supply chain is beyond, it may be in a local health district that we would provide the warning. If it is considered that we can effectively get the message out that is how we would do it. It is on a case by case basis. As I said in the lead with opium issue, it was a particular group who would not have been watching mainstream media. So mainstream media was not the effective group. There were more culturally appropriate chains and networks to get these targeted messages out. We would assess it, as we do for risks of contamination in other products, including complementary medicines or any other issue. We have a formal risk assessment of what is the likely consequence and how do we mitigate that.

The Hon. COURTNEY HOUSSOS: Ms Koff, I wanted to ask you some questions about paediatric cardiac surgery at Sydney Children's Hospital, Randwick. I know we canvassed this extensively at the previous budget estimates hearings. I want to ask you for an update. How many paediatric cardiac surgeons are currently operating at the Sydney Children's Hospital, Randwick?

Ms KOFF: I would have to take that on notice. I have not got the current schedule or rostering for the service.

The Hon. COURTNEY HOUSSOS: It was canvassed fairly extensively.

Ms KOFF: Yes, I remember we discussed it at length.

The Hon. COURTNEY HOUSSOS: It was public and we discussed it at length here.

Ms KOFF: Yes.

The Hon. COURTNEY HOUSSOS: Are you aware of any efforts to recruit a second paediatric cardiac surgeon?

Ms KOFF: As we outlined earlier, the service is networked. It is a single network service with surgeons available to operate at both sites.

The Hon. COURTNEY HOUSSOS: Perhaps I should ask you the question then, When and how will the issues concerning the two hospitals be resolved?

Ms KOFF: Arising from the roundtable that we had, there were a broad range of issues that were canvassed and paediatric surgery was one of those elements. The governance of Sydney Children's Hospitals Network was a second issue and a third issue that was raised quite strongly at that roundtable was statewide governance of paediatric services, as to how we ensured access to rural areas. Professor Richard Henry is undertaking the third part of that review for governance of paediatric services statewide.

The Hon. COURTNEY HOUSSOS: Paediatric services or paediatric cardiac services?

Ms KOFF: No, paediatric services. That is the issue that we need to ensure. We had some very strong representations from rural paediatricians as to access to the children's hospitals for clinical support, for transfers and for various other things. We are looking at the three elements.

The Hon. COURTNEY HOUSSOS: When will that report be due back?

Ms KOFF: We are hoping at the end of the year.

The Hon. COURTNEY HOUSSOS: Do you have a definite date?

Ms KOFF: No.

The Hon. COURTNEY HOUSSOS: Will you be making that report public?

Ms KOFF: We certainly will be because it will determine the future of what we do for paediatric services and child health services more broadly. I think the most important thing I would reiterate is that paediatric service exclusively refers to clinical care provided in hospital. We are really keen to ensure that child health across the State is well managed. Hospitals are not the sole providers of clinical care to children—general practitioners in primary care, baby health nurses—there are a range of providers and we need to ensure that we are providing optimal care across the range of the settings.

The Hon. COURTNEY HOUSSOS: Will that review look at current staffing levels?

Ms KOFF: No, it is not in the terms of reference to look at the staffing levels. If I touch on what was mentioned earlier in a conversation about role delineation of hospitals and what services are provided at various locations across the State and where do we concentrate health specialised services, that is part of how we network paediatrics across the State or child health care.

The Hon. COURTNEY HOUSSOS: But will it look at the availability or future workforce planning? One of the issues canvassed when this issue was particularly heated and receiving a lot of media attention was the fact that there is a serious statewide shortage of paediatric cardiac surgeons. Will that form part of Professor Henry's review?

Ms KOFF: No, he is not specifically looking at paediatric surgery.

The Hon. WALT SECORD: Is that not why the inquiry was called?

Ms KOFF: No. As I said, there were three component parts and whilst paediatric cardiac surgery was raised as the critical flashpoint issue, it then expanded into what is the governance of the children's hospitals network, which we gave a commitment to do a review of that process and also then the governance of paediatrics/child health across the whole of the State. They all have a relationship.

The Hon. WALT SECORD: The Minister and Health gave the impression to the doctors at Westmead and at Randwick that the inquiry that was taking place was going to be paediatric cardiac services.

Ms KOFF: I do not concur with that perspective, Mr Secord.

The Hon. WALT SECORD: The doctors have a different view.

Ms KOFF: The doctors are very clear about the process that will be undertaken. The commitments given at the roundtable, we need to resolve three issues that we are doing work on.

The Hon. COURTNEY HOUSSOS: I come back to my original question which is specifically regarding paediatric cardiac surgery and the issues between Sydney Children's Hospital at Randwick and the children's hospital at Westmead, what is the latest that is happening to resolve those issues?

Ms KOFF: As I said, it is part of the process of the three interconnected interrelated issues. We will be advising of the outcome of all three issues that are being progressed at the end of the year .

The Hon. WALT SECORD: You just said earlier—

Ms KOFF: It is not specifically looking at paediatric surgery.

The Hon. WALT SECORD: But you gave the impression to doctors in both hospitals that this was what the inquiry was about. This is a cruel hoax on both communities. Doctors were given the clear indication that this was paediatric cardiac services and they were told that. Now you are saying that it is looking at three different areas?

Ms KOFF: It is looking at three which are all interrelated and we have been clear on that process in terms of moving forward to the roundtable that we would make a determination around paediatric cardiac surgery, we would make a determination on the future of the network and we would make a determination on statewide paediatric child services.

The Hon. WALT SECORD: Where does paediatric cardiac services fit into this?

Ms KOFF: It is part of the three issues that will collectively be addressed.

The Hon. COURTNEY HOUSSOS: You just said that Professor Henry has no ability to cover paediatric cardiac services?

Ms KOFF: I did not say he had no ability. I am sure that has come up in his discussions.

The Hon. WALT SECORD: Have you made it clear in your discussions with him that you want paediatric cardiac services dealt with?

Ms KOFF: I think it has been raised with him on multiple occasions, as I had the last update with him on going around and engaging with many paediatric doctors and clinicians.

The Hon. WALT SECORD: Is paediatric cardiac services mentioned in the terms of reference or the contract giving him his specific duties?

Ms KOFF: I will have to take that on notice whether it is specifically mentioned.

The Hon. WALT SECORD: You do not know if it is part of his directions?

Ms KOFF: They were part of a wideranging terms of references as to how we should manage paediatric services across the State. That is one of many paediatric services across the State.

The Hon. WALT SECORD: My question is very specific: Can you find out if paediatric cardiac services are part of his terms of references?

Ms KOFF: I will take it on notice, Mr Secord.

The Hon. COURTNEY HOUSSOS: Ms Koff, you said earlier in response to one of my questions that it was not explicitly in the terms of references?

Ms KOFF: It was not specifically mentioned to him that he needed to give us a determination on paediatric services. If, however, it came up in conversations I would expect him to report on that.

The Hon. WALT SECORD: This is why the Minister and the department gave the impression to doctors at Randwick and doctors at Westmead—settle down, this inquiry will address this. Now you are telling us that it is not.

Ms KOFF: I am saying there are three components to paediatrics and child health service that need to be done. As outlined, we have had many, many reviews of paediatric cardiac services. We have had a number of reviews to date that are well documented and I think were mentioned in the last budget estimates. Arising from the distress about paediatric surgery, the doctors said the network structure is not meeting their needs. Hence there was a commitment given about what is the optimal network structure for paediatrics and should the Sydney Children's Hospitals Network continue as a governance entity for the paediatrics at both sites.

That then calls into question the interdependency of how we manage paediatrics and child health as a State: hence the third pillar of work. There are points of intersection in all of those issues because how we run statewide paediatric services from the State level obviously requires our consideration, given we have specialist children's hospitals at Randwick and at Westmead and John Hunter Children's Hospital. We have three children's hospitals in the State. We have also new paediatric services coming online and in Campbelltown we are very proud of the development of significant capital investment and the development of paediatric services down at Campbelltown. What we need as a State is clarity of the roles and functions and the governance and management of all paediatric services across the State.

The Hon. WALT SECORD: I do not want to repeat but this question comes from a line of questioning by Ms Cate Faehrmann. She asked about hospitals without doctors.

Ms KOFF: Yes.

The Hon. WALT SECORD: For the sake of clarity, Ms Faehrmann already may have asked for this but, if she has not, then I would like you or the department to provide a full list of New South Wales hospitals, including district hospitals and multipurpose services [MPSs], that do not have doctors on duty 24/7 or Monday to Friday, Saturday to Sunday. I would like the full list of hospitals in New South Wales that do not have doctors.

Ms KOFF: I think that was the repeat question.

The Hon. WALT SECORD: I just want to make sure that we have the full list, including MPSs and district hospitals.

The CHAIR: MPS being?

The Hon. WALT SECORD: A multipurpose service.

The Hon. COURTNEY HOUSSOS: Do you have real-time monitoring of when a doctor is not in a hospital?

Ms KOFF: No.

The Hon. COURTNEY HOUSSOS: Is that done at a local health district level?

Ms KOFF: No. In the devolved management structure all the districts are responsible for the recruitment of staff, the rostering of staff and the organisation of services.

The Hon. WALT SECORD: When will the Cootamundra Hospital get a doctor Monday to Friday?

Ms KOFF: We will take that on notice.

The Hon. WALT SECORD: Ms Wilcox, are all accreditations for doctors working at the Northern Beaches Hospital in order as of today?

Ms WILLCOX: The Northern Beaches Hospital has its own appointments committee led by its director of medical services. It would be the responsibility of the Northern Beaches Hospital to oversee the recruitment and appropriate appointment processes for their medical staff within the hospital.

The Hon. WALT SECORD: So the answer is that you are unaware.

Ms WILLCOX: The answer is that I am not responsible for the day-to-day operations of the hospital, and the recruitment of staff and the appropriate staff would be the responsibility of the hospital.

The Hon. WALT SECORD: You are coming into an intersection then. What about public patients being treated at the hospital? Are you aware if the doctors treating them have full accreditation?

Ms WILLCOX: The contract is such that I purchase public activity that equates to the activity that was at Manly and Mona Vale when it had acute services at a higher level of complexity and at a greater volume than we were previously able to provide. The management of that contract does not require me, on a day-to-day basis, to be responsible or accountable for recruitment of staff. That is for the management of the hospital and the executive of the Northern Beaches Hospital.

The Hon. WALT SECORD: Do you have any responsibility or any requirement to ensure that they are using properly accredited doctors at that facility?

Ms WILLCOX: The quality and safety of care at the Northern Beaches Hospital is the remit of the hospital but there are reporting requirements under the contracts that I am able to, as the chief executive of the district, delegate to oversight the contract so that I can see that the quality and safety is performing at a level that is satisfactory. That does not require me to be the person who signs off on the recruitment of individual clinicians to the hospital. That is a matter for Healthscope and the executive of the Northern Beaches Hospital.

The Hon. WALT SECORD: As part of the reporting requirements, do they tell you if the doctors are accredited and that full accreditation is occurring at that hospital?

Ms WILLCOX: There would be no reason for them to share that with me. The only time that would be an issue would be if there was an issue with a particular clinician that may have escalated into an incident or a

complaint that then I would be made aware of by virtue of there being some event that triggered it. There is not any real reason on an operational level why I would need to be told.

The Hon. WALT SECORD: You know that in the past there have been problems with accreditation and oversight and accreditation involving junior doctors. Have you sought assurances from the Northern Beaches Hospital in this regard?

Ms WILLCOX: That junior medical officers [JMOs] have a different set of circumstances because they are actually employees of the local health district. In terms of their supervision, their education requirements and their workforce needs, the district obviously has a very important role in that as our employees. We work with the team at the Northern Beaches Hospital to look after our JMOs in that regard

The Hon. WALT SECORD: Are the JMOs all fully accredited at this time in all the various accreditation bodies?

Ms WILLCOX: The JMOs are all within the requirements of their training requirements through the Health Education and Training Institute [HETI] and the training programs—all of those matters—are intact. The roles and responsibilities and credentialing of each individual visiting medical officer [VMO] or career medical officers or locums who might work at the Northern Beaches Hospital are absolutely a matter for the executive of the Northern Beaches Hospital.

The Hon. WALT SECORD: Has the Northern Beaches Hospital and NSW Health overcome the interconnection problems involving the transfer of data between the two? Has that been resolved?

Ms WILLCOX: Yes. I am very pleased to be able to advise the Committee since we last met at the Northern Beaches inquiry that that very, very significant body of work has been completed. Just to restate—and I use the term not lightly—this is groundbreaking in terms of allowing access to medical records between the private and public sector.

The Hon. WALT SECORD: Tomorrow is the first anniversary of the Northern Beaches Hospital opening.

Ms WILLCOX: It is. It is the one-year anniversary; that is right.

The Hon. WALT SECORD: Tomorrow, yes.

Ms WILLCOX: Yes, it is, and I will be sending them a happy anniversary card and gift. It has been an interesting year.

The Hon. BEN FRANKLIN: It is on the record now.

Ms WILLCOX: Indeed. I should not have said. Now I have blown the surprise. I organised a hamper for them.

The CHAIR: They were hoping for a cake, actually, but don't worry!

The Hon. WALT SECORD: Be mindful that you are using my time.

Ms WILLCOX: I take your point, Mr Secord; about a year has elapsed.

The Hon. WALT SECORD: Is it in fact operating at the standard that you would be expecting it to be operating at?

Ms WILLCOX: It is. To be able to access the medical records sounds like a simple concept but it has not been. You may recall that when we last met through the Northern Beaches inquiry a decision was made by Healthscope outside of the controls of the local health district or the ministry to opt for a different electronic medical record system in the hospital. That meant that there was no compatibility between the two.

The Hon. WALT SECORD: You bought a cheaper system.

Ms WILLCOX: I do not know about the cost. But there was significant time and investment by both district and Healthscope to put in some contingencies around that and manage that interface so that we could ensure patient care and transfer of information were safe. That is what happens every day in the health system now. What we now have is an enhanced ability so that the staff of Healthscope at the Northern Beaches Hospital and the staff in any of the hospitals in the Northern Sydney Local Health District can now see where that patient has been, the day before, the hour before.

The Hon. WALT SECORD: One year on, is it now a world-class health facility?

Ms WILLCOX: I think that the team and the staff at the Northern Beaches Hospital would say they were a world-class hospital. We do not have particular measures that call something world class but I can say that, with the governance and oversight that we have and the collegiate relationship with the Northern Beaches executive, I am confident in terms of the quality and safety of care and the operations of that hospital.

The Hon. WALT SECORD: You said that there were regular reporting requirements. Since the hospital is now coming up to one year, has NSW Health subjected the Northern Beaches Hospital provider, Healthscope, with any financial penalties?

Ms WILLCOX: The provisions of the contract allow us to—there are points provided as to whether it is performing at a certain level. In terms of the specific, I guess, financial arrangements between the local health district and Northern Beaches, I would consider those potentially commercial in confidence and I would like to take that part of the question on notice, if that is acceptable.

The Hon. WALT SECORD: I am not asking you to spell it out financially, I just want to know. It is a yes-or-no question: Did they receive full payment or were they penalised for inability or not meeting expectations? I am not asking you to break any commercial in confidence—just a yes/no. Did they receive any penalties?

Ms WILLCOX: I would like to take that question on notice.

The Hon. WALT SECORD: Do you know the answer?

Ms WILLCOX: I believe there are some commercial elements to the question. I would rather be prudent about that and take the question on notice and come back to you.

The Hon. WALT SECORD: But do you know the answer to my question?

Ms WILLCOX: In part.

The Hon. WALT SECORD: Yes, thank you. Ms Chant, how did we fare—

Ms KOFF: Dr Chant, sorry, Mr Secord.

The Hon. WALT SECORD: Dr Chant! I apologise. Dr Chant—

The CHAIR: We will have to have another supplementary hearing just to get it right.

The Hon. WALT SECORD: How did we fare during the flu season this year?

Dr CHANT: In severity it was a moderate flu season. I would like to acknowledge the frontline workers and our GP colleagues in managing the system and also acknowledge the good response to vaccination messages. We are waiting for the data to fully come in—there is a lag—but we are hoping to see that there has been a good uptake of the child vaccination program we instituted. We generally have good levels of adult vaccination but we can always aim to improve them.

The Hon. WALT SECORD: The Pharmacy Guild told me at a function last week that one million vaccinations were provided in Australia through pharmacies. Are there any plans to expand vaccinations in pharmacies in New South Wales?

Dr CHANT: The Minister has taken this issue to the COAG Health Council. We are about to consider a paper that is going next week to the Australian Health Protection Principal Committee [AHPPC] that New South Wales is leading the development of, which looks at trying to harmonise the lower age level for access to vaccines delivered through pharmacies. We see that pharmacies are an important access point. We acknowledge the work that pharmacists have done in this area.

The Hon. WALT SECORD: I am familiar with the work that is occurring there. Is the New South Wales position lowering the age to 10 or 12 as part of the package?

Dr CHANT: I think it would be most appropriate that these policy processes go through the normal phase. We are presenting a paper to AHPPC next week. The process we have gone through is we have risk-assessed the various vaccines in terms of a complexity rating and a rating for side effects. For instance, the Q fever vaccine is a very challenging vaccine because you need blood tests and things like that; clearly the rabies vaccine is similarly complex. We have done a risk-assessment matrix and we have also looked at those issues about the age cut-off, as you said. That is processing, I believe, at the upcoming meetings in the next week or two. Then we would like my colleagues across the other States and Territories to review that.

The Hon. WALT SECORD: What is NSW Health's response to the Pharmacy Guild's call for travel vaccinations to be provided in pharmacies?

Dr CHANT: The paper covers the full array of vaccines. As I say, we do that risk matrix where we have assessed each of the vaccines for complexity and suitability for administration in a pharmacy setting. That paper is going to be considered in the next couple of weeks and I would prefer for it to go through that usual policy formation process.

The Hon. COURTNEY HOUSSOS: Ms Koff, I want to ask about preparations for heat stress over summer. It may be only late October but we have already seen some unseasonably warm weather. What preparations is the department making?

Ms KOFF: I will refer that to Dr Chant, if I could.

Dr CHANT: I think you are probably aware of our "Beat the Heat" campaign. We do encourage people at this time of year, particularly those with chronic illness, to discuss with their GPs the implications and talk about medication management and what other steps they should take to achieve optimal health outcomes, particularly in the heat. There are a lot of practical recommendations in that "Beat the Heat" program. NSW Health does go out when there are heatwave conditions, but is also important that we do not lose the salience of those messages by going out too frequently. We also work collaboratively across our local health districts. Our rural colleagues, depending on the geometry, bear heat in different ways. Telling them it is hot when we feel it is hot in Sydney sometimes sees an incongruence in the messaging. We work both locally with our local health districts, which will support messaging, and also do it at a State level, particularly when there are more widespread impacts across the State or the broader Sydney region.

Heat stress can have other broader impacts. For instance, we do make sure our hospitals are resilient to bushfires, have tested all their emergency management plans, have got good generator backups—our normal way in which we interact across government agencies to support response. Often, as I said, heatwaves are amplified by risk. We are conscious that many of our areas are going through a very severe drought. Obviously that means there has been often a lot of work done at emergency management, local area, to have that contingency planning.

The Hon. WALT SECORD: On the matter of drought, what is NSW Health doing? There are 40 communities that are on the verge of having no water. What are you doing for kidney dialysis? Can you guarantee that patients are getting proper care? What is your advice to those 40 communities where people may be on kidney dialysis? What is happening there?

Dr CHANT: I would like to reassure them that those issues are front and centre. I think I mentioned before that dialysis machines work on reverse osmosis, so they do not present an issue with some of the salinity issues that are encountered.

The Hon. WALT SECORD: But if there is no water in those communities?

Dr CHANT: That goes to the whole-of-government response. I think that is probably better directed to other agencies.

The Hon. WALT SECORD: Are hospitals given priority over other—

Dr CHANT: The community will be the priority and the hospital is obviously a critical piece of infrastructure. However, that planning is done in the whole-of-government framework. You have probably seen that in some instances there have been pipelines built; in other instances there has been additional filtration. Case by case, there has often been the accessing of bore water and changing over the water source. NSW Health's role in this is really to support the local water utilities in understanding the potential challenges of changing the water source and what additional filtration systems or other things we might need to make sure that the community does not perceive the changing water source—notwithstanding our fundamental role in making sure that the water is safe.

The Hon. WALT SECORD: Are there any hospitals, multipurpose services or districts that have had to reduce services or cut back services due to a lack of water to those facilities?

Dr CHANT: That has not been raised with me, Mr Secord. I would be happy to follow up any issues.

The Hon. WALT SECORD: Can you take that on notice?

Dr CHANT: Certainly.

The Hon. WALT SECORD: In those hospitals, is the State Government providing bottled water to those facilities?

Dr CHANT: Generally facilities will be on the mains water supply for those regions. Clearly NSW Health uses bottled water in some of the facilities for patient use, often for a convenience factor. The issue of water supply to our hospitals has not been raised with me as impeding the operation of those facilities. I would be happy to take that on notice. I would just like to say that some of those questions about the broader intergovernmental response to the drought are really matter for other agencies, but Health is a willing participant in those meetings.

The Hon. WALT SECORD: This morning we woke up and all of our cars were covered in dust.

Dr CHANT: Yes, bushfires.

The Hon. WALT SECORD: As well as dust. Has NSW Health issued any warnings or advisories to the community involving some of the worst dust storms we have had since 2009?

Dr CHANT: It is actually a combination of smoke and dust. I would have to seek advice about that. I certainly did notice it was smoky around today. A smoke advisory was issued on 30 October at 6.55 a.m. It reads:

Smoke is affecting large parts of New South Wales. The smoke is being blown from large bushfires burning on the north coast and northern New South Wales.

North-easterly winds are pushing the smoke along the coast to areas including Newcastle, Sydney and Illawarra.

The smoke is expected to settle in these areas and may continue for the next few days.

NSW Health reminds people that children, older adults and people with heart and lung conditions are most susceptible to the effects of air pollution and excessive smoke.

If you have asthma or a lung condition, reduce outdoor activities ...

Asthma sufferers need to follow their Asthma Action Plans ...

That is part of it.

The Hon. WALT SECORD: Thank you very much.

The Hon. COURTNEY HOUSSOS: I have one follow-up question. Dr Chant, on the issue of bushfires, we have already seen, despite it not yet being summer, bushfires in areas where we are not used to seeing bushfires. Has NSW Health issued any directives or asked its hospitals or other services to undertake any additional preparations in light of that?

Dr CHANT: Every year NSW Health issues guidance to its facilities to remind them of the things that tend to happen at this time of year, including bushfires and floods, notwithstanding the freak nature of those events, even though the forecasts are for a very hot, dry summer. We send that meteorological information out, which is shared in a whole-of-government way. That is fed into the planning that the districts need to do in terms of their risk assessments and what threats they are likely to see on an ongoing basis. We have robust emergency management plans. They are often checked and various districts put in place discussion exercises and they will refresh their contingency plans in light of any changes to the forecast or information we are provided about a changed risk assessment or threat level.

The Hon. WALT SECORD: Dr Chant, has NSW Health done any work in the area of concussions and youth sport? I know *The Medical Journal of Australia* did a major report into that in September.

Dr CHANT: I will have to do a little bit of research before I can answer that question more fully. But I would expect that various parts of NSW Health, particularly our child safe groups, have been involved either in an academic or other form. It is an emerging issue and is obviously something we take seriously.

Ms CATE FAEHRMANN: I want to go back to the dangerous illicit substances line of questioning. Within the NSW Police Force and NSW Health, where is the information database around the current illicit drugs in circulation?

Dr CHANT: As I said, we are developing protocols to share more information. Police have provided information for the methamphetamine report about the purity of the doses and the purity of the capsules and the tablets. That has shown and highlighted the importance of dose because there has been a change in the purity commensurate with the weight of the tablets or capsules that has meant that the capsules and the tablets have equal dose delivered. That is an example. We are now formalising the way in which relevant information is shared. As I indicated, one of the gaps in that is information that relates to large seizures; not smaller seizures, which are not being tested.

In terms of the other work that we are doing, we are working through our information to see what patients are presenting with and what toxicology is showing has contributed to their critical care admission. This is being established. It is in the early phases of that. Some of the examples I have given you are the existing surveillance systems we have. But we have become aware of carfentanyl and these issues. That is where we will work on an action plan in terms of the response to those issues.

Ms CATE FAEHRMANN: In relation to the prevention side of it—taking out the situation where NSW Health is alerted from toxicology reports once people have taken a substance—you say you are formalising a process. Is there going to be some kind of protocol that the NSW Police Force must advise NSW Health of what substances they are seizing from a health perspective?

Dr CHANT: First, I would like to take a step back. I would like to get on the record the work that we are doing more broadly. Your earlier question asked how we are reducing harms. I would like to state that, in relation to the harms associated with opioid overdoses, the Coroner made a number of recommendations and NSW Health has acted on those recommendations. For instance, we are scaling up naloxone distribution and are looking at peer-based distribution models for Naloxone. We are also trialling new long-acting pharmacotherapies for opioid treatment substitution following a successful trial in Corrections Health. We also recognise the need to increase and improve access to evidence-based opioid treatment. In terms of reducing the harms, some of those actions will be pivotal for achieving a population level reduction in harms.

In terms of the other ways we engage, we are also running a range of programs to look at opportunity points for people who are using drugs in a recreational sense who have presented to emergency departments or other points and are at the point where they recognise that their drug use has caused harm or is causing them a problem and may be more amenable to getting some support and counselling to modify, reduce or stop their drug use. I would like to give the picture that there is a broad suite of activities that we are doing to reduce the harms upfront. I know you are asking particular questions around the issue of warnings and how we can use intelligence. But most harms occur as a result of alcohol and then illicit drugs without contaminants. They are causing us the major harms.

Ms CATE FAEHRMANN: They do. Thank you for acknowledging that, of course, the most harm is caused by alcohol. But it is alcohol dosage—which is similar to what you were saying before about MDMA dosage. The question is about the link between the NSW Police Force and NSW Health. Say we are two weeks out from New Year's Eve and the NSW Police Force seize a massive batch of cocaine or MDMA that is contaminated by a potentially deadly substance and they know there is more of that drug out there. If we leave the dosage issue out of it, is there a requirement for the NSW Police Force to advise NSW Health of what they have found? Is there is a requirement now?

Dr CHANT: There is no written requirement. But NSW Health undertakes the testing. The testing for police is undertaken in the forensic—

Ms CATE FAEHRMANN: They send everything they see to you?

Dr CHANT: No, they test a proportion of it. They would not know about it. As I said, the gap is that police currently send some samples of the seized products to the Forensic and Analytical Science Service unit located at Lidcombe for the purposes of providing evidence for the seizure or for other intelligence purposes. But fundamentally the sampling that is currently done is biased towards large seizures. That is where the focus of the police activity is. What we are working with police on is to do more testing of some of the lower-level products that are seized. That would give us a more distributive view of the drug supply market.

Notwithstanding the fact that we do now have a written MOU with police, clearly as we are formalising these approaches we will consider your suggestion of having that MOU and the protocols around that being documented. But I am also confident that if our Forensic and Analytical Science Service unit detected anything that caused them concern, we would be advised. I stress that our interactions with police have been quite positive in their willingness to share information. I would also like to acknowledge that the Coroner has also been very willing to allow forensic services to provide us with information that is relevant to other cases that may have been coronial cases.

Ms CATE FAEHRMANN: I have just been having a look at your Twitter feed and I have also had a look at NUAA's Twitter feed in relation to public health alerts—

The CHAIR: Could you expand the NUAA acronym for the purposes of Hansard?

Dr CHANT: The NSW Users and AIDS Association.

Ms CATE FAEHRMANN: I have looked at their Twitter feed in relation to public health alerts and there is nothing. If there was a particularly dangerous substance in circulation that was illegal and you knew that people would be consuming that substance, despite its illegality, can NSW Health issue a public health alert on its Twitter feed, for example?

Dr CHANT: Yes, we use the full range of communication strategies to do it. As I said it needs to be on a case-by-case basis because there have also been increases in cases in the UK when there was a public alert sent about a particular circumstance. I am happy to provide this. We actually caused harm. Again it is on a case-by-case basis. Where we actually think that a public warning is needed, NSW Health routinely issues public warnings and it would be the same for any concerns we have. As I said, we balance that against, you know, if the whole product has been seized. For instance, there may be other circumstances where we might do a public announcement but we also need to do more nuanced announcements if we think people need to receive that message.

Our key issue is making sure that the information is provided to the people in a way that they are likely to act on the information we have provided. Therefore we often need multilayered communication. Sometimes, albeit later, we also communicate particular messages with our clinical community. For instance, with lead in opium, we were actually asking for people who were presenting to drug and alcohol or GPs in general to potentially just think about doing lead testing in these circumstances.

Ms CATE FAEHRMANN: Could you please provide on notice for the Committee over the last 12 months what the public health alert system has been for any detections of dangerous illegal substances?

Dr CHANT: Yes.

Ms CATE FAEHRMANN: I am assuming you are testing a lot of illegal substances, but at a point where you believe that public health is at risk and what those alert systems have been.

Dr CHANT: Yes.

The Hon. COURTNEY HOUSSOS: Ms Koff, I wanted to ask you some questions about the case of Lorelei Bellchambers, who you would be familiar with. She was a toddler who was sent home from Wyong hospital on the Central Coast despite having a broken neck. Are you familiar with the case?

Ms KOFF: Yes, I am.

The Hon. COURTNEY HOUSSOS: Can you provide an update to the Committee with the latest information on that case?

Ms KOFF: The case of Lorelei Bellchambers was rather high profile and she was reviewed on presentation at Wyong and subsequently Gosford Hospital emergency department and consultation did occur with the Children's Hospital at Westmead. I think the critical issue in care of children this age is balancing the physical investigation with the potential risks associated with unnecessary imaging that is undertaken. The other aspect about childhood imaging, as in scanning et cetera, is also the associated risk of having to do them under anaesthetic. In many peripheral hospitals the requirement to anaesthetise children and have imaging is highly complex and needs to be referred. As I understand, she is in the children's hospital recovering and we are optimistic of a positive outcome for Lorelei.

The Hon. COURTNEY HOUSSOS: When you say that there is a limitation on the ability to provide that, does that mean at Wyong, Gosford or other regional hospitals it is not possible to provide scanning?

Ms KOFF: It depends on the age of the child and the availability of paediatric anaesthetists. It is a highly specialised service and the capacity of a child to lie still while imaging is being undertaken, as I mentioned, is problematic. There are not multiple paediatric anaesthetists around the State, so decisions are made very carefully on the appropriateness to undertake images and, if necessary, transfer to the right setting.

The Hon. COURTNEY HOUSSOS: Ms Koff, was a paediatric anaesthetist available at the time at either Wyong or Gosford hospitals?

Ms KOFF: There is a review of the incident being undertaken and, as we mentioned earlier, when there is an adverse event the health system takes them very, very seriously and clinicians also take them very, very seriously. There will be a full investigation, a root cause analysis and the nature of root cause analyses is an understanding of what are the issues that led to this adverse event, how could it have been prevented and then what the district needs to do, so I would not pre-empt the outcome of what any RCA would indicate.

The Hon. COURTNEY HOUSSOS: Let me slightly rephrase my question. Is a paediatric anaesthetist available at Wyong hospital or Gosford Hospital today?

Ms KOFF: I do not know and I do not know whether they would require one either. This goes back to the heart of role delineation and understanding the complexity of what local hospitals can do. There is a perception that all hospitals are equivalent. They are not all equivalent by virtue of the nature of the demographics of the population they serve, by virtue of the range of clinical services that they provide. That is why there is always consolidation of expert services where they are appropriate and where they may be necessary. That is why we have strongly networked services, so the expertise is there. It is highly inappropriate to have a specialty of every persuasion available if there is not the volume of work going through to ensure the quality.

So you would not expect to have specialist paediatric anaesthetists at every hospital across the State. But we can determine, and I will take it on notice, whether paediatric anaesthetists are available on duty or whether the decision—as I said, the RCA needs to come to the conclusion as to what the issues were relevant to this case, rather than automatically assuming that it was a staffing issue.

The Hon. COURTNEY HOUSSOS: Ms Koff, I appreciate that part of the answer will be in the investigation but part of the answer is also about the services that are available to the community today on the Central Coast. I appreciate your testimony saying that there needs to be a variety of services and that needs to be guided by need and demand, but the question of not having an anaesthetist who is able to undertake a scan in a place like the Central Coast, which actually has above the State average for children and young people, therefore surely would be a concern to you?

Ms KOFF: You are assuming that is the case and I do not know that that is the case, so I will take it on notice.

The Hon. COURTNEY HOUSSOS: Could you also provide on notice a list of the major hospitals that do currently have paediatric anaesthetists on staff and whether that is available seven days a week?

Ms KOFF: I am happy to take that on notice but I will go back if I can to talk about the statewide review of Richard Henry for correcting the record if there is any misconstruing of what was said because I have had the terms of reference set. This is part of what the statewide review by Richard Henry is looking at. In front of me it includes reviewing how current services are delivered and noting any changes in clinical evidence that may provide an opportunity to identify new directions for system-wide activity. If I can confirm, paediatric cardiac surgery is not specifically listed in the terms of reference review because they are far broader. However, it does not prevent Professor Henry from making any comment because we are asking at a statewide level what the appropriate consideration of paediatric services in hospitals is.

The Hon. WALT SECORD: But paediatric cardiac services are not mentioned in the terms of reference in that inquiry.

Ms KOFF: No, I can specifically confirm that. I have just read them, Mr Secord, and they are not specifically mentioned.

The Hon. COURTNEY HOUSSOS: Ms Koff, I just wanted to ask you, I cannot think of it off the top of my head but there was a particular rule that was implemented in New South Wales hospitals, I want to say Ryan's Rule, around giving information to parents about seeking a second opinion for their child if they were concerned. Dr Chant might know what the actual—

Ms KOFF: I am not familiar with it, but I heard a sound to my right.

Dr CHANT: Sorry, I was trying to trawl from my—I believe that you are correct. I have not got the name of that program, but I think it originated from Illawarra Shoalhaven or—

The Hon. COURTNEY HOUSSOS: It was down on the South Coast. There was a situation.

Ms KOFF: Yes, I know what you mean now.

Dr CHANT: It was really empowering parents to raise the question. I understand it was effective and well received, but that is the extent of my—

The Hon. COURTNEY HOUSSOS: Ms Koff, are you able to tell us—I am happy if you want to do that on notice—if that particular procedure was in place on the Central Coast at either the Wyong or the Gosford hospitals at the time, and whether that is forming part of the review of Lorelei Bellchambers?

Ms KOFF: Yes, happy to do that. That program looks at what we call patient-activated escalation, and obviously in children it is a parent who activates. So there is an opportunity at any time in any facility, if there are concerns of the patient or their carer, that they can escalate by alternative mechanisms.

The Hon. COURTNEY HOUSSOS: I would be interested to know whether information was specifically provided to those parents about that particular option that was available to them.

Ms KOFF: Could I add something on Cootamundra, Mr Chair?

The CHAIR: You may, of course.

Ms KOFF: I have just had advice that Cootamundra Hospital has six general practitioner visiting medical officers on call to provide medical cover at the emergency department after hours and on weekends. The local doctors are committed to the hospital, but they are not at the hospital within working hours permanently. I think that is part of the challenge highlighted earlier about our capacity to staff rural hospitals. Murrumbidgee Local Health District is working to secure a locum doctor to provide medical cover within the hospital emergency department on weekdays and is recruiting a nurse practitioner to provide additional support for emergency presentations. That blended model of GPs being in hospitals is what is common in many, many rural areas to enable staffing, because there is not the volume of work permanently for a doctor in some instances to be based in the hospital, and they alternate between their private practice and the GP clinic and the hospital.

The Hon. WALT SECORD: Ms Koff, earlier this session—I think it was two sessions ago—we were talking about low-risk maternity services in rural and regional areas.

Ms KOFF: Yes.

The Hon. WALT SECORD: You talked about a midwifery-led plan in Forbes and Parkes.

Ms KOFF: Yes.

The Hon. WALT SECORD: Are you aware that a group of Yass Valley mums have engaged a midwife to do a report and the report came up with a similar proposal as the Yass Valley midwifery group practice led by Jasmin Jones, presented by Jasmin Jones from the local council? Does a midwife-led low-risk maternity service have a possibility at Yass District Hospital?

Ms KOFF: I think earlier, Mr Secord, I outlined some preconditions that we think would be appropriate for such a service. If those preconditions were in place, we would have to assess it. We can take it on notice. I have not seen the report. I have not seen the content of the report.

The Hon. WALT SECORD: I asked some questions to Ms Chant about the flu season that has just passed. What are the expectations for the 2020 flu season? Are there any learnings from this year's flu season?

Dr CHANT: I think I have answered this question at the previous budget estimates.

The Hon. WALT SECORD: And the one before.

Dr CHANT: And the one before.

The CHAIR: And probably the one before that.

The Hon. WALT SECORD: This is our sixth budget estimates together.

Ms KOFF: She has been 10 years in the role.

The Hon. WALT SECORD: Six with me.

Dr CHANT: In terms of the flu season, it is impossible to predict. I think that our system and our community is becoming more aware of the impact that flu has on us year in, year out. In terms of the areas where I think we will continue to really push is our childhood coverage. It is pleasing to see that the Commonwealth has assessed the child vaccine and approved that, so I think that presents us with an opportunity to work further with parents to assure them about the need to get their children vaccinated. That is probably an area where we can improve. I think the systems of distribution of the vaccines have gone quite smoother this year, but we always have routine debriefs with our GP colleagues and pharmacists to look at ways in which we can improve those matters in terms of timeliness and coordination of the start of the flu season.

We have had the summer flu and so we will be actually going later in the year with some more messages around the need to get vaccinated if you are going to the Northern Hemisphere, and remind people around that this year. I think as we have improved our testing, we have been identifying a lot more flu than we would have

historically. So I think awareness has really increased, Mr Secord, which means that our messages are probably going to be received. Our hygiene messages—stay off work if you are unwell, do not cough over others—as well as the messages about getting vaccinated are going to resonate with the community. I think we can incrementally improve our response every year, but I am really pleased with the efforts of our frontline services, our emergency departments, our GP colleagues, our pharmacists and the community, who have really embraced the messages.

The Hon. WALT SECORD: Ms Koff, any progress on the request for the 15 local health districts involving the efficiency dividend per health district?

Ms KOFF: Not that I have come across to date, Mr Secord.

The Hon. WALT SECORD: Not yet. Okay.

Ms KOFF: We took it on notice and we are—best endeavours.

The Hon. WALT SECORD: We were hoping that we could get them before the budget estimates finished.

Ms KOFF: We will notify you as soon as they come to hand.

The Hon. WALT SECORD: Thank you very much. I received a briefing several months ago after a briefing with the American Chamber of Commerce in Australia—the AmCham—on a call for working with the Federal Government to increase clinical medical trials in New South Wales because of our population mix in Sydney, particularly that we have the entire world population and the breakdown of the world population, making it eligible to do clinical medical trials in Sydney. Has any work been completed or movements in that area?

Ms KOFF: It is very impressive, but I would not stand in the way of Dr Chant, who is responsible for this area, so I will hand it to her immediately.

Dr CHANT: I think I would like to agree with you, Mr Secord, that we do see clinical trials investment. New South Wales has generally done fairly well in attracting clinical trials, but I think we need to acknowledge we are working in an international marketplace where we are getting competition from the region. We have done a couple of key initiatives. We have established a New South Wales clinical trials support unit within the office of health and medical research, and that is going to establish a single entry point for massive transfusion protocol [MTP] clinical trials in New South Wales. It is also going to draw on international and national best practice. We are also looking at standardising the engagement with local health districts, like standardising fees and charges and simplifying it for big pharma and other proponents of clinical trials.

We have also gone out with a new framework for early clinical trials, and we have gone to the market and secured a service to speed up the ethics committee review. We have established turnaround times for that. The ethical review occurs—I think within 20 to 30 days is the benchmark—and we are working with the districts collaboratively to reform the site-specific governance components of it. We see this as a big strength—there is much more work to be doing but we do think that New South Wales can actually lead in this. I agree with your point that because we have such networked services, we actually can identify quite significant patient pools. So, disproportionately to our overall population, because we are so connected we can provide sufficient numbers into clinical trials.

The Hon. WALT SECORD: Thank you. You have my support on that.

The CHAIR: How are the Canadians represented in New South Wales?

The Hon. WALT SECORD: There are 7,000 of them.

The Hon. COURTNEY HOUSSOS: Ms Koff, I ask you a follow-up question to a question that you took on notice during our last hearings around properties that are currently owned in Forster-Tuncurry. In an answer provided on notice you said that the Health Administration Corporation owns three properties in Forster-Tuncurry. Are you able to provide the addresses of those on notice?

Ms KOFF: I will provide them on notice, yes.

The Hon. COURTNEY HOUSSOS: I ask you specifically about some of the promises that the Government made prior to the last election, just to see if you have commencement dates for them. The Bankstown-Lidcombe Hospital, do you have a commencement date for construction there?

Ms KOFF: Unless I can pull it out quickly, I will take it on notice because I recall too we discussed at length last time that the commencement date is not determined until the planning process is undertaken, the clinical services, the site selection, et cetera, and all those gates and processes needed to be gone through before a definitive

commencement date can be given. Hence if the Government is committed to doing it within the period we will do it within the period, and I think Health Infrastructure has a very impressive record of delivering all hospital infrastructure on time and on budget.

The Hon. COURTNEY HOUSSOS: With that caveat at the beginning, if you can tell me if there is one for Bankstown-Lidcombe Hospital? Have you got one at hand there?

Ms KOFF: No, sorry.

The Hon. COURTNEY HOUSSOS: Have you got one for Ryde Hospital?

Ms KOFF: No.

The Hon. COURTNEY HOUSSOS: Shoalhaven Hospital?

Ms KOFF: No, but, as I said, if it was given as a commitment in the term of the Government it will be.

The Hon. COURTNEY HOUSSOS: I am specifically interested about when construction will commence and if it has not commenced at what point it is anticipated? Surely there is some kind of working towards date. If you could provide that on notice that would be great.

Ms KOFF: Yes.

The Hon. COURTNEY HOUSSOS: I ask you about Tumut Hospital, and I am sure you are familiar with the recent Coroner's report into the death of Naomi Jane Williams.

Ms KOFF: Yes.

The Hon. COURTNEY HOUSSOS: Are you able to tell the Committee what specific changes have taken place at Tumut Hospital to address the unconscious bias and racism concerns raised in the Coroner's report?

Ms KOFF: Just to refresh people's memory, it was a tragic incident and our apologies go out to Naomi's family. Naomi was a 27-year-old Aboriginal woman who was 26 weeks gestation and she died in Tumut Hospital from septicaemia, which is a blood infection. Recommendations were made by the Deputy State Coroner on 29 July. The Murrumbidgee Local Health District gave a full commitment to progressing the actions of the Coroner's recommendations. These included the implementation of a new safety alert policy and facilitation of specific staff training on safety alerts; the establishment of a district steering committee for the implementation of a nurse-delegated emergency care procedure; the development of a cultural competency training package to strengthen the cultural capability of all staff, and that tool includes an auditing element to it also. Part of our target also, which is reflected here, is to increase the Aboriginal and Torres Strait Islander workforce in healthcare delivery because it is only through recruitment of more Aboriginal and Torres Strait Islanders that we believe that we can provide a culturally appropriate service.

Since the death, the Murrumbidgee Local Health District has implemented a number of other system changes beyond specifically the Coroner's recommendations: an online training module for all staff asking the question about the identification of Aboriginal people. There is actually on the admission sheet a capacity to identify Aboriginal, yes or no, on the coversheet, and many times I think staff make the assumption, incorrectly, of the nature of the person presenting whether they are Aboriginal or not. It is important to ask that each and every time. The district actually has had regular conversations with local community representatives and Tumut Hospital managers. The part of understanding how to provide culturally safe and appropriate services is to listen and engage with the local community as to how services should be delivered.

There has been the appointment of Aboriginal representatives to the Tumut Local Health Advisory Committee and I think an important gesture is to remove—which has been undertaken—the restricted hospital visiting hours to enable patients to receive support from families and friends at any time. It is a range of diverse initiatives that have been implemented and the new hospital work being undertaken. They are very keen to design a new outdoor area in partnership with the local Aboriginal community to welcome Aboriginal people to the health facility.

The Hon. COURTNEY HOUSSOS: I am happy for you to provide this on notice, Ms Koff. What is the current rate of employment of Aboriginal and Torres Strait Islander people across the different local health districts? I think this is something that we discussed at length during the last hearing. If you can provide that on notice. If you can also provide on notice across the local health districts or if you have got it at a more granular level—sorry, this is unrelated—are there unfilled positions within the mental health worker space, psychiatrists, psychologists or any other mental health workers that are unfilled across the local health districts?

Ms KOFF: I will take that on notice. I was going to say unless the Aboriginal employment one, Mr Minns has got at his fingertips, I am happy to take it on notice.

The Hon. WALT SECORD: Dr Chant, earlier this year there was quite a lot of media commentary, comments from the Australian Salaried Medical Officers Federation of NSW [ASMOF] about junior doctors at the intensive care unit at St George Hospital and the barring of junior doctors there because of bullying by senior doctors. What is the current status of that situation at St George Hospital?

Dr CHANT: That is probably most practically addressed by Mr Minns.

Mr MINNS: It was an interesting process of accreditation involving the college and St George Hospital. The perspective of the college was that there were some issues that needed to be addressed and until they were addressed they felt that accreditation should be withdrawn from the program, and that of course affected the trainees. The trainees themselves were I think, if not in 100 per cent terms but certainly in very many of them, quite agitated about the decision because it affected them, and they felt that the measures that had been taken locally addressed the concerns related to culture in the unit. Nonetheless, the position remains that accreditation is not in place at the moment.

The Hon. WALT SECORD: Still not?

Mr MINNS: But there will be a process of revisiting the site and at that point again St George Hospital would make clear the measures that they have taken and the actions that have been put in place.

The Hon. WALT SECORD: Sorry to interrupt you. So what has happened to the junior doctors? Have they been transferred to other hospitals?

Mr MINNS: I think the issue was that they would still be treated as accredited trainees until they completed this year and then in the next year the hospital therefore has to organise to bring in some other career medical officers to cover the gap. And for trainees it can be a situation where they are working as a trainee who is not part of an accredited training program at that point. That is relatively common across the system. Not all of our third-, fourth- and fifth-year doctors are actually on accredited training programs; they are seeking to get on one. All those measures take place and I guess the point I would make is that I think it is in the order of 500 departments across the State that get accredited through the college framework. I think we had a peak of six, which is now down to five, where accreditation was not provided at the visit process².

The Hon. WALT SECORD: There are five units where accreditation has been withdrawn or withheld?

Mr MINNS: Yes, across the whole system, and only two of those reflect issues raised about workplace culture. The others are questions that go to volume of procedures being available in the facility—so it is about that issue of service delineation. If the trainees cannot receive sufficient supervised exposure to the procedures they are learning about then the college will have the view that it cannot be an accredited unit.

The Hon. WALT SECORD: Dr Koff, can you provide the names of those five units where accreditation has been withdrawn. I have another question going back to what Mr Minns said earlier. If bullying occurs in the medical workplace then the victims are taken away—withdrawn. The trainees are withdrawn. Is that correct?

Mr MINNS: No.

The Hon. WALT SECORD: I made a notation "withdrew trainees". So the perpetrators remain but the victims are withdrawn.

Mr MINNS: The circumstances of workplace grievance issues that are raised or bullying complaints that are raised are very particular to the case. No situation is actually the same. What is more complex in a health environment is the role of the medical colleges.

The Hon. WALT SECORD: Yes.

² In [correspondence](#) to the committee received 21 November 2019, the Hon. Brad Hazzard MP, Minister for Health and Medical Research requested a correction to the evidence of Mr Minns by replacing the words 'I think we had a peak of six, which is now down to five, where accreditation was not provided at the visit process' with the words 'Currently, there are six speciality units out of several hundred across NSW Health where the respective college has withdrawn training accreditation.'

Mr MINNS: We are the employer of the young doctors. We are the employer of the staff specialists and the career medical officers. The specialist visiting medical officers, who may be the people who are offering the training on behalf of the college to doctors in training, they are contractors to the health system. The college itself is the body, under the Australian Medical Council, that decides if a facility meets the requirements to have training accreditation. So it is quite a complex arrangement. To that end, the Minister convened about 2½ weeks ago a roundtable meeting with 15 of the colleges. We had college presidents and college chief executive officers and members across the system and junior doctors in training.

The point of that activity was to discuss just where we are with our combined efforts—colleges and the New South Wales health system—to work on culture to create respectful, safe workplace cultures. Four themes emerged from that roundtable that will be the subject of ongoing action groups. One of them is about trying to clarify how accreditation processes work. The second one is to focus heavily on how we support the people who are training our young doctors who happen to be college members.

The Hon. WALT SECORD: What has happened at St George Hospital? Has New South Wales Health investigated what happened there?

Mr MINNS: Yes, it has. Because of the privacy issues associated with that matter I could not say more than the fact that an investigation has occurred.

The Hon. WALT SECORD: What will happen to that investigation?

Mr MINNS: That matter will be dealt with by the local chief executive of the LHD and he will be the decision-maker in respect of that matter.

The Hon. WALT SECORD: When will that occur? When will the report be given to the LHD?

Mr MINNS: I expect it will be before the closure of the year.

The Hon. WALT SECORD: How many junior doctors are we talking about at St George Hospital?

Mr MINNS: It is a large number but—

The Hon. WALT SECORD: Is it 200, 20, a dozen?

Dr CHANT: I think it is better for us to take it on notice.

The Hon. WALT SECORD: Okay.

The Hon. COURTNEY HOUSSOS: I have one last question. Ms Koff, when are you expecting the upgrade of Bulli hospital to be completed?

Ms KOFF: I will take it on notice, if I could, because what its current status is I do not know.

Mr MINNS: I am able to clarify two things that were asked about earlier in the session by Ms Houssos. The Gosford Wyong trial is for 12 weeks or three months, starting 1 November. The three sites for the—

The Hon. COURTNEY HOUSSOS: Sorry, for three months, 12 weeks?

Mr MINNS: Yes. The three sites for the body-worn camera trial that runs for 12 months are the Sydney ambulance centre at Eveleigh, the Liverpool superstation and Hamilton in the Hunter-New England region. It is a split of inner city, major suburban and regional.

The CHAIR: Thank you.

Ms KOFF: If I could list the three Forster-Tuncurry properties?

The Hon. COURTNEY HOUSSOS: That would be great.

Ms KOFF: The three HACC-owned properties in Forster-Tuncurry are: Forster-Tuncurry Community Health Centre, which is at 16 Breese Parade, Forster; the Forster Living Skills Centre, which is at 76 Breckenridge Street Forster; and Tuncurry ambulance station, which is at 58 Manning Street, Tuncurry.

The Hon. COURTNEY HOUSSOS: Thank you. That is very helpful.

The Hon. WALT SECORD: Any update on the efficiency savings for the—

Ms KOFF: No, Mr Secord. I will apologise for that. The only other update I will add is to the issue about budgets and activity. In 2018-19 New South Wales purchased 228,878 episodes of elective surgery and in

2019-20, this year, we have purchased 235,000 episodes of elective surgery activity. There has been no reduction in elective surgery activity. On top of that we do 100,000 emergency surgeries every year.

The Hon. COURTNEY HOUSSOS: Can you say those numbers for me again for 2018-19?

Ms KOFF: Certainly. In 2018-19, 228,878 surgery episodes of activity and in 2019-20, 235,000 episodes of surgical activity.

The Hon. COURTNEY HOUSSOS: Just 235,000 flat?

Ms KOFF: Yes.

Mr MINNS: I have one more. As at August 2019, NSW Health employs more than 3,400 Aboriginal and Torres Strait Islander people expressed as full-time equivalent in the workforce system—that is, 2.74 per cent of the total work force. Of those, 410 are Aboriginal health workers and 14 of them are Aboriginal health practitioners. As we discussed in the last meeting of this Committee, we want to drive that second number up. We are understanding how to do that working with the Queensland health system.

The Hon. COURTNEY HOUSSOS: Thank you very much. I did pay tribute to the way that the department had engaged with the previous Health estimates and the information that you have provided to us. Thank you very much. It has been very helpful.

Ms KOFF: Thank you very much. We do our best.

The CHAIR: The Committee has resolved to provide a 21-day turnaround for supplementary questions. The secretariat will liaise with you in that regard. Thank you for making yourselves available. It has been a great opportunity to ask further questions in this very important health area.

(The witnesses withdrew.)

The Committee proceeded to deliberate.