GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 20 December 2004

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 9.30 a.m.

MEMBERS

The Hon. Patricia Forsythe (Chair)

The Hon. T. Catanzariti
The Hon. Dr A. Chesterfield-Evans
The Hon. A. R. Fazio
Reverend the Hon. Dr G. K. M. Moyes
The Hon. Hon. M. J. Pavey
The Hon. H. S. Tsang

PRESENT

Department of Health
Ms R. Kruk, *Director-General*
Mr R. McGregor, *Deputy-Director General, Strategic Development*
Mr K. Barker, *Chief Financial Officer*
Dr. B. Raphael, *Director, Centre for Mental Health*
Prof. K. McGrath, *Deputy Director-General, Health System Performance*

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

CHAIR: I declare this meeting open to the public. I welcome you to the public hearing of General Purpose Standing Committee No. 2. I thank departmental officers for attending today. At this meeting the committee will examine the proposed expenditure for the Health portfolio. Before questions commence, some procedural matters need to be dealt with. I point out that in relation to broadcasting proceedings, in accordance with the guidelines for the broadcast of proceedings of the Legislative Council which are available for the attendants and clerks, only members of the committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photos. In reporting the proceedings of this committee you must take responsibility for what you publish or what interpretation you place on anything that is said before the committee.

In relation to the delivery of messages, there is no provision for members to refer directly their own staff while at the table. Members and their staff are advised that any messages should be delivered through the attendant on duty or the committee clerks. In relation to giving answers, for the benefit of members and Hansard, could departmental officers identify themselves by name, position and department or agency before answering a question referred to them?

The committee has agreed to the following allocation of time: 20 minutes to the Opposition, 20 minutes to the crossbench, being 10 minutes each for Reverend the Hon. Dr Gordon Moyes and the Hon. Dr Arthur Chesterfield-Evans; and 20 minutes to the Government. However, we are mindful of the request that Dr Raphael be questioned first.

Ms KRUK: Committee Chair, you are aware that Dr Raphael has to appear at a National Consensus Conference in Mental Health—Response to Terrorism and Disaster. Can I also, if necessary, swear in other departmental officers as the need arises?

CHAIR: Yes. I declare the proposed expenditure open for examination. Director-General, or Dr Raphael, do you wish to make an opening statement?

Ms KRUK: No.

Dr RAPHAEL: No.

CHAIR: What is the average waiting time for a psychiatric bed in New South Wales?

Dr RAPHAEL: We do not hold waiting times. Sometimes patients wait in the emergency department but patients are admitted to beds. We do not having a waiting list of patients: we have a bed management system which looks at where beds are available and vacant and we have set in place a number of systems to improve the time in which people might be held in emergency departments while waiting to be transferred into an acute bed if it has been determined they need an admission.

Ms KRUK: Could I add to that because there have been some incredibly good initiatives that have been introduced with the additional funding in the past year, notably the initiatives at Nepean Hospital with the establishment of the psychiatric emergency centre [PEC] facility? What is significant is actually taking a whole-of-patient approach in relation to their movement through a hospital, making sure there are very clear linkages in relation to the treatment of psychiatric patients in an emergency department but also to ensure their moving through the hospital facility and back into the community is as effectively managed as possible.

There has been a significant reduction in the number of hours that patients actually spend within the emergency department and that has largely been through the work of the clinical staff of all types in the emergency department and the linkages that have been made with the mental health staff and mental health nurses to ensure that their care is primary at the outset. I will rely on my departmental officers to give me those numbers because I think they are worth touching on.

CHAIR: Do you track how many mental health patients commit or attempt suicide each month?

Dr RAPHAEL: A number of patients are reported from the mental health system. If you wait a moment I can give you the numbers.

Ms KRUK: Are you aware of the establishment of an independent committee, the Sentinel Events Review Committee, that provides advice in that regard? That information is publicly scrutinised. The department's response to unfortunate deaths within facilities is a public document, I think most recently, Dr Raphael in terms of timing?

Dr RAPHAEL: Yes.

The Hon. MELINDA PAVEY: You said "within facilities"?

Ms KRUK: Are you looking more broadly?

The Hon. MELINDA PAVEY: Yes.

Dr RAPHAEL: The first report of the Sentinel Events Review Committee, *Tracking Tragedy*" was about patients who undertook a suicide act while inpatients. The next report will be reporting on patients who have been discharged from hospital but within a month of their discharge—

Ms KRUK: I have a range of statistics, which are probably of interest to the committee. The official data on mortality rates, as you know, and cause of death including suicide is actually assembled by the Australian Bureau of Statistics [ABS] from the State Registrar of Births, Deaths and Marriages and the State Coronial data. The data is generally available 12-14 months after the end of the year of registration. The latest released data, which is December 2003, of mortality data by year of registration from the ABS shows that the number of registered deaths in New South Wales for 2002 has decreased by almost 12 per cent from 785 deaths in 2001 to 690 deaths in 2002, a decrease of 93 deaths. This has caused the New South Wales suicide rate for year of registration to decrease from 10.4 per 100,000 in 2002, from 11.5 per 100,000 in 2001. Nationally the registered suicide death rate in 2002 was the lowest for New South Wales after the Australian Capital Territory.

CHAIR: Is that the general suicide rate?

Ms KRUK: Yes, that is the general suicide rate.

CHAIR: What about in relation to mental health patients?

Dr RAPHAEL: These are possible suicide deaths because it is only when they are confirmed by the Coroner, but in 2003 there were 108 for the whole year, which is an average of less than 10 per month.

The Hon. MELINDA PAVEY: How does that compare to previous years?

Dr RAPHAEL: The previous year 151, the year before 106, and we go back over a number of years since that has been recorded.

CHAIR: Do you track mental health patients who commit homicide or attempted homicide?

Dr RAPHAEL: They are tracked and reviewed under the department's excellent reportable incident briefing process and the review process set in place by the department with root cause analysis. But, in addition, clinical reviews are usually carried out by the Area Health Service if they have been committed by patients in contact with the mental health service. The majority of homicides are not committed by patients who are in contact with the mental health service. A recent estimate was about a maximum of 10 per cent of people who commit homicide have a psychiatric diagnosis. But that does not mean all of those were in contact with the mental health service. The homicide rate in New South Wales has remained fairly constant over many years.

The Hon. MELINDA PAVEY: That is for homicide, do you have any figures on mental health patients in the system who have committed assaults?

Dr RAPHAEL: If they have assaulted anyone else that would come in as a reportable incident brief. That data is being analysed but we do not have figures on that as I speak.

The Hon. MELINDA PAVEY: That is for any timeframe?

Dr RAPHAEL: Yes.

The Hon. MELINDA PAVEY: But you are looking at that now?

Dr RAPHAEL: We are looking at that now because that comes in under the reporting incidents that has been formalised by the department, and assaults would be identified within that. But that data has not yet been analysed.

The Hon. MELINDA PAVEY: Is that a new procedure?

Dr RAPHAEL: The procedure has been place for a while.

The Hon. MELINDA PAVEY: For how long?

Dr RAPHAEL: For about the past 12 to 18 months.

Ms KRUK: There have been memorandums of understanding between NSW Health and the police for some time. Professor Raphael would know the exact numbers. A lot of that work is actually being progressed through the human services chief executive officers group, which supports a Cabinet subcommittee. I think members would be aware of the fact, following the upper House inquiry led by the Hon. Dr. Brian Pezzutti, there were a number of recommendations that picked up the need to improve the interface between the justice services, the health services and the welfare services, just to mention a few, in relation to mental health generally. That is certainly one issue. The data is one component, but I think what is important is to look at the circumstances and if there are gaps in care that are evident in relation to those particular cases, what we need to do across the various agencies to deal with that.

Dr RAPHAEL: That is being looked after through an interdepartmental committee with respect to outside issues. With respect to assaults within the mental health system that would come under the reportable incident brief, but there is also the violence task force that has met and completed its report. A number of measures have been put in place, including training for staff about the prevention and management of aggression in the health workplace, the zero tolerance and increase in the security framework of all the health services, including the mental health service, and reports that were done under the violence task force. Those could be made available to the committee should it wish.

The Hon. MELINDA PAVEY: Dr. Raphael, in October 2003 you told the *Bulletin* that the number of mental health deaths in New South Wales would be publicly released in 2004. Has that occurred to date?

Dr RAPHAEL: The suicide-related deaths are in the *Tracking Tragedy* report which was released publicly before the end of last year and there is further reporting this year in the Chief Health Officer's report.

Ms KRUK: We are quite happy to make those documents available. From memory, it was at the end of December because there was some commentary about the release time. But certainly the Chief Health Officer's report also picks up on those contemporary data.

CHAIR: Who is the author of that report?

Dr RAPHAEL: Professor Peter Baume is the chair of the ministerial committee and the *Tracking Tragedy* report was released by him.

Ms KRUK: It is a section 20 committee.

CHAIR: Is that the report known colloquially within the department as the Rivers of Blood report?

Ms KRUK: I have never heard it referred to in that respect. I have always heard it referred to as the Tracking Tragedy report. There has actually been some debate as to whether that is an appropriate title in that regard. It is important to stress here that any death of this type is a tragedy, but it is important also to look at where New South Wales sits in relation to comparators. Those figures do offer some encouragement, but I do not think they offer us any room for complacency. The reality is there is a whole range of things we can do within the management of our own facilities and in the management of issues pertaining to mental health patients across whole of government.

CHAIR: If you are not aware of the report called the Rivers of Blood report, are you aware of any other report that is called the Rivers of Blood report?

Ms KRUK: No, I would remember a report referred to by that title. In all strands it is known as the Tracking Tragedy report, and there was commentary at the time—and there has been obviously a lot of discussion about the report's recommendations in the interim; and a lot of action has followed in the last 12 months that has made significant gains. I am certainly aware of the fact that the Minister has met with the Hon. Peter Baume on a number of occasions and he would no doubt indicate if he was not happy with progress.

CHAIR: What period of time does that report cover?

Dr RAPHAEL: It covers the period up to the end of 2003 and the next report will cover the period since.

CHAIR: How many client death report forms were submitted to the Centre for Mental Health in each month of 2003-04?

Dr RAPHAEL: We would have to take that on notice.

Ms KRUK: If you have some photocopy facilities, I am happy to give a copy of this report to you during the course of this session, if that is useful.

CHAIR: Thank you. With respect to taking the question on notice about client death report forms, there is a 35-day time limit.

Ms KRUK: I was hoping that you were not going to get us to do it on Christmas Eve. There are 35 days in terms of timing, are there?

CHAIR: Yes.

Ms KRUK: What is significant in relation to the section 20 report is that we have a commitment to preparing this on a yearly basis. That will come out to the public on a very regular basis.

Dr RAPHAEL: I support the director-general by noting that other States are following our lead in this regard and setting up similar committees.

CHAIR: Crossbench members may now ask questions.

Reverend the Hon. Dr GORDON MOYES: Professor Raphael, you are on the record as saying back in 1996 that you need a large increase in beds and that the New South Wales Government has listened to you and is delivering funds for 300 more beds. Dr Alex Campbell, the acting head of the Central Coast Area Health Service, told the Ben Chapman inquest one year ago that there were plans to treble the number of beds to 75 but that the department could not staff even the existing 25 beds. Has that situation changed?

Dr RAPHAEL: I am pleased to inform you that 75 beds are open on the Central Coast as we speak, functioning, fully staffed and supported by the department and the area health service.

Reverend the Hon. Dr GORDON MOYES: He said at the time that the working conditions were so poor, with staff dissatisfaction, burnout, incapacity to actually do what they want to do with

patients, to help and treat them adequately, that people do not want to go into that system. What strategies have been put in place during 2004 to change that situation?

Dr RAPHAEL: The area director, Ms Sandy Carpenter, put strategies in place both to support and educate staff, and to recruit. The units are functioning now with recruitment and with staff satisfaction. She recently made a presentation to an area review of that service and gave a number of excellent examples of the support programs in place to support staff.

Reverend the Hon. Dr GORDON MOYES: Presumably that was to encourage other areas, so how are other areas across the State changing?

Dr RAPHAEL: All areas are concerned about the issue of recruitment and retention of staff.

Reverend the Hon. Dr GORDON MOYES: Including the Far West?

Dr RAPHAEL: Including the Far West, where some excellent progress has been made. We are appointing a senior officer, who will come on line from 1 January, who will co-ordinate further the work force initiatives. Both in terms of rural psychiatry and mental health nursing, with the initiatives we have put in place we have been able to staff and open all of our rural services.

Ms KRUK: Can I add to that because, despite the excellent work done by the Centre for Mental Health, this is a serious problem and I look with great concern at the number of young graduates who are interested in going into the field of mental health and psychiatry, particularly in relation to speciality, and there is a significant issue here. I think one of the driving forces in relation to the recent amalgamations of a number of area health services was to put in place better networking across the better developed and less-developed areas and one of the drivers was in relation to psychiatric services. I am still genuinely concerned, despite our efforts, to recruit overseas, which we have done. We have got a number of excellent professionals through Professor Raphael's contacts and those of other members within the health system, but there is a serious issue emerging.

We have, I think, under way a number of strategies to look at drawing upon a whole range of other professional groups to provide services to our mental health clients but at the moment the number of psychiatrists coming through the system is short. What has also been significant is that we are employing the services of the Medical Training and Education Council, which is a group that most recently assisted us to provide better networking for physicians across the State. We similarly will ask them to provide assistance for psychiatric services, but it will, I think, be one of the major limiting factors for us in the future. It will require workplace reform. It will require reform in relation to the categories of employees that we utilise in this area and there is also an issue in relation to numbers going within those professions. Beverley, would you like to add to that?

Dr RAPHAEL: No, it is a worldwide problem and it is a major issue. You mentioned Bernard Sartorius, who was previously head of mental health, who said that burnout for the health professionals generally is a major issue confronting health services as well as mental health services worldwide.

Reverend the Hon. Dr GORDON MOYES: Beyond Blue, the national depression initiative, has been very strongly supported by the Victorian and also Commonwealth governments. In what way is the New South Wales Government supporting Beyond Blue?

Dr RAPHAEL: Beyond Blue does provide some programs in New South Wales, however New South Wales invested in the Black Dog Institute and numerous other service-framed services for people with respect to depression. For example, we have funded, through the area health services, the schooling program in partnership with that Department of Education and Training, which focuses on depression in young people, with the aim of preventing and lessening the risk of suicide. There is a program for the older person who is depressed through screening and suicide prevention networks. There are several other programs. A decision was made by the Government that rather than investing in Beyond Blue, they would work collaboratively but endorse local programs which provide service delivery on the ground.

Reverend the Hon. Dr GORDON MOYES: So the national initiative was rejected by the Government?

Dr RAPHAEL: I cannot speak to that. It has not joined but there are further ongoing discussions with the Executive Director of Beyond Blue, Ms Leonie Young, about how we may work better in partnership. A high level of investment was required initially without clear evidence of what the gain would be.

Ms KRUK: Can I stress that Professor Raphael was actually one of the major authors and drivers of the mental health strategy. It is recognised that there are a whole range of groups that have an important role to play in that regard. Beyond Blue is obviously one of those and Black Dog. Each State tends to have a group—as you know better than me—that has formed a core and is actually driving a range of initiatives. We are reluctant to espouse the merits of one of those groups over and above others. They all have a critical role to play in regard to services of this type.

Reverend the Hon. Dr GORDON MOYES: Would you not agree that that was a political decision, not a mental health decision?

Ms KRUK: I would argue very strongly that services of this type do need to have an evidentiary basis. I am not aware of a political decision in relation to this particular group. A massive amount of support has gone into the non-government sector generally and I would say, as a matter of principle, I am incredibly supportive of any organisation that can engender both financial material and human capital support for this particular community group, all politics aside.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I wonder if you could perhaps explain why there was such a long delay in response to the Tracking Tragedy report?

Dr RAPHAEL: Much of the Tracking Tragedy report was already being implemented and the response is now available, as you know. A great deal of material covered in there has already been put in place and under way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But one might have expected that the response would be quite early in the year and that the committee would report annually. I gather that the report has been so delayed that it is not reporting until some time next year, is that correct?

Dr RAPHAEL: The next report from the committee will be in March, to the Minister.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The previous report was in November, was it not?

Dr RAPHAEL: No, it was in December.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: December last year.

Dr RAPHAEL: And it was criticised by many people because it was close to Christmas. The next report could have been provided now. It was not delayed because of the response to the first report but in recognition that people considered it was a bad thing to release it just before the end of the year.

Ms KRUK: You are also aware of the various announcements the Minister has made in relation to additional funding for mental health, from memory I think over $240 million over the next couple of years.

Dr RAPHAEL: Yes, that is right.

Ms KRUK: A number of the strategies in the report were backed with additional resources. I do not necessarily understand the concern about the delay in the report being released, but a number of the strategies were tied in with budget-based proposals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But this report was only released publicly last week. I think I only got it Thursday of last week.

Ms KRUK: It was released early in December, yes.

Dr RAPHAEL: That is the Government's response. Actions have been under way in all of the areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it not the case that Professor Baume was unhappy with the Government's response and, therefore, the Government's response was delayed while the Government and Professor Baume negotiated?

Ms KRUK: That is not my understanding.

Dr RAPHAEL: That is not my understanding either.

Ms KRUK: My understanding is that, having actually attended a meeting with the Hon. Peter Baume and the Minister in the past, I think progress has been achieved. There is no doubt we have always been quite upfront in saying that a lot more work needs to be done, but in relation to the recommendations that Peter Baume identified, I have not been made aware of any concerns raised by him. Professor Raphael, are you aware?

Dr RAPHAEL: No, we have met with him on occasions, as has the Minister, and he is pleased that the report has been implemented in part and is being fully implemented over the time frames listed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think it is satisfactory to take 12 months to respond to a report, the essence of which was foreshadowed by the mental health report?

Ms KRUK: I think the content of the report and the Government's response to the report are probably the most significant issues. The timeliness, if the Committee is critical, I accept the criticism in that regard, but I do think that the recommendations have been responded to substantively. They also raised quite difficult issues. I am aware—and Beverley would be more aware than me—that there were varying views within the psychiatric community regarding some of the recommendations. It is not just a matter of accepting the response holus bolus; it is also a matter of ensuring that the area health services are in a position to actually get action under way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would presumably deny that the department has a culture of secrecy then?

Ms KRUK: I think again what is important in a response of this type is what we actually do. The Baume committee is an independent committee that reports directly to the Minister. The reports are made public. The recommendations of that report and the response may have taken longer than your Committee believes is acceptable—and I accept the criticism—but what is important is what we have done in response to those recommendations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If I could just speak of my questions in response to your response to the mental health report. Because of the problem of accounting for where mental health money was spent, one of my questions was: can you now do a spread sheet of where the money has been spent and at what level, the answer to which was yes.

Ms KRUK: Is that not good?

Dr RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well no, one might have expected: "Yes, it is available on our web site and here is a copy." I now have to ask again and it seems to me to be systematic of the secrecy?

Ms KRUK: You raised—and I understand it was raised in the Pezzutti inquiry—issues in relation to the accountability for the expenditure mental health moneys. A whole range of initiatives was put in place to strengthen those. What is important in the organisational structures that are currently being confirmed in the area health services is the fact that the Director of Mental Health has a defined budget and that the Director of Mental Health has a direct linkage with the chief executive officer so there are no concerns and so that there is tightened accountability in that regard.

The various parliamentary committees can take due credit for those changes being introduced. The transparency is important. It is also significant given the substantial injection of funding for mental health services that we, and arguably more importantly the community, can see the outcomes of that expenditure. Therefore, transparency is an important initiative.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there still a problem with the final examination of graduates in psychiatry?

Dr RAPHAEL: Yes, there are still issues that the final examinations are such that not everyone passes, which is to do with the standards required by the profession.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there not a shortage of opportunity for them to do their viva and graduate? Is it correct that they cannot do their final exam because there is a shortage of viva opportunities? I understand that it is not a question of the quality of the candidates.

Dr RAPHAEL: I cannot comment. We can take the question on notice. However, to my knowledge, if that has happened it has been rare.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand there is quite a logjam in the subject.

Dr RAPHAEL: That could be the case, but I do not know it formally.

Ms KRUK: What was the concern?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are people ready to undertake their final examination in psychiatry but they cannot do their vivas because they are not timetabled to do them by the college.

Ms KRUK: I am not unhappy to take that up with the college if there is a problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I asked a question on notice about the number of psychologists. The committee was provided with an answer, but, interestingly it referred to the fact that psychologists were in allied health professions. There was a stab at the fact that a percentage might be clinical psychologists. What does the department define as a clinical psychologist—a psychologist working in a clinical context or someone who has done clinical psychology specialist training? Far be it for me to suggest that the response indicated that the person writing it did not know what a clinical psychologist was.

Ms KRUK: Speaking as a clinical psychologist, I know what one is. However, I am not sure about the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The question asked how many clinical psychologists there are practising in New South Wales Health. The suggestion is that it is an under-utilised profession in a time of crisis in mental health.

Dr RAPHAEL: We have implemented a major initiative with clinical psychologists and the Australian Psychological Society [APS] in New South Wales and provided a report that is now with the work force division dealing with the optimal ways of using clinical psychologists and psychologists generally as core components of the mental health work force.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, you have had a meeting with them.

Dr RAPHAEL: I have had several meetings with them and they have prepared a report that has gone to the department's work force division.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That report is not yet available.

Dr RAPHAEL: Not until it has been formally assessed in terms of the overarching planning.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When is that likely to be available?

Dr RAPHAEL: Probably in the new year.

Ms KRUK: As you are aware, we briefed the committee on this issue last time we appeared. We are pulling together a work force plan for the health system as a whole. As I mentioned earlier, one of the issues in relation to the shortage of psychiatrists is ensuring we make the best use of a range of other disciplines in this regard. I am quite happy to get back to the honourable member with more detail. His questions were, in effect, how clinical psychologists are counted in the department. Of course, the issue is whether someone is working as a clinical psychologist or whether he or she is qualified as a clinical psychologist. I do not think that our work force data is sophisticated enough to be able to split that up into those categories. We have information about people's qualifications, whether they have a clinical degree, whether it is a four-year degree and so on. However, I would have to seek clarification about the detail.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Given the fact that clinical psychologists are quite expensive, the department is unlikely to have them and not use them in that role.

Ms KRUK: A range of clinical psychologists may not be working in clinical psychology positions. I am an example. I am a clinical psychologist and I may show up in the work force data as such, but I would in no way claim still to have the expertise to practise.

Reverend the Hon. Dr GORDON MOYES: How many adolescents and children were in adult psychiatric beds during the past year?

Dr RAPHAEL: I would have to take that question on notice.

Reverend the Hon. Dr GORDON MOYES: Is there a shortage of beds for adolescents?

Dr RAPHAEL: The Government has funded a major initiative—the Child and Adolescent Mental Health Services Network [CAMHSNET]—to open new beds in this area across the State. There is a progressive development of inpatient as well as community-based services in child and adolescent mental health. This issue has been very actively and supportively addressed in terms of those needs.

Reverend the Hon. Dr GORDON MOYES: I appreciate that, but you did not answer the question. Is there a shortage of adolescent inpatient beds?

Dr RAPHAEL: There has been a shortage. I believe we will have better estimates when we look at the full opening of all the beds, which is underway. Most of the adolescents who have been in adult psychiatric beds have been, on average, about 17 years of age; that is, close to the adult age range. The CAMHSNET program includes specialising nurses for young people who for one reason or another are placed in either paediatric or adult units. Those nurses ensure care is at an optimum throughout the process.

Reverend the Hon. Dr GORDON MOYES: You have told me that things are getting better.

Dr RAPHAEL: Yes.

Reverend the Hon. Dr GORDON MOYES: However, my question is: Is there a shortage in 2004 of adolescent psychiatric in-hospital beds?

Dr RAPHAEL: The shortage has been actively addressed. I have not had reports in recent weeks of adolescents in adult beds. They usually come in as a report direct to the department. The director-general may wish to respond.

Ms KRUK: In various committees that Professor Raphael has appeared before and in comments made by both by the former Minister and the current Minister for Health we have acknowledged that we must increase the acute bed base, but not necessarily at the expense of supported care and a range of other non-acute services. Without unpacking here in any detail and making use of the committee's time, a significant number of new beds have been put online this year and a number are pending, whether it be because of capital works that we need to put in place or some of the work force restrictions. Therefore, without being able to say that there is a shortage in a particular location, I can only echo Professor Raphael's comments that we are building in additional acute beds across a range of locations. That does not replace the need to have better networking, particularly in the adolescent services area. Obviously, acute services are one component. There is also a significant injection of resourcing going into early intervention. Schooling programs are critical. You are aware of the work Roger Wilkins is leading; it is critical and beds are one component of it.

The Hon. HENRY TSANG: In response to a question asked by Reverend the Hon. Dr Gordon Moyes about the shortage of trained nurses I would like to hear about the strategies implemented by the New South Wales Government in collaboration with the Commonwealth Government to overcome the shortage of trainee nurses and how nurses are being trained to move from general nursing to psychiatric nursing. Is there any training for psychiatric nurses to take on some of the work done by clinical psychologists?

Ms KRUK: Mr McGregor has responsibility for nurse recruitment and retention. Many incentives are being offered specifically to attract nurses into the mental health area.

Mr McGREGOR: In the past two years we have been successful in recruiting an additional 3,000 general nurses across New South Wales using a range of strategies, such as Nurse Reconnect. That program has been successful in encouraging nurses who have spent some time out of work force to rejoin. They have been provided with mentoring and other services. We have achieved a very high retention rate with those nurses. It is fair to say that the wage increases recently granted by the Industrial Relations Commission have been a factor. However, a number of categories represent challenges in terms of recruitment of nurses. Recruiting intensive care nurses is a constant challenge and mental health nursing remains a long-term issue that we need to address. In the past couple of years, $5.4 million was allocated to implement a range of mental nurse education strategies to build and market career paths in mental health nursing. We have seen an increase in the number of mental health nurses, but there remains a shortage in that area. It goes back to the number of nurses being trained in universities and we continue press and discuss with the Commonwealth Government ways in which it might improve the undergraduate intakes to improve supply. There is also the issue of the skill mix of nurses generally and we are endeavouring to increase the number of trainee enrolled nurses and enrolled nurses employed in the public health system:

Dr RAPHAEL: A number of the initiatives put in place using the $5.4 million have been very effective in helping us to open many of our rural units. These involved funding the universities with nursing courses for mental health nursing and looking at better undergraduate experience in terms of placements, post-graduate courses and scholarships and a range of other initiatives that have helped enhance the recruitment of mental health nurses. One of the department's initiatives that has been particularly effective has involved mental health nurses in emergency departments. That major initiative has been piloted and it now involves 60 nurses. The group is called the "consultation liaison nurses". I have never seen a group with better esprit de corps and competence. It is a very exciting part of the profession. In addition, we have nurse practitioners. The career development of mental health nurses has been a major initiative within mental health along with the accredited persons program. We have trained a large number of people under the accredited persons program, and most of them have been mental health nurses. They have been trained to write schedules. That has been responsible for decreasing some of the demand on the other services.

The Hon. HENRY TSANG: Congratulations on those initiatives.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is there a director of psychology in each area health service under the new scheme?

Dr RAPHAEL: No, there is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should there not be under the APS guidelines?

Dr RAPHAEL: There is a senior psychologist who may take the role of director in that area. However, the department's initiative includes a director of allied health workers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Clearly there is not much in common between psychologists, physiotherapists and radiographers. Surely, given that you are trying put together a clinical psychology service, it would be good to have a head psychologist in each area?

Ms KRUK: The increased use of psychologists will not solve the problem of the shortage of psychiatrists. I have had discussions with the college, the APS and with the work force area generally. We are undertaking a detailed assessment of the skill mixes we require for various forms of treatment. That is why the use of specialist nurses is being progressed in a number of spheres, whether it involves a nurse practitioner assisted by various protocols or a mental health specialist or psychologist.

I also then look at some of the models that have been trialled overseas. It is making use of a psychiatrist for an initial point of diagnosis, but then obviously having a treatment regime that draws upon various components of care. The reality is that the shortage in this area—and in a whole range of other areas—will be one of the major drivers for us to change, both as to role and skill mix, and a whole range of other requirements. I am reluctant to have another director of a service, for then I would be subject to criticism for having, by definition, too many administrative and non-clinical service-type positions. What I think is important is having a clear sense of a case management approach that draws across a whole range of professions. We have put in place a chief allied health officer, in effect recognising that it is a titular opposition because it does pick up such a range of professional groupings. But that person is not a professional support. The professional support would be provided through the normal channels, as is dictated by the APS.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you accept the contention of the APS that an organisational structure in the New South Wales director of psychology be established within NSW Health to develop the new clinical psychology workforce as a core component of the mental health workforce? Do you accept that proposition—that there should be an organisational structure of New South Wales director of psychology, with appropriate funding within NSW Health?

Ms KRUK: No, because then you run the risk of creating a massive bureaucracy. I have been one of the drivers of putting in place a workforce unit that seeks to bring together all of the disciplines. I think Health has been hidebound by having a stream that looked at nursing shortages, a stream that looked at medical shortages, and a stream that looked at allied health shortages, whereas the focus should arguably be turned around to: What are your patient needs? What are the disciplines that can be used to support the model of care that you wish to introduce? It has been the tightness of those streams that has actually stopped some quite significant changes in the model of care. We do not have enough physiotherapists, as we do not have enough podiatrists, and that is why I am somewhat distressed when I see university courses being abandoned. One of our major pushes is to look at what is the care we have to provide, and then the discipline best able to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you done any comparisons between psychologists and psychiatrists in treating diseases?

Dr RAPHAEL: There is a large amount of data looking at different and specific treatments. The complexity of most patients who come into the public sector system means it is critical that psychiatrists are involved at one level and that the skills of clinical psychologists, as with other health professionals and as with psychiatrists, are used appropriately. So I strongly support what the director-

general has said about looking at the skill mix that is required to deal with the complex and very unwell group of patients who come into the public sector mental health services. Clinical psychology leadership can be provided in a range of ways without having a central bureaucracy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand you are using the spectre of bureaucracy. But surely someone involved in the direction and integration of a clinical psychologists workforce need not be a non-clinical bureaucrat; presumably that person can have professional responsibilities as well.

Ms KRUK: With respect, I am not using the spectre of bureaucracy. I am saying that you need to very much look at the model of care that you wish to provide. One of the most significant changes in the past couple of years was the recognition that psychologists are able to apply to the criteria of MBS. Prior to that time, if you had any disorder requiring some form of psychiatric intervention, you would have to get support from a psychiatrist. What also has been a significant move is for a whole range of nurse practitioners to be eligible for recompense—wrong term, but you know what I mean in that regard. What is important—and it is a challenge that I do not think any health jurisdiction has dealt with effectively—is to look at those workforce requirements on a patient basis, not on the basis of a particular discipline.

One of the most challenging things for me—and I meet with deans of medicine, deans of nursing and deans of allied health disciplines—is to move to a far more integrated health sciences qualification, recognising that there will be a number of common streams of care that sit beneath that, and to build in a far more flexible workforce than has been the case in the past. That carries with it, obviously, the need to have professional support. If you choose to be a psychologist, the APS should quite sensibly say that you should have professional mentorship, a certain number of hours of professional support, as is currently the case. That should not be prescribed by saying: For every psychologist within NSW Health you need to have, say, one director for every ten staff, because in many instances you can get that support from elsewhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is not this very convenient? You are asking for generic jobs, and then effectively not hiring clinical psychologists because they are more expensive? So that a lot of the jobs advertised are very generic, which is consistent with what you are saying, but the suggestion is that you are not willing to pay clinical psychologists, and therefore there are very few of them within NSW Health.

Ms KRUK: Can I say that if I make a comparison in relation to the salaries of clinical psychologists and the salaries that can currently be attracted by a psychiatrist, you are looking at a significant differential. What I am saying is that there will be areas of shortages. A clinical psychologist is not a cheap way out. It is recognising, for me, that there are differences—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, they are not, and that is why I am saying you are not using them.

Ms KRUK: There are different models of care. I think we can make more use of psychologists. I think, in the past, that has been resisted for a whole range of reasons. Professor Raphael has indicated that that is now a part of our figuring in relation to different models of care, but there have been institutional constraints, there have been professional constraints, and there have been financial constraints in being able to do that.

Dr RAPHAEL: And, if I may add, the general mental health professional position is not for clinical psychologists. There are positions for clinical psychologists, and a range of people apply for those general positions. Often, it might be a four-year graduate who does not have any extensive clinical experience at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the worry, is it not: that there is such a shortage, and there are not many opportunities for clinical psychologists, despite the severe need?

Dr RAPHAEL: I believe there are great opportunities for clinical psychologists and, as the director-general pointed out, there is also the initiative that is funded to provide psychology services through general practitioners under the Better Outcomes in Mental Health initiative.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this not just cost shifting? General practitioners do not have either the time or the expertise to provide significant services.

Dr RAPHAEL: I do not personally believe so. I believe it is an excellent initiative. It has enabled an access and support program for very appropriately referred patients.

Ms KRUK: Can I pick that up? If it was cost shifting—were that life be so simple—the issue is that the first point of contact is most often with a GP. And then, to touch on another front, the first point of contact is quite often in the schooling system, and I think we would be negligent in our duty if we did not actually offer some support. Also NSW Health has actually provided some quite significant financial incentives to the GP cohort to facilitate that training. So, if there is a cost shifting, I think we are probably losing in that equation. But, in relation to spectre of care, I do not think we can do otherwise. A number of GPs, in relation to their own career development, are keen to look at opportunities beyond the day-to-day services they would provide as GPs. What has been critical in areas such as Greater Murray—which, I think, has provided some exceptionally good services at those primary healthcare level and also at the acute level—has been the ability to have put in place some effective relationships between a primary provider and NSW Health. Beverley is aware of those.

Dr RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many unfilled positions are there in the community and mental health nurse teams?

Dr RAPHAEL: I cannot tell you that. I would have to take that question on notice.

Ms KRUK: Dr Chesterfield-Evans, we would not collect that data. One of the challenges in workforce planning to date obviously has been that each area health service has collected its own data, and done so in its own way with its own and various codings. One of the ambitions that we now have as a result of the merger is to have a common data set, with common data standards, so that we can get an accurate figure on where our vacancies are in some of the shortage areas. We are better progressed in relation to nursing. Some of the numbers that Mr McGregor referred to are the result of quite detailed analyses of our nursing workforce. Similarly, in relation to the medical workforce: it is a database that I would still describe as being reasonably embryonic. But, in relation to the allied health area, it is something we still have to build up.

CHAIR: Dr Raphael, thank you very much for your attendance.

Dr RAPHAEL: Thank you very much for your indulgence.

(**Dr Raphael withdrew.**)

CHAIR: We will now revert to the normal time frame. Ms Kruk and Mr McGregor, are there any plans to replace the Ambulance Service's EDNA, or emergency department network activation, system?

Ms KRUK: Can I touch on that? I mentioned earlier Nepean hospital as being one of the sites where there is some very innovative work taking place in relation to patient flow: quite simply, looking at what some of the obstacles are for a patient's movement right through the health system—that being from the first point of contact, obviously right back to care within the home. What have come up through those ten sites have been recommendations by clinicians about the fact that we can be smarter in relation to ensuring that patients get to the right hospital in the quickest and most efficient manner—the right hospital being the hospital that provides the appropriate level of service. I am expecting a report on some of those system-wide recommendations about how we can make better use of our ambulance services. The Auditor-General, as you will remember, provided some commentary on the EDNA system and encouraged us to look at it to determine whether there is a better way of ensuring the distribution of patients across NSW Health, but also to do that in the most

effective manner. I am conscious that the Victorian Government has made some changes that are of interest. What is clear is that anything we will do will be done in close consultation with the clinicians. I would like to see what the results of the work across the ten hospital sites has been. A number of the teams that have briefed have personally made some good recommendations about ensuring that patients get to the right hospital most quickly. They have provided some very useful input in relation to ensuring that the best care is provided within the emergency department environment. Bob, do you want to add to that?

Mr McGREGOR: In relation to the emergency department network access program, there has been, as part of our ongoing dialogue with the health services unions, discussions about concerns they have in regard to their members who are ambulance officers. They have asked that we review that in consultation with them to see if there are ways in which we might be able to improve that system. It has been in place only a couple of years. It is built on a United States model. That has been refreshed. We need to look at ours again to see whether we can improve it.

CHAIR: When do you anticipate a new system being in place?

Mr McGREGOR: We have only undertaken to review the existing system in consultation, as the director-general said, with the clinicians, but also with the unions. We will do that rationally over the next several months. But there is no specific time frame or outcome planned.

Ms KRUK: Having seen over the last winter the demands on the emergency departments over that period, the Ambulance Service has put in a range of facilities—I use the terminology carefully because I do not want to cause any upset with the concept of a fat controller—in effect, to try to ensure that resources are used most effectively across the system. What is disturbing in the eyes of the community—and I think this in many ways is an issue we need to address—is that the EDNA system in some way seems to imply that the hospital is closed. I know that honourable members around this table are aware that that is clearly not the case, and that it is a matter of getting patients to hospitals in which they can be seen most quickly. But, in the eyes of the public, if there is an indication of there being a red, the media reports it as the hospital being closed, which is totally wrong. The Ambulance Service has under way a number of initiatives that I think are very encouraging. It has various trials under way across various area health services in relation to the allocation of patients. I will only encourage that. I think that is an important issue.

CHAIR: Arising out of the Nepean hospital's patient flow study, do you anticipate changing the concept of code red/orange/ green?

Ms KRUK: What is more important—and I come back to what I was saying—is that that is a quite small part of the equation. The work that is actually being led by clinicians across the ten hospital sites—which I think the Minister has spoken about in Parliament on various occasions—is that it really does seek to look at it from point of entry to point of acceptances back at home again.

What has been important in the feedback that I have had from a whole range of emergency department clinicians is that we can do a whole range of things smarter and better in relation to care. One simple initiative, which I saw at Prince of Wales led by Dr Sally McGrath, was to look at the staff at the first point of contact; to put in the first contact the most senior clinicians. That had a major impact in relation to the immediate diagnosis, the level of care, and the ordering of the various tests. It is a very simple concept when you look at it from our levels, but one that had a major impact in relation to patient care.

We recognise that the Ambulance Service is a critical component of the care provided in that regard, but it is only one component. The Ambulance Service obviously has to link effectively with the emergency department. Some of the initiatives introduced in the past 12 months have been quite superb. Professor McGrath may want to add to that, she has been leading the initiative.

Professor McGRATH: The Nepean study in the way the red, yellow and green code works has been very interesting. One of the most successful strategies designed by staff at Nepean was to be far more proactive about escalating when the hospital was looking like getting to full occupancy. One of the rules they introduced quite early was that the hospital continue to make sure that it always had six empty beds within the hospital. That is a far more effective escalation plan than reacting when the

emergency department is already full. One of the issues that has emerged through the recent study and work referred to by the director-general is whether we can manage the busy periods far more effectively by a different model.

Certainly this higher level, much more proactive approach, of early warning signs of when the busy periods are coming, early warning signs of when the need is to escalate and mobilise, gives staff a lot more time to look at more effectively discharging people who may be getting close to their discharge, rather than trying to do everything in a crisis environment. This is about moving to a far more proactive, well-planned, building on previous experience, approach. It is that sort of initiative that has now been taken up and looked at across quite a number of other sites, including looking also at when the emergency departments start to get full. When there are only two or three trolley or bay areas available, what can be done to trigger a further reaction across the hospital? It is a far more proactive approach.

CHAIR: Under the Nepean trial, if that is what it is—

Ms KRUK: We have trials at 10 hospital sites.

CHAIR: Who makes a decision for the hospital to go to code red?

Professor McGRATH: Under the current operating system, and there has been no decision to replace that at this time, the staff within the emergency department and ultimately the chief executive officer of the area health service makes that decision.

Ms KRUK: Given that the Auditor-General has picked this up I will have to look at it. What is significant is the ambulance, and I have gone out with ambulance drivers at night on a couple of occasions. I encourage all members to experience that. The ambulance drivers will say that code red seems to be different at different hospitals. They will say that the system is not working uniformly. It was intended to provide an equity, to encourage access. There has been encouragement from a number of ambulance officers, as Mr McGregor said. The health services union has encouraged that to be looked at.

From my viewpoint, clinicians across 10 hospital sites are best placed to say what is the best way to proceed. I anticipate that some of those recommendations relate to the local environment. Nepean has put in place some superb fast-tracking facilities so that when people have a lower level of need, triage five—arguably those who can be seen by general practitioners—are fast-tracked through the emergency department. Prince of Wales and other hospitals have had locally based strategies, but excellent strategies. They have all said that we had to look at the ambulance movements.

When you get an out-of-area patient, obviously one who comes from a significant distance away, that will carry with it a range of consequences that may mean that that patient is in hospital for a number of additional days, it may mean that they do not have the level of tertiary care they require in the first instance, and they are all consequences of the point of first entry. We acknowledge that there probably will be a better and smarter way of doing that. We do not know what that way is as yet and we are waiting on advice from the clinicians.

The Hon. MELINDA PAVEY: What might be the new name for "code red"?

Ms KRUK: That is not really relevant, I argue. I go back to the principles, and Mr McGregor knows the history more than I do: clearly EDNA was put in place to ensure that people were seen in the most timely manner. Obviously you can go to your closest emergency department and you will be seen. The issue was to ensure that ambulances had the quickest access possible. There has to be a network system, there has to be system that ensures ideally that the patient gets to the right hospital with the right level of care most quickly. At some hospitals the Ambulance Service has developed some quite detailed protocols with the area health service. Off the top of my head some of them work in the South Eastern Area Health Service, the old one, and also at Blacktown and Mount Druitt, they are already saying that if a patient has a high-level trauma it is ideal that the patient be taken to a hospital that is set up to deal with trauma in the first instance, as opposed to going to a smaller metropolitan hospital and subsequently requiring additional transport, maybe the next day.

Whatever we call it, the non-negotiables will be a network system, getting the patient to the right hospital at the quickest possible opportunity and will draw up on the expertise of clinicians. As Professor McGrath said, there has to be in escalation protocol. Our hospitals are busy, given that they are ageing, that the demand has been between 3 per cent and 4 per cent higher this year than last year; there are things that we can do smarter. That is a clear call. Having visited each of the 10 hospital sites, as has the Minister, I am confident that the answers are there. But there is not a quick fix on high demand.

The Hon. MELINDA PAVEY: Mr McGregor, when the Committee last meant you said that you were facing reforms because the Ambulance Service was failing to meet its benchmarks for response and turnaround times. We are now three months down the track and the service's figures show that in August, September and October this year there were fewer transports than in 2003. So the patient number demand on the service has fallen. However, the average transport turnaround time has increased by up to 20 per cent; the number of transports turning around within 30 minutes has dramatically increased on last year; the number of responses within 10 minutes has also risen; and the number of crew hours lost while sitting in driveways has gone up by about 52 per cent. Those figures refer to periods after you implemented measures such as ambulance release teams to babysit patients in ambulance driveways. Why are things still not improving?

Mr McGREGOR: There are continuing demands on the Ambulance Service: on the patient load that it carries, the patient transport load, the emergency load, the impact that the low level emergency departments have as well. I do will go back a step, because I want to talk about code red a little more. I first saw code red several years ago in the United States of America, in some respects I am sorry that I did. It was used in San Diego with a network of 20 hospitals. They did not have orange, they had only red and green. It was operated by nurses who sat in offices behind the emergency department. I spoke to them about that because, as some of you would know, we had the infamous "Life Threatening Only" here. I asked them what sort of criticism they received about that system from the community and the media. They could not quite understand my question.

They said, "We do this because it is in the interests of the patient to come to our hospital to get care and treatment in the quickest possible way. If we cannot do it for them at our hospital we arrange for them to be diverted through the ambulance network to one of our five other hospitals or one of the other 20 that operate in San Diego." They actually understood why it worked on how it worked in the best interests of the patient. It is a pity it is not as well understood in New South Wales. That is what the system is about, about coping with surges in demand that inevitably occur, particularly in winter, and at other periods such as the middle of summer on the North Coast where many people holiday. It is unfortunate that it is seen in that context.

We have introduced a whole host of initiatives within the Ambulance Service and the chief executive officer is probably best to talk to that. I will talk about one initiative that has not been publicised. At the moment in a pilot program we have employed a number of nurses who sit behind the call-takers in the Ambulance Service operational centre in Sydney. We encourage some people to talk to them, because they may not necessarily need ambulance transport, they may need a referral or to be encouraged to see their general practitioner. Some may be given advice over the telephone. That is built on call centres that operate in other emergency services around the world. It is a pilot program, it is early days yet, but we are hopeful it will assist do this some of the burden on the Ambulance Service.

Regarding technology, the Ambulance Service talks about fluid deployment, which is something it is working on with the Health Services Union. It means that a vehicle may be declared immediately available after release from transporting and treating a patient and having the patient admitted to the emergency department. They declared themselves immediately available, rather than going back to the station to replenish supplies, they are able to do that by having some supplies at the emergency department. Therefore it is more readily available. These things are not without difficulties but we are working through those as well.

The Hon. MELINDA PAVEY: You are conceding that basically the code red system, although its name will be replaced, because it has been a public relations disaster?

Mr McGREGOR: I have not considered that at all. I said we are reviewing it.

Ms KRUK: To the contrary. We have said we will come into play, whatever eventuates. We could be criticised if we left a system in place that firstly, has received commentary from the Auditor-General; secondly, the staff who are working part of the system have raised it has been of concern; and, thirdly, they have actually given us some very good ways to look at it.

The Hon. MELINDA PAVEY: In relation to my question about the figures I referred to, despite the new implementation we have not seen improvements in the latest release of figures. Do you have a comment on that?

Mr McGREGOR: No, other than to say that the Ambulance Service continues to be under strain to meet the demands imposed on it.

Ms KRUK: I will clarify that. What is important is to look at the fact that admissions through emergency are between 3 to 4 per cent higher than they were.

The Hon. MELINDA PAVEY: Higher than when?

Ms KRUK: Previous years. There has been an increase of 3 to 4 per cent. That is significant in relation to the type of people who present at emergency departments. By definition their needs are far more complex. If you look at the demographics of the population, that will not lessen. Presentations will be more complex, the likelihood of admissions has increased and obviously lengths of stay, by definition, will also increase. We have been fortunate. Professor McGrath will know the data better than I do. Over the past 10 years there has been a reduction in the average length of stay in hospital from 12 days to between four and five days, that has to do with technology, a move to day surgery, et cetera. The pressure on us is very much to do with the aged cohort that we are now seeing. Those figures are of great concern. The Ambulance Service is part of that equation.

What has also been encouraging is the model trialled by the Ambulance Service in relation to the fast responders. No doubt members would have seen them across Sydney, they are the small Subaru vehicles, manned by a paramedic. Their figures are incredibly in proceed in providing early point of care. That was a different level of care driven by the Ambulance Service. As Mr McGregor indicated, we also have to ensure that we have the necessary staff and equipment focusing on emergency care treatments. They are a number of calls on the Ambulance Service that are not associated with that. I do not have an easy answer for that challenge.

CHAIR: Director-General, what are the plans as to Camden Maternity Unit? Does the Government intend to close the unit at the end of January?

Ms KRUK: Chair, I think you would have seen the statement issued by the area health service on Friday. Certainly I noticed it in the media on the weekend. The acting administrator has requested that Dr David Henderson-Smart and I think also Professor Bill Walters have a look at the unit. You will remember, given the comment and scrutiny on this issue last year, that David Henderson-Smart was called in to provide advice in that regard. He has agreed to look at the service again in relation to some concerns raised by staff members. I must admit I am not privy to the particular nature of those concerns, but from my viewpoint the chief executive officer [CEO] has acted very quickly in addressing those.

CHAIR: Does that have a time frame?

Ms KRUK: I am not aware of the time frame. When I was advised of the matter I encouraged that it be done in consultation with the clinical, nursing and midwifery staff. It is an issue obviously of some significance in the community. What is paramount is the safety of the mothers and children who use that unit.

CHAIR: Is that an admission there are inadequate resources?

Ms KRUK: No, that is not an admission that there are in adequate resources. As I think Dr Henderson-Smart indicated at that stage when he did the initial review, work force factors would be our major limiting factor in that regard and patient safety was paramount.

CHAIR: What has Dr Henderson-Smart been asked to do?

Ms KRUK: I do not have his terms of reference. Also Professor Bill Walters is to look at the services again, given his experience in looking at them in the past. He is acknowledged to be both a national and an international expert in this regard.

CHAIR: Are you able to provide us with those terms of reference?

Ms KRUK: I can certainly endeavour to do so.

CHAIR: Are there any plans to downgrade or reduce services at Sydney Hospital?

Ms KRUK: Not that I am aware of. I would suggest that Sydney Hospital, given it is part of an area health service that has a whole range of network facilities, is part of any clinical services planning. I think, Chair, you are aware of the fact that one of the requirements on each of the administrators is that they pull together a clinical services plan. I am conscious that Dr Gordon Fulder at St Vincents is working closely with the ED physicians at Sydney Hospital. I am not aware of any plans over and beyond that. I would certainly encourage as part of the clinical services planning that Sydney Hospital is an important component of that network.

CHAIR: Are there any plans to downgrade or reduce services at Canterbury hospital?

Ms KRUK: Canterbury hospital was one of the 10 hospital sites that we were working on for the sustainable access program. If anything, additional beds were provided to that facility during the course of the trial. I am conscious the general manager in briefings to both myself as CEO and the Minister indicated that the work force was a challenge for him in relation to attracting and retaining VMO cover in a range of areas. Again, Canterbury hospital is part of a broader network. I am not aware of any changes. If you are aware of changes, Chair, please raise them.

CHAIR: I am certainly aware of some rumours.

Ms KRUK: Health is never short of rumours.

CHAIR: Would you take the clinical services plan further? Is there a review across network hospitals?

Ms KRUK: As to the genesis of that, members would be very aware of the clinical services plan that was done in relation to South Western Sydney. From memory, about 500 clinicians across that area health service were consulted to look at the best configuration of both acute and non-acute services to meet the needs of that population. One of the driving forces of that—and we were also very clear about that at that point in time—is the work force limitations. Whether it related to obstetricians, anaesthetists or intensive care specialists, the issue was to ensure that there were safe and appropriate levels of service at each of the hospitals.

The clinical services plan for South Western Sydney was a leading document in terms of the fact that it recognised that certain hospitals would develop particular specialties and that it was a networked service. I need not remind members that one of the issues that was of concern in relation to the South Western Sydney exercise was there was little, if any, communication between Campbelltown and Liverpool hospitals, despite the fact they are less than half an hour apart. What is critical in the development of that clinical services plan, as you know, is coverage of multiple sites, far better professional networking and co-joint appointments with the academic bodies. That is what sits at the heart of the critical services planning.

That area is now well placed. Some of the other areas and some of the work that has been done already in relation to the former Central Coast and Northern Sydney I touched on in relation to mental health services. As Dr Raphael has indicated, there has been a shortage in the past in relation to mental health workers up at the Central Coast. Some of the work that has taken place between Northern Sydney and the Central Coast goes in part to easing that. Some of the issues in relation to

clinical services planning between the newly formed Hunter and New England area health service also has at its heart some better networking in that regard.

What is important is that it will not be a process that is done behind closed doors. It was a very publicly discussed process at South Western Sydney. A lot of professional expertise was drawn upon. What is important is also to involve the community. The Minister's announcement that set in place health care advisory councils with a statutory force behind them is a very clear commitment to do that in an open manner.

CHAIR: Would you outline the proposals for the intensive care services at Mona Vale hospital?

Ms KRUK: There was commentary about that in the paper on the weekend. There are two issues that are being debated. I gather they have been discussed in the House. I need not go over territory that has already been canvassed. Obviously there are a number of sites subject to deliberation. The Minister has made a statement in that regard. The Greater Metropolitan clinical task forces—I think members would be aware of them in their former role as the greater metropolitan transitional task force—are looking at some potential service reconfigurations. They are again driven by work force limitations and the primary issue is the care and safety of the patients. I understand that a document prepared by that group of clinicians and circulated to staff puts forward a various range of options. That is my latest advice on that. You may have more recent advice. I gather there was some discussion about it in the media on the weekend. I presume that relates to that discussion paper.

Reverend the Hon. Dr GORDON MOYES: Director, I remember you speaking with some confidence about the future of recruiting registered nurses [RNs] and the worldwide shortage. What has been the expenditure involved in the Nursing Reconnect program and the results as far as RNs coming into the health service?

Ms KRUK: I want to say a couple of things. At the moment our nursing work force is not sustainable. The numbers coming up through the universities are not enough to meet the needs. I will ask Mr McGregor to identify the shortfall.

Reverend the Hon. Dr GORDON MOYES: I understand that. That is why I asked the question.

Ms KRUK: What in effect we are trying to do—because the area health services are today planning already for the winter demands of next year—we have issued three contracts to attract international nurses, with the intention of going to Europe, Asia and America. I think that was announced publicly a number of weeks ago. We will and have already provided a number of incentives to both overseas nurses and our local nurses to make nursing as attractive as possible, recognising the work force demands. The Nurse Reconnect initiative—and I am sure Mr McGregor is speaking to the right section in the notes—has been a successful initiative on many fronts in terms of bringing back nurses who were part of the work force and may have left for various reasons. We believe that there are additional opportunities to attract nurses back. I will ask Mr McGregor to talk both on the quantum and the work.

Reverend the Hon. Dr GORDON MOYES: Mr McGregor, would you give me how much and how many?

Mr McGREGOR: I am not able to give you how much because the costs are borne by the area health services themselves. Substantially the cost is around mentoring—having someone work with them on a supernumerary basis to reorient them back into the work place, which has changed over the years and is constantly changing. Some additional costs are involved in terms of educational reskilling courses that we have made available to them. They are the major costs associated with it.

Reverend the Hon. Dr GORDON MOYES: The cost of advertising programs?

Mr McGREGOR: Yes, there was an advertising program, but I do not have the costs on me. I can obtain that information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it $4.2 million?

Reverend the Hon. Dr GORDON MOYES: I think that was earlier, from the beginning of the program in 2003.

Mr McGREGOR: Over that period of time. I can report as at November 2004 1,156 nurses have returned to working in public hospitals since the program began operating in January 2002. Of those, 352 nurses have been employed throughout our rural health services. The balance of 700 have been employed in the major urban areas. I suggest, by any measure, that program has been successful in providing opportunities for mainly women who have left the work force to raise their families and have now found a way to be encouraged back and feel comfortable in returning to the nursing work force. I do not have their specific numbers but my understanding is that the retention rate for nurses who have returned is also very high. It is not that we are just attracting them back through a range of measures, we are in fact retaining a very significant number of them. The vast majority of them are staying with us. The program now has been going since January 2002. Because it has been successful, we intend to continue with it.

Reverend the Hon. Dr GORDON MOYES: Mr Barker, what is the trend in workers compensation claims over the past 12 months? What programs do you have in place to reduce the claims? What percentage is involved in patient violence against nurses and allied health professionals?

Mr McGREGOR: I might make an introductory comment and give Mr Barker time to look up his papers, or it is probably in his head. New South Wales Health and the area health services have been shown by a variety of reports to probably be one of the most successful employers in terms of workers compensation and return to work of our employees. One would expect that, given we are a health agency and we provide health services. I think we are probably the most outstanding performer in terms of workers compensation and employee rehabilitation back into the work force.

Ms KRUK: Can I confirm that, having met with the Treasury Managed Fund [TMF] and the head of WorkCover only a couple of weeks ago that New South Wales Health, even in comparison with other health services but as an employer in New South Wales is one of the best, if not the best.

Reverend the Hon. Dr GORDON MOYES: They are the trends. What programs are in place?

Mr BARKER: We have a range. As Mr McGregor said, we would devolve this to the areas. Each area has a risk management officer who goes out in conjunction with their human resource people and looks at occupational health and services issues. There have been a range of initiatives, including reducing the pressures on nurses with their lifting and back injuries. We certainly have had a substantial reduction. If you read the information in our annual report, for example, when we got our final hindsight for 2003-04 which came in post-30 June, it resulted in $51 million coming back to us in the hindsight adjustment.

Our experience in how that is assessed compared to interstate experience and in terms of WorkCover is better than our peers. We do a lot of work and we devolve it down and the results are in the outcome. The health services take a very highly proactive approach reducing the number of injuries. You asked about the reduction in claims. We have certainly reduced our claims. They each do it differently. They workshop twice a year so they can compare what they are doing and take best practice approach in claims management and early return to work and a number provide their own rehabilitation services to improve our workers compensation experience.

Reverend the Hon. Dr GORDON MOYES: Has there been a reduction in the number of claims connected with patient violence?

Mr BARKER: I would have to take that one on notice and get the exact answer to that question.

Reverend the Hon. Dr GORDON MOYES: That was a significant problem.

Mr BARKER: On a materiality basis I do not believe it is because our premiums are around $160 million a year. You have to take these things in context. No-one wants to be injured at work. No-one wants to be assaulted at work. You have to make that point. But on a materiality basis, a lot of our injuries are in the body stressing side of the business.

Reverend the Hon. Dr GORDON MOYES: Can you get back to me with the number of patients assaults on staff?

Ms KRUK: We can, yes.

The Hon. HENRY TSANG: Just following up the question of Reverend the Hon. Dr Gordon Moyes about training nurses, are there enough university places for nurse training? If there are not enough places to fulfil the demand, are there any plans to encourage private institutions to provide training for private students who are prepared to pay extra to be trained as nurses?

Mr McGREGOR: The short answer is that there are not enough nurses being trained through the undergraduate programs. When New South Wales passed responsibility for nurse education to the Commonwealth and universities in the early 1990s, prior to that transfer I think we were training something like 2,400 a year and I think we are now down to just over 2,000. There is a shortfall. As I said, the responsibility is a Commonwealth one. As I said earlier, we are in discussions with the Commonwealth to try to encourage them to increase the numbers that are trained through the university system.

The Hon. HENRY TSANG: Could there be an opportunity for private investors to provide private institutions to train private students?

Ms KRUK: I am not aware of any. I know, having met with the deans of nursing, that a number have overseas fee-paying nurses. I think we have been hitting our head against a brick wall in relation to nursing numbers so far. I am trying to do what I can to look at other opportunities, vis-a-vis TAFE in relation to enrolled nurses and career pathways to encourage others to go through the system. But our cap at the moment is literally the number of nursing places, and that caused some frustration up into the announcement of the numbers this year and also the location of the numbers. Like I said, I feel as though I am hitting my head against a brick wall with this one at the moment. If you have any ideas, we are happy to look at them. There was a meeting of the Health Department heads and the education department heads at the request of the Ministers a few weeks ago, but our cap at the moment is just bums on seats.

Reverend the Hon. Dr GORDON MOYES: Can I answer the uncertainty of the director-general's question and also answer the question of the Hon. Henry Tsang in one fell swoop with an unpaid commercial? Part of Wesley Institute, part of Wesley Mission, has nurse training programs. We have private students. I think there are about 80, or maybe a few less, graduates coming up. There might be 70. I am not quite sure. There is a little fall off.

(Short adjournment)

Mr BARKER: On page 181 of our 2003-04 annual report we talk about risk management insurance.

Reverend the Hon. Dr GORDON MOYES: I looked up some of your estimates.

Mr BARKER: You will notice from there that the number of claims was 7,287 compared to 7,398 in the prior year. You will note also that the majority of those claims, 50 per cent, relate to nurses, although that is a 1 percentage improvement on the prior year and body stress, which, as I said, is manual handling, is around 41 per cent.

Reverend the Hon. Dr GORDON MOYES: This is mainly backs and manual handling, but you should have got rid of many of those claims with lifting devices and new techniques.

Mr BARKER: As I said, there have been a number of strategies about that. You will see also that the claims cost is due to some timing issues, but we are still confident that that will continue.

We indicate there how things are in place. The other question about the violence claims, our information from the fund manager was at 30 June 2004 there were what we call eight open claims. An open claim is a claim that is still current, which related to workplace or occupational violence, which would be assault in the workplace, which is in respect of nurses, which is a very small number at that point in time. But we take the point that we want a zero tolerance working environment, but these things, unfortunately, will happen from time to time.

Reverend the Hon. Dr GORDON MOYES: This question comes from some constituents. I understand in the Hunter there is a requirement to recruit a specialist cardiologist. This person intends to work within private hospitals in the Hunter, but that person is not allowed to work because the Hunter is not declared an area of need. Can you make comment on that?

Ms KRUK: I am just whispering to Professor McGrath, who was a former CEO of the Hunter Area Health Service. There is quite a detailed process that we need to go through to justify for area of need, as you are aware, that links in with the Commonwealth. It is actually much scrutinised by the colleges as well. I might ask Professor McGrath if she is aware of the circumstances surrounding this individual, or I am quite happy to follow it through for you.

Professor McGRATH: I am not aware of the circumstances of the individual, but I think the Hunter would struggle to be considered an area of need for cardiologists. It has a very strong cardiology service that has recruited extremely well.

Reverend the Hon. Dr GORDON MOYES: That is my understanding, and that is why the person is not allowed to come into the area because there are a numbers of cardiologists in that area. Are there areas of need nearby, Upper Hunter for example?

Professor McGRATH: Not within what was the Hunter Area Health Service because you would not provide those services really outside the major specialty. You would have one clinical stream, and that clinical stream goes all around the Hunter, including clinics that started about 12 or 18 months ago in the Upper Hunter. I think there were some particular personality issues in the private sector that maybe—

Reverend the Hon. Dr GORDON MOYES: Could I ask the director-general to follow up?

Ms KRUK: If you would provide me with details, I am happy to. I also have the statement made in relation to Camden Hospital maternity services, which I am happy to table. It advises that the work of Henderson-Smart and Professor Bill Walters will be completed in the New Year following the holiday, and actually details the scope of that review. I am happy to table that for the benefit of Committee members.

CHAIR: Does that include the terms of reference?

Ms KRUK: It indicates their scope, so that goes to the answer you sought.

The Hon. MELINDA PAVEY: Reviewing your hospital waiting list figures from your web site, there is an incredible blow-out in the waiting list of more than 12 months for patients from 2,295 to 9,246 in 2004. Given that the AMA has said that doctors are prepared to work over the summer, why are New South Wales hospitals shutting down on elective surgery activity for up to six weeks?

Ms KRUK: Can I pick up a couple of things there? If it were as easy as working over the Christmas period to solve the waiting list problem, I think it would have been done already. The issue is, and I referred to it earlier, the waiting lists are in large account reflective of the increase in our emergency demands. That is also on similar records, which I think you have accessed. What is important, and it is not a matter of just throwing money at surgery, is having a work force and access to theatre facilities and appropriate backup staff to deal with the waiting list in a structured manner. Members may be aware of a committee chaired by Dr Patrick Creegan involving some of the top surgeons in the State and a number of other clinical staff from various areas that has been commissioned by the Minister to look at how best to address the waiting lists, but also the management of surgery in its entirety. It has been very encouraging.

The Hon. MELINDA PAVEY: But it is largely about money, is it not?

Ms KRUK: No, it is not. If it were largely about money, again I think it is an issue that would have been solved at that point in time. You will remember that the Government, and I may have to be corrected by Mr McGregor or Mr Barker, allocated $35 million in the context of this budget to deal specifically with the long waiting list.

The Hon. MELINDA PAVEY: How much will the six weeks down time save the Health Department?

Ms KRUK: I do not have those figures. I am happy to look into it. The issue is—

The Hon. MELINDA PAVEY: Is that an issue you will get back to us on?

Ms KRUK: Can I also respond? You have asked me a number of questions, and if I can respond, the AMA bases its comments, I understand, on a survey that interviewed, I think, fewer than 10 per cent of surgical staff across the system. I deal with surgeons every day, day in and day out. There is an issue for people to have a stand down over Christmas period. We had a major workshop of surgeons at Ryde last week where this, amongst other issues, was debated. The very clear consensus was that we could manage our access to theatre times far better. We can actually look at the management of the waiting list far better. We can look at quarantining beds, insulating beds is the right terminology, to ensure that we, as little as possible, impact on our surgical waiting lists. We cannot, and you understand this, in effect control our emergency surgery demands.

That is not an issue that the health system has any control over, but you can look at providing greater predictability in relation to access for surgery. I might ask Professor McGrath, who has been leading this initiative, to give you a bit more background. It is not as simple as keeping the hospitals open over the Christmas period. It is quite clear that patients do not want to be in a hospital over that period of time. Can I also say, I know most members would have visited emergency departments, there is an issue also in terms of staff requiring time out. It is not just a matter of one or two staff, there is a full surgical team that is required from anaesthetist, top nurses, intensive care staff that need to be on board over that period, and that is not a period that is highly sought after by patients.

The Hon. MELINDA PAVEY: You mentioned that you would get back to us on the money that would be saved over this period.

Ms KRUK: I do not know that I could provide it with that degree of specificity because it is not a saving. In effect I still have staff in hospitals over that period of time. At this point of time already I have a number of my own clinical staff who are on leave, and I would encourage that. I would not discourage that. I do not see it as being a saving.

The Hon. MELINDA PAVEY: Are area health service CEOs required to report to you on a regular basis on the current financial position?

Ms KRUK: As I have indicated before and as I think is also detailed in the annual report, there are a number of dashboard indicators that affect all areas of the operation of the health system, whether it be quality and safety, whether it be in relation to access for services, whether it be the financial performance of the area health service. Each CEO reports to me in some detail across those dashboard indicators. In addition—

The Hon. MELINDA PAVEY: Is that a pro forma document?

Ms KRUK: Yes. In addition—

The Hon. MELINDA PAVEY: What is the name of that document?

Ms KRUK: It is the annual performance agreement. In addition there are a number of matters they are required to report on, which may be unique to particular service configurations in the area health service. In setting up the combined areas, amalgamated areas, there were a number of

unique challenges that came up in my consultations, that came up in statewide consultations, which would also be included in the performance agreements for the CEOs.

The Hon. MELINDA PAVEY: How many public hospitals in New South Wales are currently over budget?

Ms KRUK: It is not information I control at the moment. All the—

The Hon. MELINDA PAVEY: Is there a percentage or an estimate? Is it a problem? Are you worried about it?

The Hon. AMANDA FAZIO: Point of order: I am actually interested in the answers Ms Kruk is giving. I would appreciate it if she were allowed to provide the answer to the question asked without being interrupted with a follow-up question.

CHAIR: There is no point of order.

Ms KRUK: Can I clarify here? Area health services report on a monthly basis. We are half way through the financial year on the budget.

The Hon. MELINDA PAVEY: When was the last monthly report?

Mr BARKER: The November reports have come in, but they have not been analysed and compiled at this point in time.

The Hon. MELINDA PAVEY: Have the October reports been analysed?

Mr BARKER: Yes, they have.

The Hon. MELINDA PAVEY: How many public hospitals were over budget?

Mr BARKER: We do not get the information specifically on a public hospital. We fund area health services on an annual basis. They have their budget and they then internally distribute that to their cost centres, facilities and locations in compliance with our allocation letter and then they report back to us on a consolidated area health service level.

The Hon. MELINDA PAVEY: Was there pressure showing on the area health services in the October figures that you have analysed?

Mr BARKER: There are one or two health services that we are having discussions with. Others are in their normal cycle. It comes back to one of your earlier questions of the director-general. Health services get a 12-month budget and they do not divide it by 12 and, therefore, expect to spend one-twelfth of their budget each year. They manage their budget over what they believe is the activity levels, there staffing needs and those types of things. These are the organisations and we hope they take a reasonably good, sophisticated approach to how they do their budgeting.

They rely on that for the money from the Government as well as money they retain from revenue charges to cover the costs of the services they have agreed in the performance agreement the Director-General spoke about in terms of delivering that required outcome of services.

The Hon. MELINDA PAVEY: Ms Kruk, the document I asked about was named by you as the annual performance agreement, so that be submitted on an annual basis, but what are the monthly reports called?

Ms KRUK: No, monthly, just finance reports. I would think that chief executive officers in relation to their own hospitals have very regular reports at their own hospital level. We give out a global budget. As Mr Barker has indicated, they manage within that budget across a whole range of services. What has been significant is the significant increases in resources they have received over the past few years, but we also do not shy away from the fact that our demands are also going up. We were unfortunate in having lost a significant proportion of Commonwealth contribution in the

Australian Health Care Agreement [AHCA] agreement that has also caused strains. There are strains in relation to the ageing cohort that goes for our emergency departments but we have been very open about that, and the stresses that has actually caused.

The Hon. MELINDA PAVEY: Mr Barker, what were the area health services that were showing a bit of pressure?

Mr BARKER: South Western Sydney is one that we are in active discussions about their budget result. The Greater Murray Area Health Service we are also in active discussion with and that is part of how and what we have to do. I have been in Health in this area longer than most and we have to go through the areas, we talk to them, we work out a plan, we put a plan in place and then we expect them to abide by that.

The Hon. MELINDA PAVEY: Has that cost pressure at Campbelltown hospital forced the cut-back in so-called nonpolitically sensitive areas, such as speech pathology?

Mr BARKER: I would not be aware of that.

Ms KRUK: Can I pick up that? All of the area health services are required at the moment to develop savings plans to reduce their administrative staff. One of the things that came up in relation to South Western Sydney and also the other area health services was an increase in our administrative staff across the health system. As part of the restructure that is one of the specific requirements they are asked to look at.

The Hon. MELINDA PAVEY: What is the target?

Ms KRUK: Can I finish before I get another question? It is quite clear in relation to areas where there is direct service provision that staff recruitment goes ahead. The issues in relation to clinical staff and allied health staff are not unique to South Western Sydney: there have been difficulties in recruiting staff in a number of locations. The clinical services plan is funded for South Western Sydney and resources are available for there but all of the hospitals, all of the area health services, have requirements to look at their administrative staff. I think also there have been various announcements made by the Government in relation to that money going back to the particular area health service so the benefits stay locally.

The Hon. MELINDA PAVEY: Was a target set for cutting back on administrative staff?

Ms KRUK: Targets are being discussed with various area health services. It obviously depends in relation to the work that has already taken place. A number of area health services have already introduced some quite significant corporate services reforms. You will understand that I have two management structures that are, in effect, being folded into one. So we have had various reviews of their current staffing situation. Most of the area health services are now quite developed in sorting out their organisational structures. Targets will be negotiated with each of the area health services, depending on those structures.

CHAIR: How many chief executive officers of area health services have received pay rises in the past 12 months?

Ms KRUK: As you are aware, the Statutory and Other Officers Remuneration Tribunal [SOORT] made the decision to provide 4 per cent, subject to satisfactory performance. I am in the process of reviewing the performance of all chief executive officers across NSW Health. You will understand that is now half the chief executive officers that I had in the middle of the year.

CHAIR: What long-wait waiting list criteria are set for chief executive officers of area health services in their performance agreements, for example, reduction of long-term wait patient numbers, medical activity and waiting time targets and all waiting time targets met?

Ms KRUK: I will ask Professor McGrath to give detail because this is obviously one of her responsibilities. What we are looking at with the provision of additional resources to focus on surgery are targets that reflect the circumstances of each area health service. So rather than having a target

which is zero in eight years' time or whatever, we are putting in place a series of stretch targets that reflect their current numbers. So that will vary on area health service by area health service.

Professor McGRATH: In terms of waiting list targets, the $35 million that was distributed in the budget in July was designed to achieve an overall reduction of 45 per cent in the long-waits, and the stabilisation of the waiting lists. Now the achievement of that very much depends upon any growth in emergency surgery that comes in because clearly the budgets around surgery are distributed across both emergency and elective surgical work and the funding needs to be distributed. No doubt, we are seeing this year with the growth in the emergency demand that there is perhaps an increasing balance to the emergency end of that spectrum as opposed to the elective. Those targets are to be met by June 2005.

The flowing of those targets and the achievement of those targets is flowed throughout the year. So area health services do very much look at the times when emergency demand is less so the non-winter periods and the non-holiday periods are the times to catch up. So we have seen, I think, about 600 additional cases done in the past month as on the previous month. We have started to see some reduction in the number of people waiting over the past month but we do expect to see a significant contribution to achieving the targets in February-March-April which is classically the time when a lot of work is done on the elective surgical fronts. I think we are really not going to be able to assess the efficacy of the efforts this year until we get closer towards the end of the financial year.

CHAIR: In a question that was taken on notice and answered as part of the process the Minister said that a number of area health chief executive officers had met their target of zero long-wait patients during the past two years. What is that number?

Professor McGRATH: I would have to take that question on notice, I am not across the detail of that figure.

Ms KRUK: Chair, it is very clearly our hope that long-wait patients are eliminated. I was reading on the weekend a United States of America report that looked at the demand on one of the hospital systems there. This is an incredibly imprecise area in relation to being able to accurately predict what is an achievable target because it depends very much on what your throughput is in relation to your emergency surgery. We have always had that as an aspirational target, and that will continue to be the case. What I am now building into the performance agreements are targets which are reflective of various staffing points because the demand is not even across the system. We have far better data in relation to throughput, complexity and the various services that actually impact on that so it will be quite a different and I think a far more detailed process than it has been in the past.

CHAIR: But zero long-wait still remains. You said it is an aspirational target but is it still included in the performance agreements?

Ms KRUK: We intend to have a target that is far more reflective of the starting point. It is very clearly our hope that no patient waits longer than 12 months. Some of the figures in various area health services have been very encouraging and some have been disappointing through a range of factors. We need to look at what has actually impacted on that performance. I have absolutely no doubt that each and every one of the chief executive officers is looking at every possible opportunity to address the challenges of the waiting lists. The enthusiasm with which they have approached the 10 hospital trial and the fact that they are also actively participating in the surgical services review taskforce work, and they will continue to do so. There are a number of factors that are not within our control but there are, equally, a range of others that are, and it is a matter of addressing those.

The Hon. MELINDA PAVEY: Why has NSW Health set a period for payment of creditors as 45 days compared with private sector standard that is usually 30 days?

Mr BARKER: That is not our policy at all. In our annual report you will clearly see the policy of the Department of Health is that creditors should be paid in line with the contract terms or within normal suppliers' terms where there is no contract. We have set a benchmark that we assess health services against. You will also see in our annual report last year three health services exceeded that benchmark of 45 days and we have set differential benchmarks for 2004-05. We are now monitoring the health services on those differentials and with the new combined area health services

we will recast them to reflect the combined structure. But there has never been a policy of NSW Health that health services are allowed to extend the contract terms.

Approximately in October or November a Dunn and Bradstreet national survey of how suppliers, both private and public sector, make their payments showed that we are around two days better than the national benchmark, including a whole range of private sector organisations in mining, agriculture, retail industry, wholesalers and that type of thing.

Ms KRUK: Chair, can I use the opportunity to private a bit more information? In relation to long-waits, while the annual report data actually shows a rise from the previous year in the number of long-wait patients in category 1 and 2 patients who are overdue, what is important to note also in the area is that the majority of patients are admitted for their procedures within the clinically appropriate timeframes. At the end of June 2004, on average, patients who were admitted have waited just 12 weeks for their booked surgery. For medical patients, the average wait was less than 5 weeks. One of the things that is important in the work of Dr Creegan's task force is also to look at being able to provide what is an access to other surgeons. The other point is that it is well acknowledged within the health system that the waiting lists in many instances really do require a lot closer scrutiny to ensure that patients are provided clinically appropriate treatment in a timely manner. Arguably, if surgery can be provided by another surgeon at another facility far more quickly then that opportunity is actually encouraged.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Air Ambulance dispatch system in Newcastle seems to have been favouring Air Ambulance over contracted air ambulances which are being used by the Department of Health because they are cheaper. As an outcome from the Air Ambulance report which was released on Friday, is it the policy of the Health department that there will be neutrality between ambulance and private ambulance, if you want to call it that, in the dispatch of ambulance and co-ordination with the air ambulances?

Mr McGREGOR: Are you talking around rescue helicopters?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were arguments about the dispatch of rescue helicopters and the lack of utilisation in Wollongong which is, to some extent, addressed in the report which says that there will more or less be standardisation. But I am referring to fixed wing aircraft doing transport and having difficulty liaising with ambulance dispatch or going from the airport to hospitals, particularly the Newcastle area.

Mr McGREGOR: Other than clarifying a couple of points, I think I will have to give you a more detailed response than I can give today. But in terms of the tasking of helicopters in Newcastle, unlike most of the other State, they are actually tasked by the local operation centre, not by Sydney.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am asking about local operation centres. If a patient is going on an inter-hospital transfer or any other ambulance function, are they taken by an ambulance owned by St Johns or by an air ambulance contractor, will there be neutrality in terms of the despatch procedures?

Mr McGREGOR: My understanding is that the Medical Retrieval Unit, which is based in Sydney, tasks the most appropriate and relevant form of transport, be it a helicopter if retrieval is needed, or a fixed wing if it is simply patient transport, or whether it is by road ambulance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you will guarantee that there will be no preference given to one form of ambulance over another; it will be done on clinical need?

Mr McGREGOR: It is based on clinical need and on the utilisation of the resources that we have available.

Ms KRUK: If there is a specific concern, let us look into it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have written to the Minister about this concern.

Ms KRUK: We will follow that through.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I just want to get the policy. The problem was that a private aeroplane, chartered for an interhospital transfer, had difficulty getting a road ambulance to meet it.

Mr McGREGOR: I see.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the air ambulance being used is not a St John's ambulance but a private plane being chartered by the Health Department in order to save money because they are cheaper—

Ms KRUK: So it was ground support that was your concern.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Lack of ground support was the problem.

Mr McGREGOR: If the private contractor was tasked to transport the patient and then from the airport to the hospital road transport was needed, it should have been provided by the Ambulance Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is correct. I ask that it be done on medical need grounds. Since it was an interhospital transfer the Health Department was intimately involved, and I want to guarantee that this will be neutral in terms of the allocation of work.

Mr McGREGOR: We will certainly look into the particular case that you have raised but we do not have that as a general issue being raised with us across the State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But certainly it has been raised with regard to helicopters. This Committee considered the possibility of an investigation into that. We are looking at neutrality in terms of the use of helicopters and I am asking for neutrality in terms of use of contract—

Mr McGREGOR: We will check it out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You will not give me a policy guarantee that you will be neutral?

Mr McGREGOR: I think that there is neutrality, but you are only talking about—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it the policy to be neutral?

Mr McGREGOR: No, in terms of neutrality, what you are saying is that here we have a situation where a private contractor with a fixed wing was tasked by, probably the Medical Retrieval Unit, to bring a patient to a place where they needed then to have road transport. That road transport should have been provided by the Ambulance Service. You are saying that it was not. I am saying that it should have been. It is not a question of neutrality but what is appropriate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am asking that the general policy be neutral between who is providing the transport and for it to be by medical need.

Mr McGREGOR: We have a fleet of fixed wing aircraft, which are essentially provided to us by the Royal Far West Flying Doctor Service. We task those facilities as appropriate. If they are available they will be tasked. If they are not available, then we look for other methods, including the private sector but, by and large, we task our vehicles first if they are available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you use the private sector I am asking that they be treated the same as if you use the Ambulance Service.

Mr McGREGOR: And I am saying that they are. You have given an example of where they were not and we have said that we will investigate that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So your policy is that they will be.

Mr McGREGOR: They will be treated the same.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Thank you. With regard to hospitals closing down over Christmas, Ms Kruk gave a long explanation about different ways of approaching waiting lists. Surely, if doctors are willing to work and the waiting list is there, shutting a hospital for six weeks must have an adverse effect and must be resource-related?

Ms KRUK: Can I just pick it up and Professor McGrath will respond. One, I clarified that hospitals will not be closed over the Christmas period.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They will be closed to elective surgery.

Ms KRUK: Second, it is not a matter of a surgeon being available; it is a matter of a full team being available—anaesthetists, specialists, nurses and the like. Third, it is a matter of people being prepared to be listed for treatment over that period, so there are a range of factors.

Mr McGREGOR: You need a patient to perform surgery. That is all I am saying.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely, you are not telling me that patients on the waiting list for more than 12 months are being precious about not being available for surgery for the six weeks over Christmas?

Professor McGRATH: If I can comment, as a former chief executive officer who has tried to run one of these programs, and also about how funding for elective surgery works, and in terms of the additional funding distributed this year, it is very much a need to give the team a break over January and you do struggle to find complete teams who are prepared to keep elective surgical lists going through January. Also, you often struggle to find patients because they go off to their families, and a whole range of issues.

That is also true in the private sector. As someone who is married to a surgeon I know also what applies in the private sector. You will find that even private hospitals now, particularly in my experience directly in the Newcastle area, close over the Christmas period for exactly the same sorts of reasons. The funding that we give out around elective surgery is cash flowed for 12 months, so the discussions we have with those areas are when their peaks of activity are going to be in order to expend the resources they have on elective surgery, and they do factor that by particularly striking cyclical events, which is the winter period, when they do control the amount of elective procedures in order to meet emergency demand. The other is the need to give the system a break over Christmas because that is what staff and patients say they want.

It does not impact on your budget because you save the money you do not spend then and you gear up to do a whole lot more work in the February, March, April period.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are saying that the six-week close down does not affect the waiting list and is not resource-related?

Professor McGRATH: I am saying that it is not resource-related. The cash flowing is over the 12-month period and the areas need to look at how they are going to achieve their elective surgical targets over a 12-month period and they do have periods of high activity and they have periods of low activity and that is fine.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you cannot presumably do more activity than a certain amount because you then pay a lot of overtime. It would be better to pay normal day rates surely? If you do not have sufficient money to run the theatre for 12 months but only for 10½ months, then effectively it is a resource question.

Professor McGRATH: You have sufficient money to do an agreed level of activity and it is how you phase that level of activity. You do not have an open-ended resource for elective surgery. Each area health service goes through a process of determining what resources they are going to give to elective surgery and how many cases that will do over the year and then they schedule those at varying intervals over the year. You often find that if you give surgeons full scope, they can often complete what is a year's work in six months, if it is totally unfettered. But there is an agreed resource, there is an agreed level of activity and that is flowed, timed and scheduled over a 12-month period.

The biggest issue that stops you getting completion of that tends to be the amount of emergency work that is coming in through the front doors. It has been commented here previously that in the last 12 months that has been in the order of 3 per cent to 4 per cent. We are also seeing on the system the impact of the elderly and the ability to move elderly people through the various processes around elective surgery is proving much more time consuming.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These must surely be long-term trends, though. If the number of patients being targeted, tasked or scheduled is less than the number needed, surely you will get an everlasting increase in the waiting lists, and that is what is happening.

Professor McGRATH: The targets are there and the resources are there to achieve those targets. The thing that has been impacting in a big way is the growth in emergency demand, which has been higher than we were predicting and that 4 per cent has been higher. Part of what we have been doing around the access block improvement process is to really try to understand why that demand is coming in. I think it relates to a whole range of issues, particularly in nursing homes; for example, access to general practitioners to provide on-site services within nursing homes. As you get issues arising with the frail elderly, often general practitioners find it takes a lot of time and they will often refer them to the local hospital where they believe there is more time to sort out what are often multiple problems. These are the issues that are really impacting on our ability at the moment to achieve the outcomes.

Ms KRUK: Can I say quite simply, first, theatres are open over the Christmas period because we clearly have emergency surgery, which continues over that period of time. Secondly, if the surgical taskforce believes that this is going to be an effective way of actually ensuring more theatre throughput, I would welcome a recommendation along those lines, but they have basically said there are far more gains to be had by looking at the hours in relation to theatre covering, looking at the scheduling in relation to theatres, the operation, the backup staff. They have been quite unequivocal in their advice to me and the Minister that there are better and smarter ways of doing it. There was a lot of distress at the coverage in the newspaper by the surgeons that this could in some way be a fix to take away their holidays, so it was an interesting theory. Were that it were so simple.

Reverend the Hon. Dr GORDON MOYES: I would like to ask about public-private partnerships between the department and, in particular the troubled area of Port Macquarie and Mayne Health. We could ask a thousand questions about that.

Ms KRUK: I could only answer very little probably.

Reverend the Hon. Dr GORDON MOYES: What legal costs has the department incurred in the attempt by Mayne Health to flick past the contract to Affinity Health Care?

Ms KRUK: I will bow to Mr McGregor's knowledge, but as we are actually still involved in potential for litigation with that company, I do not think we are in a position to provide you with a figure. I am also, you will understand, incredibly cautious as to what I can say in this arena or any other.

Reverend the Hon. Dr GORDON MOYES: Is there a problem revealing the legal costs to date?

Mr McGREGOR: I do not have them before me at the moment but certainly we can provide them to you. Whilst that litigation is on foot, we will continue to incur some costs associated with that.

At the same time, we are in discussions, as a responsible department, to attempt to minimise any costs associated with that litigation by having discussions with Mayne.

Reverend the Hon. Dr GORDON MOYES: Are there any other public-private partnerships?

Mr McGREGOR: I do not think it is fair to call Port Macquarie a public-private partnership in the sense that we understand them now. It was a pilot program in the early to mid 90s. It does not have the hallmarks of a classic public-private partnership. Under public-private partnerships, as we understand them now, as they matured at the end of the contract period the physical facilities are returned to government. Unusually, in this case, this is a build, own and operate, where, at the end of the contract period in the year 2014, the facility remains in the hands of the operator.

The Hon. MELINDA PAVEY: Did you attempt to have that contract rewritten so that the public would own the hospital at the end of 2014?

Mr McGREGOR: It takes two parties to rewrite a contract.

The Hon. MELINDA PAVEY: Did you attempt to?

Mr McGREGOR: If the other party is unwilling to do that, then it cannot occur. To rewrite the contract in a way that would be more fair, yes, we did have discussions with Mayne about that. They were futile because Mayne only saw that it would be to their disadvantage, and I can understand that.

Reverend the Hon. Dr GORDON MOYES: In other words, your feeling is that that was a very generous Government offer at the time?

Mr McGREGOR: I think the Auditor-General has already reported on the fact that under the arrangements that were entered into, the Government of the day effectively paid for it twice and if the Government wishes to have it in some way, through settlement, returned to the public hospital system, it will have to pay for it a third time.

The Hon. HENRY TSANG: I was interested to hear about the loss of revenue from the Commonwealth-New South Wales agreement. Can you tell me how the agreement was written down and how ongoing discussions are progressing about whether the New South Wales system is going to hand over to the Federal Government?

Ms KRUK: I think there has been a lot of discussion about the impact of the reduction in the agreement on the New South Wales budget so I do not need to restate that. It has had an impact on us quite clearly and I might get Mr Barker to give a bit more detail. I am certainly aware that there have been discussions at the COAG level between the Prime Minister and the Premier about the desirability for reform. New South Wales has, for a number of years, already put various proposals on the table, health share being one of those, whereby we have been more than happy to put forward the concept of a combined pool of resources from which the best collection of health services can be provided, irrespective of whether they are Commonwealth or State in their origin. I know that Minister Iemma has been a very strong advocate in relation to pushing the reform agenda in his term of office.

At the moment we are awaiting some indication from the Federal Government. I understand it has set up a task force lead by a former head of Health, Mr Andrew Podger, to assist in forming the Commonwealth position. This matter has been discussed at all of the previous Health Ministers' meetings. New South Wales has been one of the major advocates for reform. Mr Barker will summarise the impact of the cuts on our budget.

Mr BARKER: There are two issues. When we signed the 2003-08 agreement the Australian Government revised its indexation provisions downwards. That resulted in a reduction in New South Wales funding over five years of about $95 million to $14.107 billion to $14.0102 billion. Australia wide that is about $150.6 million, which is from $41.9 billion to $41.8 billion. The Commonwealth Government revises these forecasts on a regular basis. Compared to when we signed the agreement, we now know that under these sharing arrangements the Commonwealth Government is supposed to

give New South Wales $2.554 billion, but the State received $2.547 billion, which is a reduction of about $7 million. That is a direct reduction in the money coming to New South Wales Health to provide health services. That is under the methodology we agreed with the Commonwealth as to how to go forward. The other interesting fact is that in 2003-04 for every $1.61 in total funding that the New South Wales Government contributed, the Commonwealth contributed $1.00. In 2004-05, for every $1.65 the New South Wales contributes the Commonwealth contributes $1.00. It is a problem; we are not getting anywhere the growth we need in New South Wales.

The Hon. MELINDA PAVEY: I refer to the earlier question about payments. Given that the Auditor-General recently noted that area health service annual reports on the number of creditors not paid within 45 days does not reflect performance at all times of the year. What efforts is the department making to ensure that creditors are paid on time all year, not only when it makes annual reports look acceptable?

Mr BARKER: The 2004-05 allocation letter strengthens creditor reporting. As I said, we have now given health services differential benchmarks that we expect them to comply with. We have also improved the level of reporting. Not only are they required to give specific information by various times so that we can monitor them, but they are also required to provide specific information about major creditors. We ask them to identify what issues are in dispute. From time to time there are disputes with suppliers about quantum, quality or price. We explicitly exclude them. We have improved that area. We have also put in place some specific internal controls at a health service level to ensure that the value of orders is being raised within available funds and linking back into the overall recruitment process, which includes an assessment of the capacity of areas to engage additional staff within budget. That comes back to the full-year budget and how turnover is moving. In that arrangement they must factor in the frontline clinical staff and turnover issues they normally experience so that they can pull together the situation to get some liquidity. We have done that because we want them to focus on planning the costs of those decisions rather than reacting when the invoices have to be paid and trying to work out how they can pay. We have asked them to plan forward.

The Hon. MELINDA PAVEY: Many of those improvements probably came about because of various instances, for example, the Southern Area Health Service racked up bills of $10 million last financial year. How is that area health service going in paying those bills?

Mr BARKER: I was there about three weeks ago. There is still a problem with ACT patient flows. Apart from that, my view from the discussions I had with the administrator and his senior staff is that it will comply with the financial agreement for 2004-05.

The Hon. MELINDA PAVEY: So Stuart is doing a good job.

Ms KRUK: Of course he is.

Mr McGREGOR: I refer to the implication that the private sector pays within 30 days. A couple of surveys have been conducted by Dunn and Bradstreet showing that the average payment time in the private sector two years ago was well in excess of 50 days. It is now down to 48 days. Our requirement of the area health services is more stringent than that applying to the private sector.

The Hon. MELINDA PAVEY: But the Southern Area Health Service was not even meeting a 100-day payment schedule.

Mr McGREGOR: As you know, Mr Scott is dealing with that issue.

The Hon. MELINDA PAVEY: I refer to Accenture reports to New South Wales Health. Is that company undertaking the report referred to earlier in respect of code red?

Ms KRUK: I said that that organisation won the tender to work on the ten trial hospital sites with sustainable access programs. Some of the issues being raised in that work relate to the use of ambulances between the hospitals.

The Hon. MELINDA PAVEY: What is the tender price for Accenture to provide that work?

Ms KRUK: I would have to seek advice on that.

The Hon. MELINDA PAVEY: How many hospitals in New South Wales are not fully airconditioned? I would like a list of them.

Ms KRUK: I will take that question on notice. We may have provided some information on this previously.

Mr McGREGOR: I think we have. I am confident in saying that virtually all patient care areas in rural hospitals have airconditioning or air cooling. However, I will take the question on notice. Unlike the situation 10 or 15 years ago, the department's policy is that any major refurbishing or rebuilding must include airconditioning. We also have sustainable energy programs to combat the cost of that work.

The Hon. MELINDA PAVEY: I refer to the clinical information systems. What is the total budget of the department's new hospital software project—the patient administration system and the clinical care system?

Ms KRUK: I would have to take that question on notice.

The Hon. MELINDA PAVEY: It was reported in *The Australian Financial Review* that $160 million has been spent.

Ms KRUK: I would have to check that. We are aware of that article and a number of aspersions in it. I am happy to provide that material.

Mr McGREGOR: We have had a number of patient administration systems in place for many years that we have bought and sustained. It is a question of when we start counting and what we have spent on the systems. We need a time frame.

CHAIR: I refer again to the Accenture reports. Does the information you have undertaken to provide include the details of which reports Accenture has been commissioned to write?

Ms KRUK: I understood the honourable member wanted the cost of the Accenture exercise. I am happy to be corrected, but I gather there have been various FOI requests about the reports. It is significant that this is not an exercise being carried out behind closed doors; in many instances it has been widely reported to the local community. At the heart of it is using outside facilitators to work with hospital staff to improve services provided to patients. That is hard to argue with in terms of the merits of the proposal. As I have also indicated, the Minister and I have been to all the hospital sites and some of the results are really encouraging. We do not have a silver bullet in New South Wales Health in terms of being able to fix it on that basis. However, some of the recommendations have been superb, whether they relate to speed of access to services or efficacy in getting community care. They are at the core of services we provide. I hope that all honourable members, irrespective of the politics involved, will understand that this is fundamental to the next steps of reform in health. I make that plea.

CHAIR: What hospitals were covered by with the report?

Professor McGRATH: Nepean, Westmead, Royal North Shore, Gosford, Liverpool, Campbelltown, Canterbury, Prince of Wales, St George and Wollongong hospitals.

The Hon. MELINDA PAVEY: I refer to area health service amalgamations. What is the most recent estimate for the number of job losses from area health service mergers? You have made it clear that they are targeted at the administrative area.

Mr McGREGOR: We have been going through a process with the administrators. First, we have appointed the chief executive staff to take effect from 1 January. We have recently advertised and recruited the second tier. Over the next few weeks we will review their total staffing structures under the disaggregated system and what they will be under the aggregated arrangements. We expect

them to submit to us what they believe they will achieve in administrative savings and efficiency improvements from those mergers. They have not yet provided the details of those numbers; we should have that information in mid to late January.

The Hon. MELINDA PAVEY: Once those savings are identified, will the area health services be able to keep them within their budgets?

Mr McGREGOR: They will be able to retain the savings, but they must be devoted to clinical services, and we will monitor and audit that over time. The savings accrued will come from a number of sources over two or three years. The Director-General has referred to shared corporate services, and that is another step we will take to achieve further savings.

The Hon. MELINDA PAVEY: There will be savings from administrative staff positions that are no longer required. However, you are also saying that there will be savings because of the corporatisation.

Ms KRUK: Not corporatisation. It must be understood that one of the big drivers was that we had 17 separate health departments. They could have had 17 different salary systems and so on. So a number of system-wide efficiencies can be introduced by way of corporate services reform.

The Hon. MELINDA PAVEY: Not only staff losses.

Ms KRUK: Yes. That is the grouping we have introduced. Obviously that will involve a range of things such as information technology systems and so on.

The Hon. MELINDA PAVEY: We who will keep those savings?

Ms KRUK: The commitment is that they will go back to patient services. The amalgamation of area health services is clearly about combining two administrative structures into one. The honourable member talked about Stuart Schneider already having done some good work in the Southern Area Health Service. He has taken a number of steps, so his staff savings will be somewhat different from those achieved in, for example, the metropolitan area. All of the money saved from corporate services or amalgamation savings goes back to frontline services. That is a clear commitment.

The Hon. MELINDA PAVEY: In each of the regions in which the savings are made?

Ms KRUK: Yes. It is hard to work out in some areas in relation to how the benefits will accrue. However, there will be so many people watching us on this that it will be a much-debated issue. The savings go back to clinical services. I am sure that the honourable member also understands that a number of our clinical services are not provided within only one area. For instance, Liverpool Hospital is important in providing support services to many rural and regional hospitals. Obviously, we have networks in addition to normal area boundaries.

The Hon. MELINDA PAVEY: What happens if employees refuse to take redundancy? Will they become unattached public servants?

Ms KRUK: The pattern across the public sector is that the response to offers of redundancy has been more than able to meet the requirements of the various administrations. I think that will be the same for New South Wales Health. The department is arguably the biggest employer in the Australian context. We will make every effort, as is our policy, to find appropriate positions for displaced staff. However, we will also encourage redundancies. The experience in the Southern Area Health Service has been very good. The issue is to ensure that it is targeted at the appropriate positions, and they cannot be clinical services.

The Hon. MELINDA PAVEY: Were NSW Health employees excluded from the eight new director-general of corporate service positions?

Ms KRUK: The decision was taken—and this is in accord with what I believe to be appropriate human resource practice—in the first instance, to advertise those positions within the New

South Wales public sector. That was done for a number of reasons, including firstly the intention of reducing our overheads on displaced staff, but secondly because health administrations right across the country and internationally continually approach us and take our staff. It is, arguably, despite the size of the industry, quite a small cohort. Where it has not been possible in the first round of interviews—which are taking place this week—to find appropriate staff, those positions will be advertised more broadly, in other words, across Australia.

Reverend the Hon. Dr GORDON MOYES: Could I direct a follow-up question to the director-general?

Ms KRUK: I am sorry, but Mr McGregor is correcting me here. Second-tier positions initially were advertised within NSW Health only. I advertised the CEOs more broadly. My apologies.

Reverend the Hon. Dr GORDON MOYES: Were multiple interviews held for those CEO positions? It seemed to be that the same names were coming up again.

Ms KRUK: The interview panel for the CEO positions was made up of Dr Col Gellatly, myself and Dr Neil Shepherd. In many instance, the applicants applied for only one position. In a smaller number of instances, they applied for a number of positions.

Reverend the Hon. Dr GORDON MOYES: Did you interview a number of applicants?

Ms KRUK: We interviewed over a number of days. Applicants asked to be considered, I think, in a small number of cases, for a number of positions, and they indicated a preference for the position that was their first choice.

Reverend the Hon. Dr GORDON MOYES: The criticism in the press was that it was from a closed circle.

Ms KRUK: The criticism within the press I noted. I come back to the fact that NSW Health employees are very highly sought after by every other health jurisdiction. Having just undertaken a recruitment action for the head of the Clinical Excellence Commission, where we looked both nationally and internationally, I am confident that our people compare more than favourably with anyone within Australia and also internationally. I was also quite clear that, where it was not possible to find someone suitable for the position, I would advertise externally. That was made quite clear to all involved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The suggestion made was that people applying for the jobs were already in them. How many people applied for the positions and were interviewed for the positions?

Ms KRUK: I would have to check. In the normal manner, we short-listed a number of applicants for interview, and a number were culled and not considered appropriate for interview.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many positions were there?

Ms KRUK: There were eight positions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many people were interviewed for those eight positions?

Ms KRUK: Off the top of my head, I cannot remember. I recall we culled; in other words, a number of applicants were not considered suitable for interview. Given the number of positions that we were advertising for, we just applied the normal merit principles in that regard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So how many of the eight positions went to people who were already working as area health service CEOs?

Reverend the Hon. Dr GORDON MOYES: I think eight.

Ms KRUK: No. Dr Claire Blizzard was not working as a CEO. You would expect, if there were 17 area health services, and thus 17 CEOs going down to eight positions, you would have a former CEO being a very competitive applicant for the position. What is clear is that a number of the CEOs actually elected to go for positions different from the ones that they were currently occupying, because they are quite different area health services. For instance, in relation to the amalgamation of Central Sydney and the former South-western Sydney, that is a considerably different job. The amalgamation of Hunter with New England will also bring with it quite a range of different challenges, as was the case with Stuart Schneider. So they are quite different jobs. You would also expect that we would already have some very competent and well experienced CEOs who would be more than able candidates. I have, in the last six to twelve months, had a number of my deputy CEOs and CEOs become CEOs in other health administrations, so I was more than conscious of the market, and had already sat on panels for interstate applicants.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will those who were not successful be eligible for redundancy pay?

Ms KRUK: In the normal manner, I think that proposition has already been made to them. They are, technically, unattached at the moment. They are obviously free to apply for second-tier positions or for other positions within NSW Health. If there is no position available for them, their contract obviously ceases. Mr McGregor, do you want to add to that?

Mr McGREGOR: A number of them will be eligible for, and probably will apply for, VR.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For redundancies?

Mr McGREGOR: For redundancy. Because they are SES, they will have to apply to the Statutory Officers Remuneration Tribunal for compensation.

Ms KRUK: It is actually not technically redundancy. That is why I was being careful in my language.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With regard to medical indemnity, I asked the Minister a question on 14 September about using the Utah model, and the reply was regarding the open disclosure standard, which apparently was from the Health Ministers meeting in July. Does this mean that there will be a situation where there is open disclosure? And, if there is open disclosure, will the health department meet the costs of medical indemnity of people employed by it?

Ms KRUK: I am not sure of the background of this.

Mr BARKER: The medical indemnity, I think, was about the Utah model referred to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, it was.

Mr BARKER: I think you actually provided the transcript.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I did.

Mr BARKER: It was about three or four years old. The way that medical indemnity works within NSW Health is quite clear. If you are an employee, and you are acting in your normal approved work practices with the consent of your supervisor, which would involve open disclosure, and if there was then an issue in which you were involved, you would be covered by the Treasury Managed Fund [TMF] for any claim made against you as a result of that open disclosure policy. If you are an independent contractor—which would be a visiting medical officer—and you had your signed services contract and you had also accepted your contract of liability coverage for your public patients—again, providing you were doing so consistent with our requirements—you would be indemnified. If you did not elect to be within the Treasury Managed Fund, that would be a matter between you and your own medical defence organisation if you were then taken on. My understanding is that virtually every VMO has agreed to TMF for their public patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that they get separate representation should there be a difficulty?

Mr BARKER: Within the TMF, we have separated the VMO pool, and they have separate legal representation where there is a cross-claim involving a VMO and a health service, to protect the interests of both the health service and the VMO.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that so also for salaried officers?

Mr BARKER: Salaried officers would be involved in the normal TMF issue as they are our employees.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. But should the hospital and the doctor be sued at the same time, obviously it is in the doctor's interests to have his or her own representation.

Mr BARKER: We indemnify them as our employee. If they wish to have their own professional advice, that would be something they would normally do of their own volition or on advice from their other association.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there might be a tendency to put the blame on them, as opposed to some system failure, which is of course very important in medical misadventure.

Mr BARKER: I think you are taking a broader view. It is certainly a case-by-case issue in terms of looking at what the issue is. One of the principles of open disclosure and early notification of incidents is to try to institute corrective action as soon as possible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am all for that.

Mr BARKER: It is done in an environment of no blame. It is not done in an environment of "Let's find someone to blame." That is not the objective at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No. That is a separate issue. The issue of separate representation is very important in terms of the confidence of the staff.

Mr BARKER: We normally do not provide separate legal advice for staff to be represented. They are represented as part of the TMF. As I said, if they are unhappy with that, they can seek their own advice or go to their own professional association. We do not have as a policy that they can seek their own professional advice and we will pick up the cost of that professional advice. That is not a normal part of our practice.

CHAIR: Are there any questions from Government members? No. Out of interest, when did the person who has been on the surgery waiting list the longest actually go on the waiting list?

Ms KRUK: Do you have the answer?

CHAIR: No.

Ms KRUK: I go back to the answer I gave in relation to the average times. All I can do is make the commitment in relation to working with the surgeons to look at what we can do in relation to the efficiency of the system.

CHAIR: But you are also going to answer the question taken on notice?

Ms KRUK: Off the top of my head, I cannot. If you would like me to have a look at it, I am happy to do so.

CHAIR: I would like you to take the question on notice.

The Hon. MELINDA PAVEY: In relation to amalgamations of area health services, there has been an announcement by the Minister that there will be a special subcommittee to oversee the transition to the extended area health service. Has any consideration been given to a similar initiative, particularly in the Hunter/New England amalgamation? There has been a lot of community concern, particularly in that region, to ensure that outlying hospitals and medical services do not feel alienated along the lines expressed by the Far Western Area Health Service.

Ms KRUK: I think members are aware of the concerns raised by the Broken Hill community and in a number of other parts of the State.

The Hon. MELINDA PAVEY: It is very similar with Armidale and Tamworth.

Ms KRUK: The process that is under way at the moment has been a very consultative one in relation to the unions. The setting up of the Health Care Advisory Council at local level as well I think will provide some oversight in that regard.

The Hon. MELINDA PAVEY: I am referring to the far western area.

Ms KRUK: I think members are aware of the far western situation. The discussions are under way, and the consultations are at local level. In relation to New England and Hunter, I am conscious of a number of the concerns of Tamworth, having met with Tamworth clinicians—although, interestingly enough, their concerns related more to clinical services, and I think they have been somewhat heartened by the work that has already taken place, because that obviously is part of the clinical services planning. On the issue of the impact on jobs, similarly, I think the setting up of the Health Care Advisory Council gives solid foundation to the community about the spread of jobs throughout the area. The CEO of that area, Terry Clout, I think has a very good history of doing that in a very open manner with the community, as is very much necessary anyway. Members would know that better than I. I think it has been a useful exercise to date in the far western area. It is something that we need to be conscious of.

The Hon. MELINDA PAVEY: So your options may be open for New England?

Ms KRUK: We have not closed the door to it. In the far west there were a number of concerns vis-à-vis the ongoing provision of services to the indigenous community. There were specific issues that were raised.

The Hon. MELINDA PAVEY: And the unions in Broken Hill.

Ms KRUK: The unions at Broken Hill and the concerns of a number of groups in Greater Murray.

CHAIR: Before we conclude, I should note that we have resolved that the return of answers for any of the questions taken on notice is 35 calendar days. There is an issue about whether we require anybody back for any future hearings. I can indicate that there is a very good chance that that will be unlikely before the Parliament resumes on 22 February next year.

Ms KRUK: Madam Chair, thank you for your kindness in noting the reporting back on answers. My staff were concerned that they might have to do that work before Christmas.

(**The witnesses withdrew**.)

The Committee proceed to deliberate.